Sentencing Council

Final Resource Assessment

Overarching Principles: Sentencing Offenders with Mental Disorders, Developmental Disorders, or Neurological Impairments

Introduction

This document fulfils the Council's statutory duty to produce a resource assessment which considers the likely effect of its guidelines on the resources required for the provision of prison places, probation and youth justice services.[1]

Rationale and objectives for new guideline

There is currently no guideline for sentencing offenders with mental disorders, developmental disorders or neurological impairments, and little other guidance to use. A lack of guidance could lead to inconsistencies in the way these offenders are sentenced, and there is an increasing public and media focus on mental health and associated issues generally. Therefore, the Council is proposing a new guideline for courts to use when sentencing offenders with such conditions.

The Council's aim in developing the new guideline has been to consolidate and explain information which will assist courts to pass appropriate sentences when dealing with offenders who have mental disorders, developmental disorders or neurological impairments, and to promote consistency of approach in sentencing.

Scope

As stipulated by section 127 of the Coroners and Justice Act 2009, this assessment considers the resource impact of the guideline on the prison service, probation service and youth justice services. Any resource impacts which may fall elsewhere are therefore not included in this assessment.

This resource assessment covers adult offenders with any of the disorders covered by the guideline (for the full list of disorders, see Annex A of the guideline). The guideline does not apply to sentencing children and young people. This is because mental disorders and related issues can be substantially different in both diagnosis and impact for children and young people, so it would be difficult to adequately accommodate all the considerations for all ages within one guideline.

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[1] Coroners and Justice Act 2009 section 127: www.legislation.gov.uk/ukpga/2009/25/section/127

Current sentencing practice

Any offender sentenced for a criminal offence may have a mental health issue, but it is not possible to identify from the MoJ Court Proceedings Database (one of the main sources of data on sentencing practice), which offenders have one. Instead, a summary of statistics and research related to offenders' mental health is presented below and in the Annex to this report. There are many sources of information covering a wide range of areas related to mental health issues, and therefore this summary mainly focuses on the areas covered by the guideline, and statistics related to the Council's statutory duty to consider the likely effect of its guidelines on the resources required for the provision of prison places and probation services.[2]

Crown Court Sentencing Survey (CCSS)

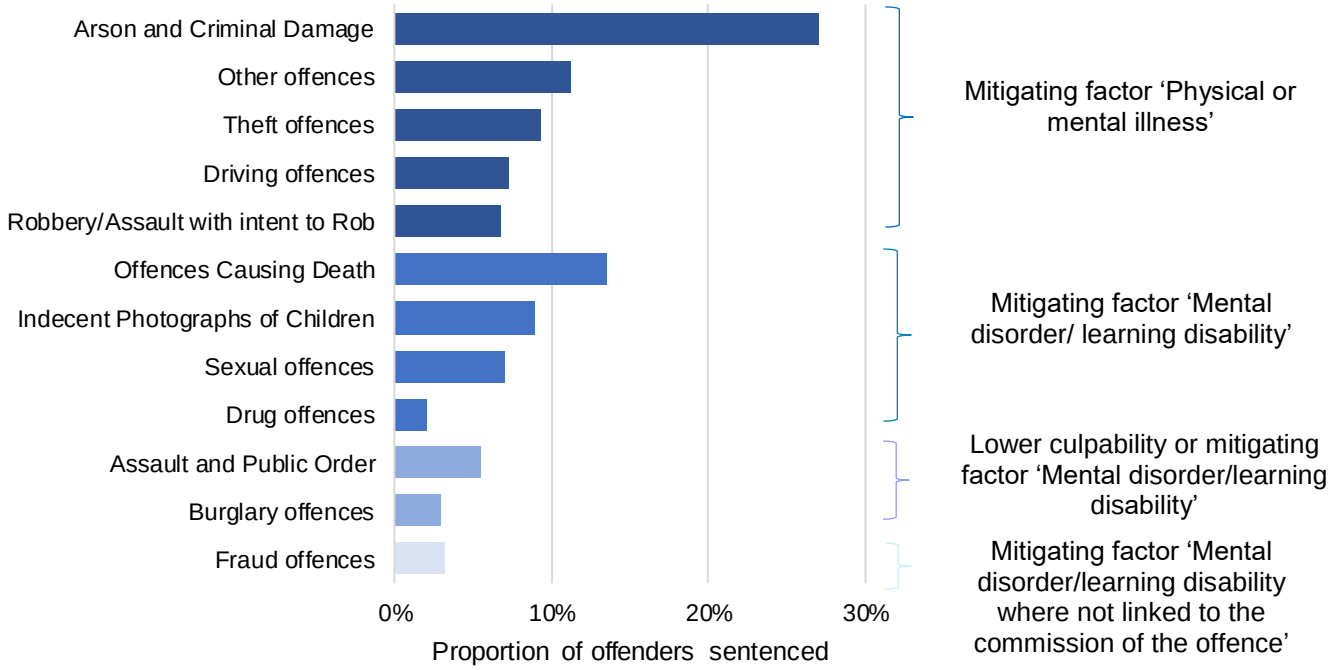
The Crown Court Sentencing Survey (CCSS)[3] included some information about sentences where mental illness or learning disorders were a feature. As part of the survey, judges were asked to record the factors taken into account when reaching the sentence imposed; these included lower culpability factors or mitigating factors around mental illness or learning disorders. The wording of these factors differed across different offences, and these differences in wording are shown in the labels to the right of Figure 1.

Based on the CCSS data, Figure 1 shows how frequently factors around mental illness and learning disorders were cited in sentencing, for different offences. The analysis shows that these factors were most frequently cited for the offences of arson and criminal damage, followed by offences causing death. However, it should be noted that these figures should be treated with caution, because in some cases the factor on the CCSS form grouped together both physical and mental illness, and it is therefore not possible to identify how often factors relating solely to mental illness were cited. In addition, there may be some instances where an offender did have a mental illness, but this was not identified and therefore was not taken into account in sentencing, or it may not have been recorded on the CCSS form.

[2] The Council also has a statutory duty to consider the impact on youth justice services, however the guideline applies to offenders aged 18 and older, and therefore will not have an impact in this area.

[3] From 1st October 2010 to 31st March 2015 the Council conducted the Crown Court Sentencing Survey (CCSS), which collected data on sentencing practice in the Crown Court.

Figure 1: Proportion of Crown Court Sentencing Survey forms where factors around mental illness and learning disabilities were cited in sentencing, 2014[4,5,6,7]



The underlying data for Figure 1 can be found on the Sentencing Council website at the following link: https://www.sentencingcouncil.org.uk/analysis-and-research/crown-court-sentencing-survey/record-level-data/

National Audit Office (NAO)

The National Audit Office published a report about mental health in prisons in 2017.[8] The report states that the number of people in prison who have a mental illness is unknown, but it cites several statistics around mental illness in prisons, including:

[4] 'Other offences' covers a wide range of offences, including possession of offensive weapons, breach of a protective order, perverting the course of justice, possession/distribution of prohibited weapons or ammunition and other offences.

[5] The figure on sexual offences covers sexual offences sentenced between 1 April 2014 and 31 December 2014. The period from 1 January 2014 to 31 March 2014 is not included, because in April 2014 the Sentencing Council's Sexual Offences guideline came into force, and the CCSS form was changed to reflect the new guideline. The period before the guideline came into force is therefore not comparable to the newer data, and has not been included in this analysis for this figure.

[6] Fraud offences refer to fraud, money laundering and bribery offences. The figure for fraud offences covers offenders sentenced between 1 October 2014 and 31 December 2014, as the Sentencing Council's Fraud, Bribery and Money Laundering guideline came into force on 1 October 2014 and so the CCSS form was changed to reflect the new guideline. Prior to 1 October 2014, these offences were captured on the Theft offences form (for which the full title was 'Theft, dishonesty and fraud offences').

[7] For Assault and Public Order and for Burglary, the figures represent those forms where either the lower culpability factor 'Mental disorder/learning disability where linked to the offence' or the mitigating factor 'Mental disorder/learning disability where not linked to the offence' were ticked.

[8] https://www.nao.org.uk/report/mental-health-in-prisons/

- In March 2017, NHS England's performance monitoring data showed that 7,917 prisoners, or 10% of the adult prison population in England, were receiving treatment for mental health problems although there might be people receiving treatment who are not included in these data.
- Around 37% of the average monthly prison population in England and Wales report having mental health or emotional well-being issues at any one time, based on HM Inspectorate of Prisons surveys.
- The most commonly used estimate is that 90% of the prison population are mentally unwell, but this figure comes from a study published in 1998 and uses a broader definition of mental illness than many clinicians would recognise.

The report also states that the available evidence suggests that people in prison are more likely to suffer from mental health problems than the general population.

Ministry of Justice (MOJ) statistics

Identified needs of offenders in custody and the community

MOJ published ad-hoc statistics on the identified needs of offenders, in June 2018.[9] These statistics are available for offenders who have had an Offender Assessment System (OASys) Layer 3 (full) assessment in custody or in the community.[10] OASys Layer 3 coverage is most comprehensive for offenders serving longer sentences, for example OASys information is available for over 90 per cent of individuals serving extended determinate and indeterminate sentences, and those recalled to custody, while coverage is below two-thirds (64 per cent) for those serving under four years in custody.

These statistics show that, of those with an OASys Layer 3 assessment and in custody at 30 June 2018, around 12 per cent were identified as having a mental health problem. For those in the community (those serving community orders, suspended sentence orders, on licence or post sentence supervision), around 11 per cent were identified as having a mental health problem.

Community orders and suspended sentence orders with mental health, alcohol and drug treatment requirements

MOJ publishes probation statistics on the use of community orders (COs) and suspended sentence orders (SSOs) where mental health, alcohol and drug treatment requirements are attached to the order.[11]

These statistics show that in 2019, 0.7 per cent (500) of offenders who started a CO had a mental health treatment requirement attached to the order. For SSOs, the proportion was 0.8 per cent (240 offenders). For alcohol treatment requirements, the

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[9] See tables 1a and 1b, Identified needs of offenders in custody and the community from OASys tables: https://www.gov.uk/government/statistics/identified-needs-of-offenders-in-custody-and-the-community-from-oasys

[10] Offenders in prison may be assessed by a trained staff member under the Offender Assessment System (OASys), and part of this assessment involves determining the offenders' mental health needs. Offenders may receive a risk assessment referred to as a 'Layer 1' or a more detailed risk and needs assessment referred to as 'Full' or 'Layer 3'. This will depend on a number of factors including risk of harm and sentence length.

[11] See 'Probation: 2019' table A4.9, Offender Management Statistics Quarterly: https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2019

proportions were 4.8 per cent (3,600) and 5.2 per cent (1,600) respectively, while for drug treatment requirements the proportions were 6.0 per cent (4,400) and 7.7 per cent (2,400) respectively.

Hospital orders

A mentally disordered offender may be diverted from custody to hospital for treatment by a court under the Mental Health Act 1983.

MOJ publishes statistics on hospital orders and restricted patients, which include figures on the number of offenders admitted to hospital under a hospital order without a restriction order (a section 37 order without a section 41 restriction), a hospital order with a restriction order (a section 37 order with a section 41 restriction) and a hospital and limitation direction (a section 45A order).[12,13]

The statistics show that around 260 adult offenders were admitted under a hospital order (without a restriction order) in 2019. From 2009 to 2010, the number increased from 460 to 540, while since 2010 the numbers have generally been decreasing.[14]

MOJ's published statistics on restricted patients show that around 250 offenders were admitted under a hospital order with a restriction order in 2019. Over the past decade, the number of offenders admitted has gradually been decreasing, from 360 offenders admitted in 2009. The statistics also show that around 30 offenders were admitted under a hospital and limitation direction in 2019. Over the past decade, the number of offenders admitted has generally been increasing, from five offenders admitted in 2009.[15,16]

Additional statistics relating to the frequency of specific mental health conditions can be found in the annex to this report.

Key assumptions

To estimate the resource effect of a new guideline, an assessment is required of how it will affect aggregate sentencing behaviour. This assessment is based on the objectives of the new guideline, and draws upon analytical and research work undertaken during guideline development. However, some assumptions must be made, in part because it is not possible precisely to foresee how sentencers' behaviour may be affected across the full range of sentencing scenarios. Any

[12] NHS digital also publish statistics on detentions under these Acts, although data from 2016/17 onwards is incomplete and therefore only the MoJ statistics have been included in this document. The NHS digital figures can be found in table 1a of the Annual Mental Health Act Statistics publication: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures

[13] See Section Three and Annex C of the guideline for further information on section 45A orders.

[14] Figures on hospital orders (without restrictions) are published in the Criminal Justice System statistics quarterly publication outcomes by offence tool: https://www.gov.uk/government/statistics/criminal-justice-system-statistics-quarterly-december-2018

[15] Figures on hospital orders (with restrictions) and hospital and limitation directions are published in the restricted patients publication, part of the Offender Management Statistics quarterly publication: https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2019

[16] See Section Three and Annex C of the guideline for further information on hospital orders and restriction orders.

estimates of the impact of the new guideline are therefore subject to a substantial degree of uncertainty.

The resource impact of a new guideline is usually measured in terms of the change in sentencing practice that is expected to occur as a result of it. For this to be possible in this case, detailed information on current sentencing practice is required. In developing this guideline an understanding of current sentencing practice has been formed by considering Court of Appeal judgments, and through discussions with interested organisations and experts, and the experience of Council members. Analysis of data on mental health has been reviewed and findings from this work have been used to estimate the impact of the guideline on sentencing practice.

It remains difficult to estimate with any precision the impact the guideline may have on prison and probation resources. To support the development of the guideline and mitigate the risk of the guideline having an unintended impact, research interviews were undertaken with sentencers during the consultation period, and these provided more information on which to base the final resource assessment. The Council also included a question in the consultation document, asking for consultees' views on the potential impact of the proposals.

Resource impacts

This section should be read in conjunction with the guideline available at: http://www.sentencingcouncil.org.uk.

Summary

The aim in developing the guideline has been to consolidate and provide information which will assist courts to pass appropriate sentences when dealing with offenders who have mental disorders, developmental disorders or neurological impairments, and to promote consistency of approach in sentencing.

The intention is that the new guideline will encourage consistency of sentencing through bringing together information on these disorders and impairments in one place. The intention is not directly to cause changes to sentencing practice. However, it is possible that by bringing this information together in a guideline for the first time, there may be an impact on sentencing practice, and this has been explored through

consultation stage research interviews[17] and a review of written responses to the consultation.[18]

Both the interview findings and a review of consultation responses showed that there was a perception from some that the guideline would not have an impact on sentencing, while others thought that there could be a change (for example, an increased use of lower culpability factors and mitigating factors relating to mental health, a decrease in sentencing severity, and an increased use of medical reports in the Crown Court and of some community sentence requirements). However, while there was a perception from some that there could be some changes in these areas, the interview findings also showed that when sentencers were given scenarios to sentence under current practice and then under the draft guideline, there was no clear evidence of any changes in sentencing practice. Therefore, the guideline is not expected to have an impact on these areas.

For hospital orders, it was generally thought that the guideline would not have an impact, as the guideline reflects current legislation and recent case law in this area. Therefore again, the guideline is not expected to have an impact on the use of hospital orders.

Interview participants felt that the guideline was part of wider trends of moving towards a more understanding approach to these disorders and impairments throughout the criminal justice system. Many of the consultation respondents felt that the guideline would improve consistency of sentencing, with some others commenting that it would increase transparency. Therefore, it may be that the guideline is part of a wider focus on offenders' mental health, which may gradually change the way that mental health is treated in the criminal justice system.

The following sections give further details about the expected resource impacts of the guideline in the areas discussed above.

Impact on sentencing severity

The guideline states that the presence of a mental health condition may mean that the offender's culpability is significantly reduced, but in others the condition may have no relevance to culpability. This may mean that offenders with a mental health condition could be less likely to receive immediate custodial sentences, and more likely to receive a CO or SSO.

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[17] A total of 29 sentencers (13 Crown Court judges, 3 district judges and 13 magistrates) took part in a two-stage exercise, designed to see whether sentencing behaviour might change as a result of using the new guideline. In the first stage, participants were asked, via an online survey, to sentence two scenarios as they would if they came before them in court today, answering some detailed questions about the process and outcome as they went along. In the second stage, several weeks later, participants were interviewed about the same scenarios. They were asked to read the draft Mental Health Overarching Principles (the draft version at that time) beforehand, and then re-sentence the same scenarios, this time with the aid of the new guideline, describing their decision-making as well as the sentence outcome for each offender. In addition to this exploration of likely sentencing behaviour, participants were asked about their opinions on whether the guideline would have certain effects in relation to sentencing. As with all our qualitative work, the sample size was small and self-selecting, which means the findings cannot be considered representative of all judges and magistrates. However, they provide an insight into how these groups may use and respond to the guideline.

[18] The review is based on the 73 responses received to question 15 of the consultation document: 'What, if any, do you think the impact of the guideline might be on sentencing practice?'. In total, 110 responses were received to the consultation overall.

Some interview participants and consultation respondents felt that the guideline might lead to increased use of the culpability and mitigating factors relating to mental health in the offence specific guidelines, whilst others thought that there would be no change. However, mental illness is already a lower culpability or mitigating factor in Sentencing Council guidelines, and statistics presented earlier in this report show that these factors are already taken into account in sentencing. Therefore, the guideline is expected to reflect current sentencing practice in this respect.

Although there was a perception from some that the guideline could reduce sentencing severity, the interview findings also showed that when sentencers were given scenarios to sentence under current practice and then under the draft guideline, there was no clear evidence of any changes in sentencing practice; end sentences generally remained similar. Therefore, the guideline is not expected to cause any change to sentencing severity.

Impact on the number of Mental Health Treatment Requirements (MHTRs)

The guideline states that courts may consider a MHTR attached to a CO as an alternative to a short or moderate custodial sentence, and that they may also wish to consider a drug rehabilitation requirement (DRR) and/or an alcohol treatment requirement (ATR) in appropriate cases. Interview findings suggested that generally sentencers did not think that the guideline would change the number of mental health disposals used in sentencing, because the use of these requirements was constrained by their availability in the community. This finding was supported by some consultation respondents, who felt that resource constraints would mean that the guideline would not have an impact, although some consultation respondents did anticipate an increase.[19]

The interview findings also showed that when sentencers were given scenarios to sentence under current practice and under the draft guideline, there was no evidence of any change in the use of these requirements. Therefore, the guideline is not expected to change the numbers of MHTRs, DRRs or ATRs.

The Council is also aware of a recent protocol developed by MOJ and several other agencies to increase the use of community sentence treatment requirements in courts in five parts of England,[20] and a commitment made to expand this provision in the NHS Long Term Plan.[21] Any increases to the number of requirements are therefore expected to be due to this provision, and not due to the guideline.

Impact on the number of medical reports ordered by courts

The guideline states that where the offender is or appears to be mentally disordered, the court must obtain and consider a medical report before passing a custodial sentence other than one fixed by law, unless, in the circumstances of the case, the court is of the opinion that it is unnecessary. The guideline reflects the legislation on medical reports, and it is assumed that in most cases, courts currently obtain and consider medical reports where this is the case.

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[19] These respondents did not give a view as to whether this could be affected by resource constraints.

[20] https://www.gov.uk/guidance/healthcare-for-offenders

[21] See Appendix, point 11: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

This assumption is supported by the interview findings which showed that when sentencers were given scenarios to sentence under current practice and under the draft guideline, there was no clear evidence of any change in the likelihood of asking for a medical report. The research also found that sentencers did not think there would be a change in requests for medical reports in magistrates' courts because of resource constraints, however some thought there could be an increase in requests for medical reports in the Crown Court. A small number (who all represent sentencing in magistrates' courts) of consultation respondents commented on the use of medical reports, saying that they did not think there would be an impact on the number of medical reports required, again due to resource constraints.[22]

Given that there was no evidence that requests for medical reports would change under the draft guideline, the guideline is not expected to cause a change in the number of medical reports required. It should also be noted that there are no available data on the number of medical reports currently ordered by courts,[23] therefore it would not be not possible to estimate any impact on the number of medical reports which may be required.

Impact on the number of offenders given hospital orders

The guideline provides a summary of the orders available to courts under the Mental Health Act 1983, and provides further details of these in Annex C of the guideline. The guideline outlines the legislation in relation to these orders, and also reflects recent case law in this area.[24] It is assumed that the legislation is currently being applied when sentencing offenders to such orders, and previous analysis of cases suggests that recent case law is also already reflected in current sentencing practice.[25] In addition, interview findings suggested that sentencers felt the needs of offenders requiring hospital orders were already very clear, and therefore there would be no change to the number of hospital orders required.[26] Therefore the guideline is not expected to have any impact on the number of offenders sentenced to hospital orders.

Risks

Risk 1: The Council's assessment of current sentencing practice is inaccurate

An important input into developing sentencing guidelines is an assessment of current sentencing practice. The Council uses this assessment as a basis to consider whether current sentencing levels are appropriate or whether any changes should be made. Inaccuracies in the Council's assessment could cause unintended changes in sentencing practice when the new guideline comes into effect. This is a bigger risk

[22] No responses were received regarding the impact in the Crown Court.

[23] Information on the numbers and costs of psychiatric assessments is not held centrally and is therefore not available: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2018-09-03/169395/

[24] R v Vowles and others [2015] EWCA Crim 45 and R v Edwards and others [2018] EWCA Crim 595

[25] See paras 6.16 to 6.18 of the Sentencing Council's Resource Assessment for manslaughter: https://www.sentencingcouncil.org.uk/wp-content/uploads/Manslaughter-resource-assessment-3.pdf

[26] There were very few consultation responses regarding the impact on hospital orders. One respondent thought there could be an increase in the use of s38 interim orders, while another thought there would be little change.

for this guideline, because so little information is available on current sentencing practice.

This risk is mitigated by information that has been gathered by the Council as part of the consultation phase. This included research interviews undertaken with sentencers as part of the consultation exercise, where case scenarios were used to explore whether the draft guideline had the intended effect. However, there are limitations on the number of factual scenarios which can be explored, so the risk cannot be fully eliminated. The Council also included a question in the consultation document, asking for consultees' views on the potential impact of the proposals. This information has provided further information on which to base the final resource assessment.

Risk 2: Sentencers do not interpret the new guideline as intended

If sentencers do not interpret the guideline as intended, this could cause a change in the average severity of sentencing, with associated resource effects.

The Council takes a number of precautions in issuing a new guideline to try to ensure that sentencers do interpret it as intended. As discussed above, research interviews were carried out during the consultation period to enable issues with implementation to be identified and addressed prior to the publication of the definitive guideline. Consultees also fed back their views of the likely effect of the guideline, and whether this differed from the effects set out in the consultation stage resource assessment.

Data collected as part of the Sentencing Council's data collection exercises will help the Council to monitor the guideline, compare sentencing practice before and after the guideline, and to ensure any divergence from its aims is identified and rectified.

Annex: Further statistics on offenders with mental health conditions

The *Overarching Principles: Sentencing Offenders with Mental Disorders, Developmental Disorders, or Neurological Impairments Guideline* covers many mental health conditions and disorders. An explanation of these conditions is provided in Annex A to the guideline, and a summary of some of the statistics available on these conditions is provided below. These statistics have been collected as part of the guideline development and do not form part of a systematic search (or literature review), but are included to give some further context about the conditions listed in Annex A to the guideline. There may be other sources of data on the frequency of these conditions which may differ from those presented below, and therefore these statistics should not be treated as comprehensive.

Where possible, statistics have also been included on the frequency of these conditions in the general population, although it should be noted that in some cases the figures will not be directly comparable due to the different ways that data have been collected for the separate groups.

Autism and Autistic Spectrum Disorder

The National Autistic Society have found that although the exact number of autistic people in UK prisons is not known, they represent 4.5 per cent of the population at Her Majesty's Young Offender Institution in Feltham.[27]

Another source of statistics on this subject comes from data collected by liaison and diversion services. These services identify people who have mental health needs, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. The data shows that four per cent of adults engaging with liaison and diversion services in 2017/18 were identified with a social and communication difficulty (including autism spectrum disorder).[28]

The Adult Psychiatric Morbidity Survey (APMS) series provides data on the frequency of psychiatric disorder in the English population aged 16 and over. Although the data are not directly comparable to the above figures, the APMS from 2014 (the latest data available) found that the frequency of Autism Spectrum Disorder in the survey was estimated to be around 0.8 per cent.[29,30]

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[27] https://www.autism.org.uk/get-involved/media-centre/news/2016-10-19-feltham.aspx

[28] See page 27 of the Ministry of Justice's Women and the Criminal Justice System publication: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759770/women-criminal-justice-system-2017..pdf

[29] See APMS 2014: Chapter 6 – Autism: https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

[30] This figure was calculated by combining the data from the 2007 and 2014 AMPS surveys to generate a larger sample for analysis.

Attentional deficit hyperactivity disorder (ADHD)

Sussex Partnership NHS Foundation Trust found that studies using screening questionnaires estimated that up to 50 per cent of adult prisoners have had childhood ADHD, with approximately 10-25 per cent remaining symptomatic.[31]

The APMS from 2014 provides general population data on ADHD in individuals aged 16 and over in England. This found that 9.7 per cent of those in the survey screened positive for ADHD.[32] However, the APMS data is not directly comparable to the above figures.

Dementia

The Prison and Probation Ombudsman published a Learning Lessons Bulletin exploring the experience of prisoners with dementia in 2016.[33] The report found that the number of prisoners affected with dementia is unknown, although they referenced the Mental Health Foundation who estimated that it affected approximately five per cent of detainees over 55 years old[34] (as of 31 March 2020 there were 13,764 persons aged 50 or over in prison across all custody categories, of whom 5,176 were aged 60 and over).[35]

Worldwide, the estimated proportion of the general population aged 60 and over with dementia at a given time is between five and eight per cent.[36] These data are not directly comparable to the above figures.

Personality Disorders

A survey on psychiatric morbidity among prisoners in England and Wales from 1997, commissioned by the Department of Health,[37] estimated that the frequency of personality disorder was 78 per cent for the male remand population, 64 per cent for the male sentenced population and 50 per cent in the female prison population.[38] Antisocial personality disorder was the most common form of personality disorder (psychopathy is considered a severe form of antisocial personality disorder). [39]

A survey on psychiatric morbidity among adults aged 16-74 living in private households in Great Britain from 2000, which used the same method to assess

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[31] http://www.sussexpartnership.nhs.uk/sites/default/files/documents/6._prevalence_of_adhd_in_prisoners_and_effectiveness_of_treatment_with_atomoxetine.pdf

[32] See APMS: Chapter 8 in footnote 29 for a link to the full report.

[33] http://www.ppo.gov.uk/app/uploads/2016/07/PPO-Learning-Lessons-Bulletins_fatal-incident-investigations_issue-11_Dementia_WEB_Final.pdf#view=FitH

[34] Mental Health Foundation (2013) Losing track of time: Dementia and the ageing prison population: treatment challenges and examples of good practice. Available online: https://www.mentalhealth.org.uk/publications/losing-track-time

[35] See Offender Management Statistics Quarterly: October to December 2019, 'Prison Population: 31 March 2020' Table 1.3 https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2019

[36] https://www.who.int/news-room/fact-sheets/detail/dementia

[37] See full report here: http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-prisoners/psychiatric-morbidity-among-prisoners--summary-report/psychiatric-morbidity---among-prisoners--summary-report.pdf

[38] Figures in the report were only available for the female prison population overall, and were not broken down further into the female remand and female sentenced populations.

[39] See footnote 37 for a link to the full report.

personality disorder as the survey among prisoners, found that the frequency of personality disorder among adults in private households was around four per cent.[40]

Post-Traumatic Stress Disorder (PTSD)

The survey on psychiatric morbidity among prisoners in England and Wales from 1997, commissioned by the Department of Health, estimated that the frequency of PTSD was five per cent in the male remand population, three per cent in the male sentenced population, nine per cent in the female remand population and five per cent in the female sentenced population.[41]

PTSD was not specifically measured in the survey on psychiatric morbidity among adults living in private households, and therefore a comparison to the general population has not been made.

Substance misuse disorders

The Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners looked at the experiences of a sample of prisoners sentenced in 2005 and 2006. The survey found that 19 per cent of prisoners who drank alcohol in the year before custody reported needing help for an alcohol problem. Of those who had drunk alcohol in the four weeks before custody, nearly half (46 per cent) reported having some concern about their drinking.[42]

The SPCR also found that 81 per cent of adult prisoners reported using illicit drugs at some point in their lives, including almost two-thirds (64 per cent) within the month before entering prison.

The survey on psychiatric morbidity among prisoners in England and Wales from 1997, commissioned by the Department of Health, estimated that the frequency of hazardous drinking in the year prior to entering prison was 58 per cent in the male remand population, 63 per cent in the male sentenced population, 36 per cent in the female remand population and 39 per cent in the female sentenced population. The survey on psychiatric morbidity in private households in 2000, which used the same method to assess hazardous drinking as the survey among prisoners, found that the frequency among adults in private households was around 26 per cent.[43]

The Offender Management Community Cohort Study (OMCCS) longitudinal cohort study of offenders[44] looked at the needs of offenders who started COs between October 2009 and December 2010. The study found that, based on OASys[45]

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[40] See table A.8 in the following report: https://webarchive.nationalarchives.gov.uk/20151014063541/http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-adults-living-in-private-households/2000/index.html

[41] See footnote 37 for a link to the full report.

[42] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/220060/gender-substance-misuse-mental-health-prisoners.pdf

[43] See footnotes 37 and 40 for links to the full reports.

[44] See Re-offending by offenders on Community Orders, table A.12: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/399388/reoffending-by-offenders-on-community-orders.pdf

[45] The Offender Assessment System (OASys) is a risk assessment and management system used to help Offender Managers identify the risks and needs of an offender in order to ensure that resources are allocated effectively.

administrative data, 41 per cent of offenders had an alcohol misuse need, while 13 per cent of offenders were identified with alcohol misuse needs based on behaviour reported to the survey[46] and 21 per cent reported that they needed help with alcohol misuse.

The OMCCS also found that 34 per cent of offenders had a drug misuse need, based on the OASys data, while 14 per cent were identified with drug misuse needs based on behaviour reported to the survey[47] and 19 per cent reported that they needed help with drug misuse, in the survey.

The survey on psychiatric morbidity among prisoners in England and Wales from 1997, commissioned by the Department of Health, estimated that the frequency of illicit drug use at any time of life was 85 per cent in the male remand population, 81 per cent in the male sentenced population, 77 per cent in the female remand population and 69 per cent in the female sentenced population. The survey on psychiatric morbidity in private households in 2000, which used the same method to assess illicit drug use at any time in their life as the survey among prisoners, found that the frequency among adults in private households was around 27 per cent.[48]

Schizophrenia

The survey on psychiatric morbidity among prisoners in England and Wales from 1997 found that the frequency of schizophrenia was two per cent in the male remand population, one per cent in the male sentenced population, and three per cent in the female prison population.[49,50]

The longitudinal study of the mental health of adults living in private households in Great Britain from 2001 noted that schizophrenia has a frequency within the community of less than one per cent.[51]

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[46] As outlined in the 2007 Alcohol Strategy, women who regularly drink over 35 units a week and men who regularly drink over 50 units a week.

[47] Defined as using a Class A drug weekly or more or injecting.

[48] See footnotes 37 and 40 for links to the full reports.

[49] See footnote 37 for a link to the full report.

[50] Figures in the report were only available for the female prison population overall, and were not broken down further into the female remand and female sentenced populations.

[51] https://webarchive.nationalarchives.gov.uk/20121006173334/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4060694.pdf