Mental Disorders and Deaths in Custody: Making the Case for Mental Health Literacy

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Introduction

The purpose of this research was two-fold. First, the review sought to investigate the potential link between mental disorders and deaths in custody, specifically exploring factors that might be associated with this link[1]. Second, the review sought to identify the level of knowledge and the attitudes to mental disorders of those working in custodial settings, on the basis that these changeable attributes could mitigate the risk of deaths in custody amongst those with mental disorders. While an overwhelming amount of evidence exists to link deaths in the custodial estate with mental disorders, evidence about the knowledge and attitudes of those working in these areas is quite limited.

Deaths in Custody – Scope of the Problem

For the purposes of this review deaths in custody refer to those deaths which occur in the secure youth estate (including secure children's homes, secure training centres, and young offender institutions) prisons, , immigration detention centres, in or following police custody, deaths of residents in approved premises anddeaths of those detained under the Mental Health Act (MHA). Between the years 2000 to 2012 there were 7,122 deaths in state custody, or an average of 548 deaths per year, and these appear to occur most commonly amongst those detained in secure hospitals and in prisons, and least often in immigration detention centres and secure settings for children[2]. A more accurate picture of the likelihood of a death in custody would be provided by the rate of deaths in custody, for example, the rate of deaths in prison per 1000 people held in prison. However, it is often difficult to determine these rates because some custodial sectors do not regularly record or report information on all those held in custody (IAP, 2014).

[1]This review covered the time period up to December 2013. Therefore, recent developments such as the HMIC thematic review of vulnerable people in custody and the Mental Health Crisis Care Concordat are not reviewed here.

[2]There were no deaths in any secure settings for children in 2012 and one in immigration removal centres.For a review of deaths across the custodial estate see IAP, 2014.

There is consistent information available about who is in prison (and young offender's institutions), as well as some more limited information about who is detained under the mental health act (MOJ, 2012; CQC, 2014). This is helpful to provide some context to the rate of deaths in custody in these sectors. Figure 1 shows the rate of deaths in prison per 1000 prisoners. For example, in 2000 there were 146 deaths in custody and 64,602 people in prison, equivalent to a rate of 2.26 deaths in prison per 1000 prisoners. It can be seen that the rate of deaths in custody per 1000 prisoners has stayed fairly constant (between 1.96 and 2.98) between 2000 and 2012.

Figure 1. Rate of Deaths in Prison per 1000 in Prison

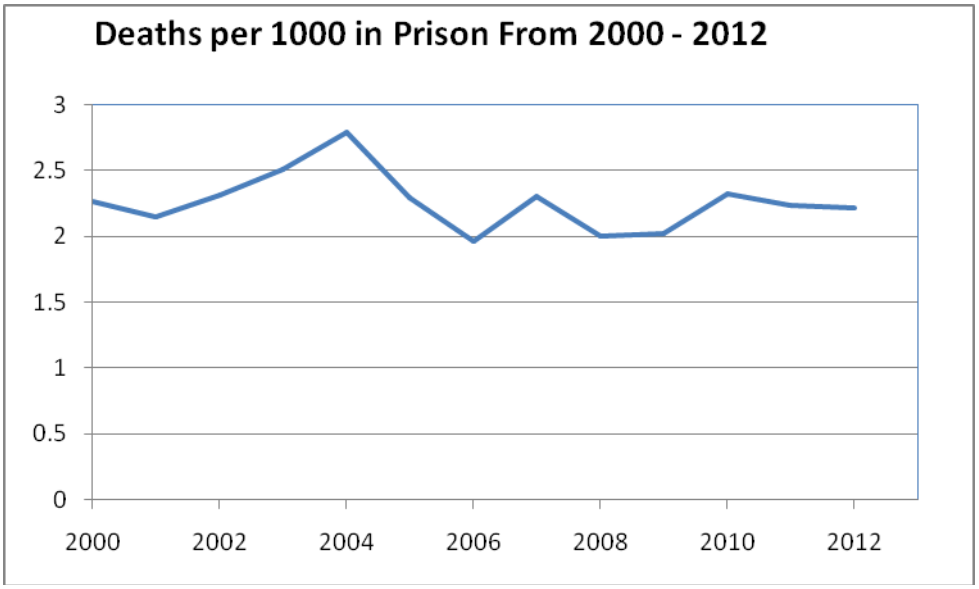
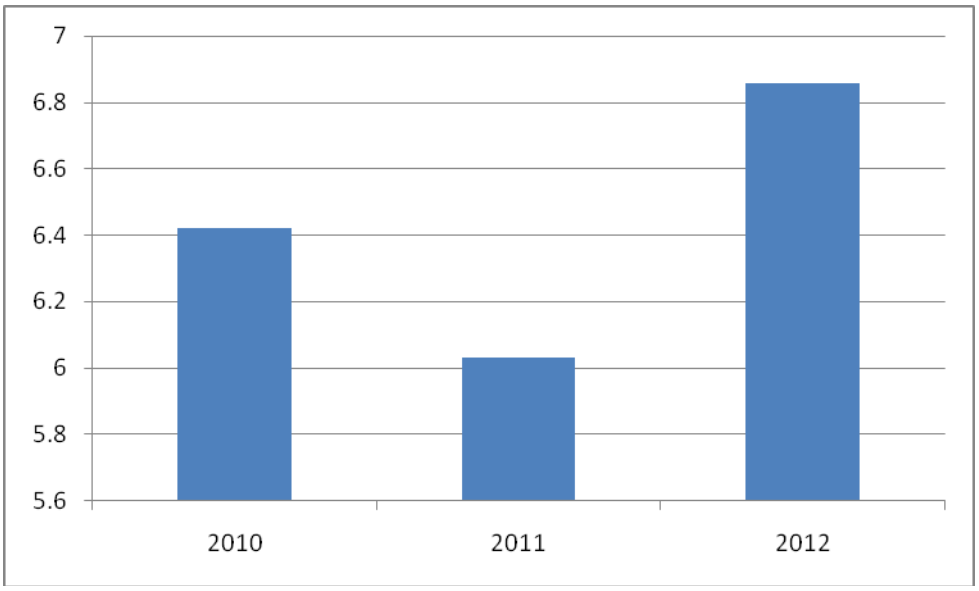


Figure 2 shows the rate of deaths in custody per 1000 patients detained under the mental health act for the years in which data was available (2010 – 2012). It can be seen that the rates of deaths in custody in this custodial setting are on average higher than in prison, however, caution should be taken when comparing rates of deaths in custody across custodial sectors. This is because the populations within these sectors might differ in key factors associated with deaths in custody. For example, those detained under the mental health act might be more likely to be older and therefore more likely to die of natural causes than those in prison. In addition, there is evidence to suggest that psychiatric patients have considerably worse general health than others, including aspects of their lifestyle (e.g. smoking, poor diet, lack of physical activity), and the association between mental

disorders and other physical illnesses (e.g., cardiovascular disorders in males and respiratory illnesses in females; Cormac, Davis & Ferriter, 2004).

Figure 2. Rate of Death in Custody per 1000 Patients Detained.



Literature Search

The literature search involved examining both the academic and non-academic literature on the potential relationship between mental disorders and death in custody using a specified set of search terms. This strategy needed to be revised slightly because the overwhelming amount of information that was being returned was only loosely related to the role of mental disorders and deaths in custody. The search terms were refined and only the most relevant articles were obtained and reviewed (see Appendix A for more detail about the literature review). It is important to note that there have been a small number of relevant studies and there may be questions about applicability to the UK context. Both the academic and non-academic literature was examined with key themes being drawn out. The key themes identified were:

- There is a clear link between mental disorder and deaths in custody, but the relationship is complex.

- Those with mental disorders are more likely to come into contact with the criminal justice system and be detained in custody than those without mental disorders.

- The experience of being detained in custody can elicit mental disorders and also exacerbate the symptoms of pre-existing mental disorders.

- The proportion of time that prison and police officers spend addressing the needs of those with mental disorders is very high, but the training for these roles contains relatively little training about mental disorders.

- Appropriate and considered care for those detained in custody and experiencing mental disorders can reduce the risk of deaths in custody, but this requires knowledge of mental disorders and their symptoms.

- There is very little research on the mental health literacy, or the knowledge or beliefs about mental disorders which aid their recognition, management or prevention (Jorm, et al 1997), of police or prison officers, and its applicability to the UK context is unclear. However, from the small evidence base available it would be reasonable to suggest that further research would be informative and point towards the possibility that mental health literacy could be improved.

Mental Disorders and Deaths in Custody

A considerable amount of both the academic and non-academic literature reviewed suggested that mental disorders and deaths in custody were linked (e.g., Brooker, Ullman & Lockhart, 2008; Corston, 2007; Edgar & Rickford, 2005; Hannan et al., 2010; NPIA, 2012; Shaw et al., 2013). Much of the relevant non-academic literature (reviewed in Appendix B) focussed on the prevalence of mental disorders amongst those in prison and highlighted the disconnect between the considerable additional care required by such individuals and the limited resources allocated to such individuals by many custodial establishments. This disconnect was viewed as a risk to neglecting the physical needs of the individual, as well as the individuals' increased risk of self-harm and suicide. For example, in their report for the Prison Reform Trust Edgar & Rickford (2009) suggested that mentally ill people often arrive

at prison without a proper assessment of their needs and that many prisons do not always have the specialist staff or resources to conduct such assessments. As a result mentally disordered individuals were being placed in segregation as the best available method of protecting the vulnerable person from the stresses of the general prison regime and to increase staff monitoring of the individual. The authors noted that segregation is known to be associated with an increased risk of self-harm and suicide amongst those with mental disorders.

Similarly, with reference to the police, Docking, Grace and Bucke (2011) suggested that about a half of all deaths in or following police custody involved individuals who had mental disorders. In some instances it was suggested that the individual's mental disorder put them at an increased risk of confrontation with police and this resulted in actions such as self-harm or suicide or restraint by the police which may have resulted in death. Also viewed as a risk were individuals held under Section 136 of the Mental Health Act 1983, which allow the police to detain a mentally disordered individual who is in immediate need of care or control, and remove them to a place of safety. This strategy was viewed as contributing to the risk of later death in custody as typically individuals are held in police cells, which can exacerbate their mental disorder and where there might be limited medical attention to address their needs.

In much of the non-academic research reviewing mental disorders and deaths in custody, mental disorder was equated with generally vulnerability and not with a specific diagnosed mental disorder.

Defining Mental Disorder

While there are established clinical classification systems (such as the Diagnostic and Statistical Manual and the International Classification of Diseases) and legal criteria (e.g., Mental Health Act, 2007), these definitions are not without considerable dispute, disagreement and controversy (e.g. Ullrich et al, 2008). When researchers make reference to the term 'mental disorder', they might be referring to specific disorders (such as depression or schizophrenia), but 'mental disorder' is not a specific condition. Mental disorder refers to an incredibly broad category of disorders of mind each with a number of potential symptoms (and severity of these symptoms), which can manifest themselves in different behaviours in different individuals.The implication of this is that certain mental disorders, or symptoms of certain mental disorders, might be more strongly related to death in custody than others, but this level of specificity should be treated cautiously. Table 1 show some of the specific mental disorders that have been linked with deaths in custody[3] along with a list of common symptoms and the research study which linked the diagnosis to death in custody[4].

Table 1. Diagnosed Mental Disorder and Death in Custody

Specific Diagnosis	Example Symptoms	Example Citation
Excited Delirium[5]	Paranoia, hyper-aggression, hallucinations.	Ho et al. (2009)
Major Depression	Feelings of worthlessness or guilt, insomnia, recurring thoughts of self-harm suicide	Marzano et al. (2010); Shaw et al. (2011)
Substance Abuse Disorders	Tolerance to, and or typical withdrawal symptoms of the substance.	Shaw et al. (2013)

[3]This is not an exhaustive list of all mental disorders that have been linked to death in custody, but these are some of the most commonly linked.
[4]Some of the research studies related to near-lethal episodes of self-harm rather than death.
[5]Excited delirium is a very contentious mental disorder and is not part of the common diagnostic devices such as the Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases (ICD) (Takeuchi et al., 2011)

Schizophrenia	Positive symptoms (delusions, hallucinations) and negative symptoms (flat affect, lack of motivation)	Rivlin et al. (2013)
Borderline Personality Disorder	Affect dysregulation, self-harm, suicidal behaviour.	Black et al (2007).

The issue of linking a specific mental disorder with deaths in custody is further complicated by the fact that an individual rarely is diagnosed with a single mental disorder. For example, in their study of 496 prisoners in England and Wales Ullrich et al. (2008) found that, of the 43 individuals who were identified as having a depressive disorder, 87% also met the criteria of having a personality disorder. This so-called co-morbidity, is particularly relevant to the study of deaths in custody as major depression and personality disorder were the two most common primary diagnosis in the case notes of those who committed suicide in prison in 2010 (Shaw et al., 2011). A similar level of co-occurrence of mental disorders has been noted cross-nationally (e.g. Abram & Teplin, 1991).

Mental Disorders and Police Custody

Compared to those without mental disorders, those who have mental disorders appear to essentially be fast-tracked into detention and custodial settings. This may be because of extraneous factors associated with mental disorders, such as increased homelessness, which might bring them to the attention of authorities. In combination, Section 136 of the Mental health act means that an individual can be detained on the grounds that they are in a public place (and those who are homeless spend significantly more time in public spaces) and 'appear to be suffering from mental disorder and in immediate need of care and control' (Bradley, 2009). There is no requirement that they were engaged in any activity that was potentially unlawful or even dangerous, although the detention is technically an 'arrest'

under the Police and Criminal Evidence Act. As part of a Section 136 the individual is to be taken to 'a place of safety', and while this should be a medical facility in practice the individual is commonly taken to a police cell, where on average, they spend longer than had they been arrested (Bradley, 2009). Additional fast-tracking of those with mental disorders has also been noted at the point of arrest. Studies have shown that police officers are more likely to arrest a person that is mentally ill if the same offence is committed by a non-mentally ill person. Furthermore, once arrested mentally ill individuals spend more time in detention both before and after their initial court appearance (Steadman, et al 1995).

It has been estimated that up to 25% of police time is spent dealing with those who have mental disorders (Glasper, 2014) and there have been several reviews of the relationship between mental health and deaths in police custody (e.g., Hannan, et al., 2010). It is widely accepted in these reviews that police custody is an unsuitable place for people with mental disorders, as highlighted by the Joint Parliamentary Committee on Human Rights (2004) and the IPCC in 2008:

> 'Police custody is an unsuitable environment for someone with mental illness and may make their condition worse, particularly if they are not dealt with quickly, appropriately and don't receive the care they need. The continued use of cells not only diverts police resources from fighting crime, but criminalises behaviour which is not a crime. A police cell should only be used when absolutely necessary, for example when someone is violent, and not as a convenience. (Bynoe, IPCC Commissioner, 2008). '

Despite this accepted wisdom, the evidence suggests that twice as many people with mental health issues are detained in police custody rather than at a hospital or another appropriate health care setting. However, there is large variation across the police forces in terms of using police custody as a place of safety for those detained under the Mental Health Act (e.g., Glasper, 2014). In 2011/12 and 2012/13 the IPCC reported that nearly half of the

deaths in or following police custody were of individuals who were detained under Section 136 of the Mental Health Act.

Acute alcohol misuse is a major issue amongst those coming to the attention of police, and it has been well established that those suffering from mental disorders are at a significantly increased risk of using alcohol to self-medicate (Fazel et al., 2006). For example, Bennett and Holloway (2004) estimated that some 69% of police detainees tested positive for illicit substances, and there are examples of individuals whose deaths in police custody were linked to alcohol or drugs (or both), who were not checked or roused as often as they should have been, and who were not adequately risk assessed because of their intoxication. An IPCC review (2010) found that different reasons were given for why there was no risk assessment at the police station, but that the most common reason was intoxication. This is particularly important since previous researchers have suggested that detainees should be risk assessed whether they show any signs of intoxication or not (Bucke et al, 2008). The IPCC recommended that police forces should adopt procedures to ensure that custody officers adhere to PACE code C with respect to risk assessing, checking and rousing. It should be emphasized that rousing involves the use of a stimulus to elicit a response from the detainee, and cell visits and checks are recorded in a timely and accurate manner. A detainee's unwillingness to participate in a risk assessment should be viewed as an indicator of risk.

In April 2014 a series of liaison and diversion services, were rolled out in ten areas across the England (Merseyside, London, Avon and Wiltshire, Leicester, Sussex, Dorset, Sunderland and Middlesbrough, Coventry, South Essex, and Wakefield) designed to ensure that those who have suspected mental disorders who come into contact with the police get

the correct treatment as soon as possible (NHS, 2014). These services will be evaluated, and if they are proven successful, will be rolled out across England in 2017.

Mental Disorder in Prison

The literature on suicide in the general community has identified mental disorder as one risk factor for committing serious self-harm and completing suicide (Williams 2001). Williams (2001) identifies two main methods for analysing the association between suicide and mental disorder: one involves following people with a psychiatric diagnosis prospectively to see if they are at increased risk of suicide and the other is to carry out psychological autopsy studies. Psychological autopsy studies involves interviewing significant others from the life of the person who has died. Indeed, Williams (2001) concludes that "the results of this method have been used to support the conclusion that the majority of suicides were suffering psychiatric problems beforehand" (Williams 2001, p. 46). One diagnoses associated with suicide is depression and it has been found that this diagnosis ranges from 29-88 per cent for people who complete suicide (Lonnqvist 2002). Psychosis (or schizophrenia) has also been associated with suicide and it is argued that people with psychosis are 40 times more likely to complete suicide (de Hert and Peuskens 2002). Other disorders associated with suicide in the general community are anxiety disorders (Allgulander 2002), alcoholism (Williams 2001), and personality disorders (in particular anti-social personality disorder, paranoid personality disorders and borderline personality disorders (Linehan, Rizvi, Welch and Page 2002, Williams 2001).

It is recognised that the suicide rate among prisoners and the mental health prevalence among prisoners is higher than in the general community (Fazel and Dinesh, 2002; Singelton et al. 1998). First, in research that has been carried out examining mental disorder and self-harm or non-fatal suicide attempts it has been found that a higher

proportion of people who have made a non-fatal suicide attempt in prison have a personality disorder compared to those who have not made a non-fatal suicide attempt in prison (Metlzer et al. 1999). In addition, Senior et al. (2007) carried out a study across four local prisons and took a sample of prisoners on open F2052SH forms (which has since been replaced by Assessment Care in Custody Teamwork; ACCT) and compared them to prisoners not on an open F2052SH form. They found that those on the open F2052SH form were more likely to have anxiety, depression, suicidal thoughts and hallucinations, compared to people not on an open F2052SH form. Secondly, some limited research has explored the link between mental disorder and self-inflicted deaths. When considering completed suicide the work of Jenny Shaw and her team on the *National Study of Self-Inflicted Deaths by Prisoners 2008-2010* found that 46% of prisoners who completed suicide in prison had a mental health diagnosis in their case notes (Shaw et al. 2013). Moreover, of these people, 35% had a diagnosis of depression and another 20% had a diagnosis of personality disorder. In an analysis of self-inflicted deaths from 1997 to 2007, Shaw et al. (2011) found that of the 766 deaths, 51% of prisoners had one or more psychiatric diagnoses recorded in their case files.

There is clear a link between mental disorders and suicide in custody, and a number of potential reasons for this link have been put forward. For example, Edgar and Rickford (2009), in their study of Independent Monitoring Board members' opinions on the mental health needs of prisoners, identified a number of key concerns, all of which are relevant when looking at the relationship between mental disorder and suicide. They found that there was a lack of adequate access to psychiatric assessment, that there was often missing information about prisoners when they arrived into the establishment, that staff were not sufficiently trained in mental health, that prisoners with mental health problems often ended up in segregation units, that there was a lack of coordination between professionals,

poor screening, lack of information, lack of sufficient mental health services. It is argued that prisons were receiving people who were not suitable for the prison environment. Indeed, "many boards also described the main effects of requiring prisons to hold people who should be the responsibility of the health service. In custody, their mental health is likely to deteriorate, and prison staff must devote disproportionate resources to looking after these individuals. (Edgar and Rickford, 2009, p 4). They also noted that "behaviour symptomatic of mental illness is sometimes treated in prison as a disciplinary rather than a medical matter" (Edgar and Rickford 2009, p. 4). This is particularly related the Incentive and Earned Privileges (IEP) scheme designed to encourage good behaviour and challenge bad behaviour in prison. There are three levels of IEP (Enhanced, Standard and Basic), with the prisoners behaviour determining their level of privilege. However, those with mental disorders may be less likely to comply with staff requests or standard procedures, in turn resulting in the removal of privileges (fewer family visits), more austere conditions (removal of TV) and increased time alone in the cell. This could increase the risk of suicide in prison by contributing to an increase in the symptoms of certain psychiatric conditions, such as paranoia or other psychotic conditions (Shaw, 2007).

The place of greatest isolation in prison is the segregation unit which is used disproportionately for those with mental disorders (Shaw, 2007). This might be used by prison staff for those with mental disorders for disciplinary reasons, but may also be used with good intentions. That is, individuals in segregation are often perceived to be easier to monitor and observe than when they are in the general population, so a prison officer may view segregation as the best available place to care for an individual. Again, however this increased isolation can have a significant negative impact on those with mental disorders and increase the risk of suicide and self-harm. In addition, segregation can also contribute to

a lack of communication between discipline and clinical staff (and between clinicians themselves) and may prevent appropriate medical care from reaching the individual (Shaw, 2007).

It has been suggested that prisoners with mental health difficulties entering custody on prescribed medication are at an elevated risk unless their medication is managed very carefully. Bowen, Rogers and Shaw (2009)summarised that "changes to medication management which accompany entry to prison appear to contribute to poor relationships with prison health staff, disrupts established self-medication practices, discourages patients from taking greater responsibility for their own conditions and detrimentally affects the mental health of many prisoners at a time when they are most vulnerable (p. 1).

Importantly, it has been also found that the majority of people who complete suicide in custody were not identified as 'at risk' at the time of their death (Shaw et al. 2011; Shaw et al. 2013). Only 35 (19%) of the 189 self-inflicted deaths between 2008 and 2010 were by prisoners who were on an open ACCT at the time of their death. This raises serious questions about the ability of the current measures for identifying people at risk.
The Royal College of Psychiatrist's (2002) responses to HMCIP (1997) *Suicide is Everyone's Concern* thematic review note that "it cannot be overemphasised or stated too often that psychiatric services, both within prisons and in the community, are grossly overstretched" (RCP 2002, p. 54). They highlight the need for improved screening, information sharing between agencies, the availability of assessment and treatment if psychiatric difficulties are identified, and the need for care to be coordinated. This report also highlights the importance of considering staffs' attitudes in relation to suicide prevention.

More recently, the report *Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?* (PRT and INQUEST 2012) provides important

themes about the treatment of children and young people who died in prison (2003-2010). They conclude that there has been failures in information sharing between different agencies and the prison, that the young people were vulnerable, that they had not been diverted from prison and were placed in unsafe cells, had experienced poor medical treatment, had limited access to psychological therapy in prison, and that systems failed to safeguard them from harm (PRT and INQUEST 2012). Other authors have called into question the limited staffing resources for mental health in-reach teams (SCMH 2007) within custodial settings.

Symptoms of mental disorders could also contribute to death in custody because the individual neglects their physical health or avoids disclosing physical ailments. This possibility would be difficult to study, but there is evidence that of a link between serious mental disorder, the experience of prison and physical health. Cuddeback et al (2010) compared the medical history of seriously mentally ill individuals, some of who had experienced prison in the last 5 years. They found that those who had experienced incarceration were significantly more likely to have infectious diseases, skin disorders, blood disorders and injuries. Overall, individuals who had serious mental disorders and a history of incarceration were 40% more likely to have a general medical problem and had a 30% increase in multiple medical problems.

Police, Prison and Deaths in Custody

Clearly, mental disorders are related to deaths in custody and there appears to be a negative feedback cycle with mental disorders increasing the likelihood of being detained in custody and the experience of custody increasing the severity of mental disorders. In some instances symptoms of mental disorders (e.g. hopelessness caused by major depression)

could be a contributing factor (or causally related) to certain types of deaths in custody, such as suicide. If this was the case, then treatment of the mental disorder would reduce deaths in custody. While a causal and direct relationship may exist between some mental disorders and deaths in custody, it is also possible that other mediating factors might influence this relationship. For example, those with mental disorders might be more likely to neglect their physical health while in custody (i.e., self-medication with drugs, concealing physical ailments) and this diminished physical health could increase the risk of dying in custody.

Perhaps the most important factor that can have a crucial moderating influence on the relationship between mental disorders and deaths in custody is the quality of care provided within the custodial settings (e.g., Dvoskin & Spiers, 2004; Kelly, 2014). That is, while mental disorders and deaths in custody are strongly linked, if a vulnerable individual, displaying the symptoms of mental disorders, is fast-tracked to receive appropriate mental health care this can significantly reduce the likelihood of death in custody (Hansson & Markstron, 2014; Kovasznay et al., 2004). However, in order for this expedient and appropriate care to be provided, first the mental disorder must be identified accurately, and there is evidence to suggest that this can be a challenge (e.g. Jorm et al, 1997).

Mental Health Literacy

The concept of mental health literacy, or the knowledge and beliefs about mental disorders which aid their recognition, management or prevention was introduced in in 1997 by Jorm et al. In a representative sample of 2031 18 – 74 year olds in Australia, Jorm et al (1997) asked people to respond to questions based on vignettes describing individuals who met the DSM and ICD criteria for major depression and another who met the DSM and ICD criteria

for schizophrenia. The results suggested that most people accurately identified a mental health issue (72% in the depression vignette; 82% in the schizophrenia vignette), but very few accurately identified the particular mental health problem (39% depression; 27% schizophrenia). Interestingly, most of those questions suggested that the optimal point of contact for the individual described as having depression was a GP, but a mental health professional for the individual described as schizophrenic (59% counsellor or doctor). The results also suggested that those questioned viewed medication as less helpful than less established treatments (e.g. physical exercise). Jorm et al (1997) concluded that the views of the general public on mental health differed from mental health professionals considerably, and that this lack of knowledge could lead the public to reject using mental health professional s and to lack adherence to the advice of such professionals.

While not specifically about mental health literacy the Department of Health (ONS, 2011) has been operating an annual survey with the general population examining attitudes to mental disorder. In 2011 this study found that 77% of the 1,741 adults surveyed agreed with the statement 'Mental illness is an illness like any other'. This was higher than in 1994 when only 71% of those surveyed agreed with this statement. However, very few people (25%) agreed with the statement 'Most women who were once patients can be trusted as babysitters', and 16% suggested that one of the main causes of mental disorder was a lack of self-discipline suggesting some fundamental misunderstanding of mental disorders still exists. A consistent finding of these general surveys of attitudes to mental health is that women generally express more positive and tolerant attitudes to mental disorder than men (DoH, 2012).

The Mental Health Literacy of the Police

There has been some research on the attitudes or mental health literacy of those working in the police. For example, Kimhi et al (1998) conducted a study of the attitudes towards mental disorder of 93 male police officers in Israel. The results suggested that police officers could identify certain mental disorders better than the general public, but this varied considerably depending on the mental disorder described. For example, over 90% of the police officers correctly identified paranoid psychosis (compared to 80% in the general public) to 28% who correctly identified alcohol dependence (compared to 18% in the general public). However, almost half (48%) of the police officers stated their reluctance to work with a psychiatric patient, and 54 percent would not hire a former mental patient. In addition, 50 percent noted that they would refuse to work in a psychiatric hospital.

Clayfield et al (2011) developed the Mental Health Attitude Survey for Police on a sample of 412 US police officers. Included on the scale were items such as 'Persons who show signs of mental illness should be hospitalized', and 'Police officers need specialized training in dealing with EDPs (emotionally disturbed persons).' The results suggested that older and female officers typically held more positive attitudes to those with mental disorders than those who were younger and male. However, older officers also felt less well prepared to deal with those who had mental disorders compared to those who were younger. Perhaps most importantly, the results suggested that police officers who had past training with mental disorders felt more adequately prepared to address the needs of those in their care.

It is perhaps not surprising that police officers' attitudes to mental disorder do not differ from those of the general public as they typically have limited training on issues related to mental health (e.g. Sainsbury's Centre for Mental Health, 2008). This lack of

knowledge was used as the impetus by one prominent West Midlands' police officer to establish an online presence and twitter campaign called Mental Health Cop. The author claims that the website, but especially the FAQ section which addresses questions such as 'We've arrested someone under a section 136 – what do we do we deal with it properly?' and, 'A&E are asking us to arrest someone under s136 and remove them to a place of safety. Can we / should we do this; aren't they a Place of Safety?!'.

The Mental Health Literacy of Prison Officers

While the amount of research on the attitudes of police to mental disorder is somewhat limited, there appears to be considerably less research on the attitudes of prison officers to such issues (e.g. Cook & Lane, 2014). Most research has tended to focus on the negative attitudes that prison staff might hold, and the negative implications that this might have for increased risk of self-harm and suicide of those in prison. The term 'terminal malignant alienation' refers to the indifference to those with particular mental disorders and some research has suggested that some prison officers may hold these views (Pompili, et al 2009). Some individuals with mental disorders, particularly those with recurrent relapses and resistance to conventional psychiatric and psychological interventions may be perceived by staff as manipulative, provocative, unreasonable over-dependent and feigning disability. Those with fluctuating suicidal ideation are particularly likely to fall into these categories and may lead to staff ignoring them. This is despite the fact that previous self-harm is the most prominent predictor of later suicide amongst those in prison (Hawton et al., 2014). This may also result in a hostile attitude toward the individual and a lower level of support, leading to feelings of alienation, and subsequently increasing the possibility of suicide.

Again, the training of prison officers does not appear to contain sufficient coverage of issues related to the care of those with mental disorders, especially considering the prevalence of such disorders in prison (e.g., Liebling & Karup, 1993). For example, a parliamentary report on prison officers observed that mental health and substance abuse was insufficiently covered in basic training of all prison officers (House of Commons, 2009). In this report it was suggested that only half a day of the initial prison officer training was spent covering mental disorders and that officers entered the job feeling unprepared to deal with such issues.

Improving Mental Health Literacy Amongst those Working in The Custodial Sector

There is evidence that the attitudes to mental disorders can be improved. Evans-Lacko, Henderson & Thornicroft (2013) evaluated the impact of the national Time to Change anti-stigma and discrimination programme directed at public attitudes to mental disorders. The programme, operated by the charities Mind and Rethink Mental Illness was established in 2007 and involved a range of activities from national advertising and media campaigns to engagement with communities at various levels (Time to Change, 2014). As part of this programme a nationally representative sample of adults in England (n~1700) have been administered a series of questionnaires annually (2009-2012) about their mental health knowledge, their attitudes to those with mental disorders as well as their actual or intended behaviour towards those with mental disorders. The results suggested that there had been little improvement in the knowledge about mental disorders from 2009 – 2012, but that

there had been a statistically significant improvement in attitudes[6], and intended behaviour towards those with mental disorders.

Interventions targeted at the mental health literacy of police officers have also proven to be successful. Hansson & Markstron (2014) evaluated the impact of an additional mental health awareness course which was added to the regular police officer training course for a sub-set of police trainees. The intervention was comprehensive and included lectures, video presentations and presentations by those who had suffered from mental disorders. There was also the opportunity for role-play observed by those who had suffered mental disorders and for trainees to talk through actual or potential scenarios with former sufferers. The course lasted for about three weeks and a total of 54 trainees participated and returned completed questionnaires six-months after completion. A total of 59 individual trainees acted as the comparison group and completed questionnaires before and six-months after the course, but did not attend the course.

The results suggested that those who had completed the course had significantly improved attitudes to those with mental disorder at post-test compared to those who had not attend the course. In addition, those who had completed the course were more willing to work with those who had mental disorders and their mental health literacy had significantly improved. Importantly this group had significantly improved in their knowledge of advice to provide those with mental disorders in order to get professional help.

Limitations of Mental Health Literacy Research

[6]The statistically significant improvement was between 2009 and 2010, but this trend (although not statistically significant) has continued.

The concept of mental health literacy appears very useful and it follows that increases in mental health literacy amongst those working in custodial sector would be desirable. Those who can accurately identify mental disorders and who have favourable attitudes to those with mental disorders will be more empathetic and supportive to those in their care, factors known to reduce the risk of suicide and self-harm (Shaw et al., 2011). It is however, important to consider the some of the potential limitations of the mental health literacy research, specifically how mental health literacy is measured. This is usually measured by administering a questionnaire, but there is some concern that questionnaires designed to measure mental health literacy might not be measuring this concept accurately. For example, O'Connor, Casey & Clough (2014) reviewed 13 studies in which mental health literacy was measured using questionnaires and found that these did not clearly demonstrate that they were measuring mental health literacy well, or that the results of these studies would be the same if they were conducted using a different sample (i.e. the results were not necessarily generalizable). They concluded that more work on measuring mental health literacy was needed.

Further complicating this is the fact that generally the questionnaires that have been developed to measure mental health literacy have been based on evaluating people's attitudes and abilities to identify more well known, and arguably more obvious mental disorders such as depression and schizophrenia. While it would be important for those working in custodial settings to be able to identify these mental disorders, those detained in custody have a very high prevalence of personality disorders, which are related to deaths in custody (Shaw et al., 2011). Measures of mental health literacy used for those working in

custody should therefore be modified to include knowledge and attitudes towards the major personality disorders found in custody (e.g. Craissati, et al., 2011).

Conclusions and Way Forward

Those with mental disorders are in disproportionate contact with the police and over-represented in prison, and these individuals are at a significantly elevated risk of death in custody. While there are a number of reasons why mental disorders and deaths in custody might be linked, it is also clear that high quality care by those working in the custodial sectors can substantially mitigate this risk. When those with mental disorders are provided with adequate health care and support and sufficiently monitored their risk of death diminishes substantially (Clayfield et al., 2011). However, a key to barrier providing such a level of care is a lack of adequate knowledge and understanding of mental disorders, which could prevent such individuals from being identified early and streamlined for support. The evidence about the knowledge and understanding of mental disorder held by those working in the custodial sectors is limited. But that which was availablesuggests that improving staff attitudes and knowledge may have a beneficial effect on improving the experience of custody for detainees with mental disorders.

There is a lack of research on the knowledge and understanding of mental disorders, or mental health literacy, of those working in the custodial sectors. A first step to developing an evidence base would be to attempt to capture the current knowledge and understanding of the range of mental disorders that those working in the custodial sectors are likely to encounter most commonly. This would need to include disorders with more obvious symptoms (such as schizophrenia), but also the less obvious (personality disorder).

This tool could then be administered to those working in the custodial sectors to evaluate average mental health literacy and explore the factors associated with mental health literacy, such as gender or years of experience. Finally, if mental health literacy was found to be low, interventions (like Hannson & Markstrom, 2014) should be developed and administered to those working in the custodial sectors to increase knowledge and understanding of mental disorders as these attributes could result in fewer deaths in custody.

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Appendix A – Literature Search

The academic databases that were consulted were:

i) BioMed Central
ii) Biomedical and Life Sciences collection
iii) Cambridge Journals and Digital Archives
iv) Cochrane Library
v) Campbell Collaboration Library
vi) Directory of Open Access Journals (DOAJ)
vii) Electronic Thesis Online Service
viii) HeinOnline
ix) International Bibliography of the Social Sci.
x) Igentaconnect
xi) JAMA Network
xii) JISC Journal Archives
xiii) Oxford Journals
xiv) ProQuest Dissertations
xv) PsychArticles
xvi) Sage Journals Online
xvii) SciVerse Science Direct
xviii) SciVerse SCOPUS
xix) Springerlink
xx) SwetsWise
xxi) Taylor and Francis Online
xxii) Web of Knowledge
xxiii) Wiley Online Library

The non-academic literature began with the websites below but also covered websites linked to these.

- The IAP website
- National Institute of Justice (US website)
- Australia National Deaths in Custody Program
- Solicitor General Canada
- Government websites New Zealand
- Independent Police Complaints Commission
- Preventingcustodydeaths.org
- Prison Reform Trust
- INQUEST
- EHRC
- Liberty

Citation	Location	Relevant for:
All Party Parliamentary Group on Prison Health (2006) The Mental Health Problem in UK HM Prisons, London: House of Commons.	House of Commons	N/A
Andersen (2004)	PsychInfo	
Andrews (2012)	PsychInfo	Drugs, mortality, released prisoners
Awofeso (2010)	Psychinfo	Suicide prevention
Awofeso, N. (2010) Preventing suicides in prison settings – the role of mental health promotion policies& programs.	EBScohost	1. Prisons as social determinants of health 2. Review of epidemiology of prison suicides in Eng & Wales 1978-2009 3. Advocates integrated approach between health & prison service.
Barry, J. M., Darker, C. D., Thomas, D. E., Allwright, S. P. A., O'Dowd, T. (2010).Primary medical care in Irish prisons BMC Health Service Research, 10. 74 - 80	BioMed Central	Primary study. Weak medical and especially psychiatric care was available. Limited administrative support.
Bersto, H. Y. & Arrigo, B. A. (2011). The ethics of mechanical restraints in prisons and jails: A preliminary inquiry from psychological jurisprudence. Journal of Forensic Psychology Practice, 11, 232-264.	Psychinfo	Interaction between restraint devices and conditions of mental illness. Mental illness increase the use of restraint – exacerbates psychological distress.
Bird. S ((2008). Fatal accident inquiries into 97 deaths over five years in Scottish prison custody: Long elapsed times and recommendations. The Howard Journal, 47, 343-370.	BioMed Central	Examining the length of time between a death in custody and report being made.
Birmingham (2000)	PsychInfo	
Borril (2006)	Psychinfo	Foreign nationals
Bowen (2009)	PsychInfo	Medication
Bradley (2009)	Online	
Brittain, J., Axelrod, G., & Venters, H. (2013) Deaths in New York City Jails. American Journal of Public Health	EBScohost	Comparative data analysis
Brooker (2007)	Online	Mental Health Services and Prisoners
Brooker C, Ullman B, and Lockhart G, (2008) Out of Sight, Out of Mind, London: Policy Exchange.	Policy Exchange	How might mental illness influence self-inflicted deaths in custody?
Brooker, C., Gojkovic, D. & Shaw, J. (2009) The Second National Survey of Prison In-reach, London: Department of Health.	Department of Health	How might mental illness influence self-inflicted deaths in custody?
Browne, D. Durcan, D. & Sunders, A. (2013) Black and minority ethnic (BME) communities, mental health and criminal justice, London: Centre for Mental Health.	Centre for Mental Health	N/A
Care Quality Commission (2011)Count me in 2010, Care Quality Commission: London.	Care Quality Commission	N/A
Caring Solutions (UK) University of Central Lancashire (2011) Review of the Medical Theories and Research Relating to Restraint Related Deaths. London: IAP.	IAP	How might mental illness influence death in custody following the use of force by police and prison officers?
Code of Practice – Mental Health Act 1983	Department of Health	

(revised 2008), Dept of Health		
Coles, D & Shaw, H. (2006). Comment: Deaths in Custody – Truth, Justice, and Accountability? The Work of INQUEST, Social Justice, 33, 136 – 141.	Swetswise	How might mental illness influence death in custody following the use of force by police and prison officers?
Coles, D and Shaw, H (2012) Learning from Death in Custody Inquests: A New Framework for Action and Accountability, London: INQUEST	INQUEST	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence self-inflicted deaths in custody? How might mental illness influence death in custody following the use of force by police and prison officers?
Coles, D. & Edmundson, A. (2012) Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison? London: Prison Reform Trust & INQUEST	Prison Reform Trust and INQUEST	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody? How might mental illness influence homicide in prison?
Coles, D. & Shaw, H. (2007) Unlocking the truth: families' experiences of the investigation of deaths in custody - Executive Summary and Recommendations, London: INQUEST	INQUEST	N/A
Corston, J (2007) The Corston Report: a review of women with particular vulnerabilities in the criminal justice system, London: The Home Office.	Home Office	How might mental illness influence self-inflicted deaths in custody? How might mental illness influence deaths in police and/or prison cells as a result of medical neglect?
CPI (2006)	Online	Risks of restraints
Cunneen, C. (2006). Aboriginal deaths in custody: A continuing systematic abuse. Social Justice, 33, 37 – 51.	Biomed	Prevalence of aboriginal deaths in custody
Dawes, D, Ho, J. & Miner, B. (2009). The neuroendocrine effects of the Taser X26: A brief report. Forensic Science International, 183 – 14 – 19.	PsychInfo	RCT. Tasers not most stressful compared to low temp, defensive tactics. Total sample of 52 undermines RCT.
Department of Health (2001) Changing the outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons, London: Department of Health and HM Prison Service.	Department of Health	How might mental illness influence self-inflicted deaths in custody? How might mental illness influence deaths in police and/or prison cells as a result of medical neglect?
Department of Justice (2009) Report of the Panel of mental health and medical experts' review of excited delirium, Halifax, Nova Scotia, Canada: Department of Justice.	Department of Justice (Canada)	How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
Docking, M Grace, K & Bucke, T (2011) Police Custody as a "Place of Safety": Examining the Use of Section 136 of the Mental Health Act 1983, London: IPPC.	IPPC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence self-inflicted deaths in custody?

		How might mental illness influence death in custody following the use of force by police and prison officers?
Docking, M. and Menin, S. (2007) Deaths During or Following Police Contact: Statistics for England and Wales 2006/07, IPCC: London.	IPCC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
Doty (2012)	Psychinfo	Self-harm
Durcan (2008)	Online	Experience of mental health care in prisons
Durcan, G et al (2008)From the Inside: experiences of prison mental health care, London: Sainsbury Centre for Mental Health.	Sainsbury Centre for Mental Health	How might mental illness influence self-inflicted deaths in custody?
Dyson, S. M. & Boswell, G. (2006). Sickle cell anaemia and deaths in custody in the UK and the USA. The Howard Journal, 45, 14 – 28.	BioMed Central	SSA might be used as an excuse for a death in custody. SSA may also be a risk factor for a death in custody if medical care isn't sufficient.
Earthrowl (2002)	Psychinfo	Screening
Edgar and Rickford (2003)	Online	Women, MI, prisons
Edgar, K & Rickford, D (2005) Troubled Inside: Responding to the Mental Health Needs of Men in Prison, London: Prison Reform Trust.	Prison Reform Trust	How might mental illness influence self-inflicted deaths in custody?
Edgar, K & Rickford, D (2009) Too Little, Too Late: An Independent Review of Unmet Mental Health Need in Prison,London: Prison Reform Trust.	Prison Reform Trust	How might mental illness influence self-inflicted deaths in custody?
Effective mental healthcare for offenders: the need for a fresh approach (2007) NACRO	NACRO	
Enforcement Instructions and Guidance (Children and Families - chap 45) (2013), UK Border Agency	UK Border Agency	
Equality and Human Rights Commission (2010) How fair is Britain? The first Triennial Review Executive Summary, EHRC: London	EHRC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence self-inflicted deaths in custody? How might mental illness influence death in custody following the use of force by police and prison officers?
Eyton (2011)	PsychInfo	Religion
Farrant (2001)	PsychInfo	MH young people
Fazel, S. & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. The Lancet, 359, 545 - 550	Bio Med Central	Prevalence of mental disorder amongst those in prison. **No control groups**
Flosi, E. (2011). Sudden in-custody deaths. Forensic Examiner, Spring 2011, 30 – 48	BioMed Central	Incredibly right-wing article defending the police's use of force. **All to Read**

Flynn, G., O'Neill, C., McInerney, C. & Kennedy, H. G. (2011). The DUNDRUM-1 structured professional judgment for triage to appropriate levels of therapeutic security: retrospective-cohort validation study. BioMed Central Open Access	BioMed Central	An 11-item scale designed to help triage those presenting people for appropriate level of security. Security screening measure not a mental health screeningmeasure.
Foreign national offenders, mental health and the CJS (2010), NACRO	NACRO	
Giblin, Y, Kelly, A., Kelly, E., Kennedy, H. G. & Mohn, D. (2012). Reducing the use of seclusion for mental disorder in a prison: implementing a high support unit in a prison using participant action research. BioMed Central Open Access,	BioMed Central	Examined the use of segregation units for mentally disordered vulnerable prisoners. Instead created a 10-bed support unit to beneficial results.
Giraud-Saunders, A (2013) Making the Difference: the role of adult social care services in supporting vulnerable offenders, London: Prison Reform Trust.	Prison Reform Trust	N/A
Goldson, B. & Coles, D. (2005) In the care of the state? Child deaths in penal custody in England and Wales London: INQUEST	INQUEST	(No online Pdf available)
Gournay, K. (2005) Deaths in Custody. Mental Health Practice,vol 8, No.5	EBScohost	Overview of Joint Committee on Human rights into deaths in custody – implications for mental health practitioners.
Grace K, (2013) Deaths during or following police contact: Statistics for England and Wales 2012/2013, London: IPPC.	IPPC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence self-inflicted deaths in custody? How might mental illness influence death in custody following the use of force by police and prison officers?
Grace, K. (2010) Deaths during or following police contact: Statistics for England and Wales 2009/10, IPCC: London.	IPCC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
Grace, K. (2011) Deaths during or following police contact: Statistics for England and Wales 2010/11, IPCC: London.	IPCC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
Grant, J. R., Southall, P. E., Fowler, D. R., Mealey, J., Thomas, E. J. & Kinlock, T. W. (2007). Death in Custody: A Historical Analysis. Journal of Forensic Science,	BioMed Central	Study of the changes in the prevalence of types of death in custody In Maryland. Conclude that suicides have increased as have

		deaths associated with cocaine use.
Guidance on responding to people with mental ill health or learning difficulties (2010), NPIA/ACPO	NPIA	
Guidance on the safer detention and handling of persons in police custody (2nd ed.) (2012), NPIA/ACPO	NPIA	
Hannan, M. Hearnden, I. Grace, K, and BuckeDeath, T. (2010) Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09, IPCC: London.	IPCC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
Harding, R. W. (1999). Prisons are the problem: A re-examination of aboriginal and non-aboriginal deaths in custody. The Australian and New Zealand Journal of Criminology, 32, 108-123.	BioMed Central	Prison deaths have remained constant while deaths in police custody have reduced in Aust. Nature of prison custodial regimes to blame.
Hart (2004)	Psychinfo	Children's services
Hart, D. and Howell, S. (2004) Report on the use of physical intervention across children's services, National Children's Bureau	Ncb.org.uk	
Healthy children, safer communities: a strategy to promote the health and well-being of children and young people (2009), DH, DCSF, MOJ, HO	Department of Health	
HM Inspectorate of Prisons (2007) The mental health of prisoners A thematic review of the care and support of prisoners with mental health needs, London: HM Inspectorate of Prisons.	HM Inspectorate of Prisons	How might mental illness influence self-inflicted deaths in custody?
HMCIP (2010)	Online	Investigating deaths in custody
Heffernan, E., Andersen, K. & Kinner, S. (2009). The insidious problem inside: mental health problems of Aboriginal and Torres Strait Islander people in custody. Australian Psychiatry, S41-S46.	BioMed Central	Highlights the link between mental illness and custody amongst Aboriginals in NZ.
House of Commons Justice Committee (2013) Women offenders: after the Corston Report Second Report of Session 2013–14, London: House of Commons.	House of Commons	How might mental illness influence self-inflicted deaths in custody? How might mental illness influence deaths in police and/or prison cells as a result of medical neglect?
Ho, D., Heegard, W. D., Dawes, D. M., Natarajan, S., Reardon, R. F. & Miner, J. R. (2009). Unexpected arrest-related deaths in America: 12-months of open source surveillance. Western Journal of Emergency Medicine, 10, 67-73.	BioMed Central	There were 162 ARD in the 12 month period. Mostly male and average age of 36. Places emphasis on the causes of ARD as 'bizarre behavior' following illicit drug use.

Howard League	Howard League Website	Deaths on probation
Howard League (2009)	Howard League Website	Women
IAP (2011) Independent Advisory Panel on Deaths in Custody Report of the cross sector restraint workshop, London: IAP.	IAP	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers?
IAP (2011) Independent Advisory Panel on Deaths in Custody. IAP E-Bulletin April 2011 Issue 4, London: IAP.	IAP	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers?
IAP Themes from the independent advisory panel (IAP) on deaths in custody review of rule 43 reports, narrative verdicts and investigations reports where restraint was identified as a direct cause of contributory factor in the death, London: IAP.	IAP	How might mental illness influence death in custody following the use of force by police and prison officers?
INQUEST (2009)	Online	Preventing Deaths
IPCC (2004) Inquiry by Joint Committee on Mental Health Bill Memorandum from the Independent Police Complaints Commission, IPCC: London.	IPCC	N/A
IPCC (2008) Deaths during or following police contact: Statistics for England and Wales 20007/08, IPCC: London.	IPCC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
IPCC (2009) Deaths during or following police contact: Statistics for England and Wales 2008/09, IPCC: London.	IPCC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
JCHR (2004) Deaths in Custody: Third Report of Session 2004-05, London: House of Lords/House of Commons Joint Committee on Human Rights.	JCHR	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence self-inflicted deaths in custody? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence homicide in prison?
Jill Dando	Online	Safer Cells
Jordan (2012)	PsychInfo	

Joudo, J. (2006). Deaths in custody in Australia 1990 – 2004. Australian Government: Australian Institute of Criminology	Web	Trends of deaths in custody in Australia.
Keogh, S. (2012) Deaths during or following police contact: Statistics for England and Wales 2011/12, IPCC: London.	IPCC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
Larney (2012)	Psychinfo	Suicidal ideation, suicide
Lennox (2012)	PsychInfo	Released Prisoners
Liberty (2003). Liberty's evidence to the Joint Committee on Human Rights enquiry into human rights and deaths in custody.	Web	More clarity in terms of procedures for inquests after deaths in custody
Liebling (2001)	Online	10 years on
Liebling et al. (2005)	Online	Safer Locals Evaluation
Lloyd, M. (2012). Dormant Data: why and how to make good use of deaths in custody reporting. American Journal of Criminal Law, 39, 301 – 325.	BioMed Central	Perverse incentives where US prisons are required to take action if they acknowledge there is an issue. This leads to prisons ignoring problems until there is an incident.
Lukasiewicz, M., Falissard, B., Michel, L., Neveu, X., Reynaud, M., & Gasquet, I. (2007). Prevalence and factors associated with alcohol and drug-related disorders in prison: a French national study. Substance, Abuse Treatment, Prevention, and Policy, 2, 1 – 10.	Biomed Open Access	Alcohol and Drug disorders are common amongst short and long term prisoners.
Meltzer (2003)	Psychinfo	Mental health, non-fatal SB
Mental Illness, Personality Disorder and Violence: A Scoping Review	Online	Mental illness and violence
MHF	Online	Mental health
MHF	Online	Young offenders
Mind (2013)	Online	Hospitals
Minogue, C. W. J. (2006). Then and now, us and them: A historical reflection on deaths in and out of custody. Social Justice, 33, 107 – 117	BioMed Central	Descriptive account written by a current prisoner.
MOJ (2010) Statistics of Mentally Disordered Offenders 2008 England and Wales, London: Ministry of Justice Statistics bulletin.	MOJ	N/A
MOJ (2011)Statistics on Race and the Criminal Justice System 2010 A Ministry of Justice publication under Section 95 of the Criminal Justice Act 1991, London: Ministry of Justice Statistics bulletin.	MOJ	N/A
MOJ (2013) Safety in Custody Statistics England and Wales Update to December 2012, London: Ministry of Justice Statistics bulletin.	MOJ	How might mental illness influence self-inflicted deaths in custody?
Moss, N. (2006). Comment: racism and custody deaths in the UK: The Zahid	BioMed Central	How racism contributed to the death of Zahid Mubarek.

Mubarek Inquiry. Social Justice, 33, 142 – 150		
National Confidential Inquiry into Suicide and Homicide (2001)	Online	Suicide, homicide, MI
National Confidential Inquiry into Suicide and Homicide (2013)	Online	Suicide, homicide, MI
National Confidential Inquiry (2011)	Online	Self-inflicted deaths in prison
National Policing Improvement Agency (2012) Association of Chief Police Officers Guidance on The Safer Detention and Handling of Persons in Police Custody Second Edition, London: National Policing Improvement Agency.	NPIA	N/A
NIJ (2011) Study of Deaths Following Electro Muscular Disruption, Washington: National Institute of Justice.	National Institute of Justice (US)	How might mental illness influence death in custody following the use of force by police and prison officers?
No Health without Mental Health: Implementation Framework (2012),	Centre for Mental Health/Dept. of Health/ Mind/ NHS Confederation Mental Health Network/ Rethink Mental Illness/ Turning Point	
NOMS (2006)	Online	Training manual
O'Brien (2003)	PsychInfo	Women
Ombudsman (2006)	Online	Death of a boy
Paterson (2003)	Psychinfo	Deaths in health and social care
Paterson (2009)	Psychinfo	
Pelfrey, W. V. & Covington, M. W. (2007). Deaths in custody: the utility of data collected from county coroners. Criminal Justice Studies, 20, 65-78.	BioMed Central	County coroner data as an addition to police data.
Pompili, M., Lester, D., Innamorati, M., Del Casale, A., Girardi, P., Ferracuti, S. Tatarelli, R. (2009). Preventing suicides in jails and prisons: suggestions from experience with psychiatric inpatients. Journal of Forensic Science, 54, 1155 – 1162	BioMed Central	Staff training and feedback tend to be missing. Able to recognize developing signs and symptoms of mental illness.
Pratt (2006)	Psychinfo	Released prisoners
Prison Reform Trust (2003)	Online	MH needs
Prison Reform Trust (2010) Factfile December 2010: Time for a fair and effective criminal justice system, London: Prison Reform Trust.	Online	Provides figures on Prison Suicides but no context
Prison Reform Trust (2011) New facts and figures reveal impact of august riots on prisons, London: Prison Reform Trust.	Online	Provides figures on deaths in custody but no context
Prison Reform Trust (2012)	Online	Fatally Flawed – suicide and young people
Protocol on the use of physical restraint in children's residential homes (nd), Dept of Health, Social Sciences and Public Safety	http://www.dhsspsni.gov.uk/	
PSI 63/2011 (2012) Management of prisoners at risk of harm to self, to others and from others, MOJ/NOMS	MOJ/NOMS	
PSO, 1600 Use of force (2005)	MOJ	
PSO, 8625 Staff fitness strategy	Justice.gov.uk	

(2001/2013)		
Rickford, D (2003) Troubled Inside: Responding to the Mental Health Needs of Women in Prison,London: Prison Reform Trust.	Prison Reform Trust	How might mental illness influence self-inflicted deaths in custody?
Robertson (1987)	Online	MDO and manner of death
Royal College of Psychiatry (2002)	Online	
Rutherford (2004)	PsychInfo	Transfer to hospital, women
Samuel, E., Williams, R. B. & Ferrell, R. B. (2009). Excited delirium: Consideration of selected medical and psychiatric issues. Neuropsychiatric Disease and Treatment, 5, 61 – 66.	PsychInfo	Excited Delirium. This is important as it is a common 'diagnosis' for a death in police custody.
Senior (2007)	Psychinfo	Identifying suicide risk
Shaw (2003)	Online	Safer Prisons
Shaw (2009)	Online	Evaluate prison in-reach teams
Shaw (Ombudsman)	Online	Mental health, prisoners
Speed (2012)	Psychinfo	SIDs prisons
Sutherfield (2007)	PsychInfo	Systematic review of MI in prison
Talbot, J (2012) Fair Access to Justice?: support for vulnerable defendants in the criminal courts, London: Prison Reform Trust.	Prison Reform Trust	N/A
Teers, R. & Bucke, T. (2005) Deaths During or Following Police Contact: Statistics for England and Wales 2004/05, IPCC: London.	IPCC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
Teers, R. & Menin, S. (2006) Deaths During or Following Police Contact: Statistics for England and Wales 2005/06. IPCC: London.	IPCC	How might mental illness influence deaths in police and/or prison cells as a result of medical neglect? How might mental illness influence death in custody following the use of force by police and prison officers? How might mental illness influence self-inflicted deaths in custody?
The medical role in restraint and control : custodial settings (2009), Guidance from the BMA	Bma.org.uk	
Violence: the short-term management of disturbed/violent behavior in in-patient settings and emergency departments (2005), NICE/Royal College of Nursing	NICE	
Vollm (2009)	Psychinfo	SH female prisoners
WHO (2007)	Online	Prison suicide prevention

Appendix B – Review of Some Relevant Studies

Coles, D & Shaw, H. (2006). Comment: Deaths in Custody – Truth, Justice, and Accountability? The Work of INQUEST, Social Justice
This article discusses the work of INQUEST. It makes some interesting points, but does not contain any direct evidence about the relationship between mental illness and deaths in custody.

Edgar, K & Rickford, D (2009) Too Little, Too Late: An Independent Review of Unmet Mental Health Need in Prison, London: Prison Reform Trust.
This report discusses how people that should have been diverted into mental health or social care from police stations or courts are entering prisons, which are ill equipped to meet their needs, and then being discharged into the community without any support. Independent Monitoring Board members provide accounts of individual prisoners stories, such as the behaviour symptomatic of mental illness is sometimes treated in prison as a disciplinary rather than a medical matter and how the Prison Service Order 1700 (segregation) can be particularly problematic for prisoners at risk of self-harm or suicide.

Rickford, D (2003) Troubled Inside: Responding to the Mental Health Needs of Women in Prison, London: Prison Reform Trust.
This report examines the extent of the mental health needs of women in prison. It exposes the gap between improved policy and bleak practice. Section 3 describes the extent and nature of self-harm and suicidal behaviour in prisons for women. Risk factors associated with committing suicide in prison include: having a personality disorder; psychoses or severe neurotic symptoms (for example, depression, anxiety, phobias or obsessions); receiving psychiatric treatment before prison and inside prison, etc. The report argues that prisons are often ill-equipped to respond to the particular needs of women with mental health problems. Despite the best efforts of individual staff and the initiatives of the Safer Custody Group, overcrowding undermines the ability of the Prison Service to provide a decent, safe environment in which women are less at risk of harming themselves. It offers a set of detailed recommendations and a ten-point action plan that, if implemented, possibly could ensure that the needs of mentally ill women inside the prison system are met.

Edgar, K & Rickford, D (2005) Troubled Inside: Responding to the Mental Health Needs of Men in Prison, London: Prison Reform Trust.
This report examines why men who have serious mental health problems end up in prison. It explores the lack of mental health care for the majority of prisoners, who have less serious, but nonetheless debilitating, mental health problems. Areas covered include self-harm, suicide and black and minority ethnic (BME) prisoners. The report indicates that for over 100 years the Prison Service has been aware that the risk of suicide is highest in the first few weeks of custody and that remand status constitutes to be a particular risk factor, without any discernible effect on the capability of prisons to prevent self-inflicted deaths. Prisoners from BME groups are identified as less likely than White prisoners to have attempted suicide or committed self-harm in prison and furthermore BME prisoners were less likely to have previously received psychiatric treatment, endured childhood traumas, or had stressful prison experiences. The report concludes with comprehensive recommendations about how to improve policy and practice.

Giraud-Saunders, A (2013) Making the Difference: the role of adult social care services in supporting vulnerable offenders, London: Prison Reform Trust.
This briefing paper reveals high rates of multiple need - including mental health problems; learning disabilities; substance misuse and homelessness - among adults in contact with the criminal justice system but does not cover deaths in custody.

Talbot, J (2012) Fair Access to Justice?: support for vulnerable defendants in the criminal courts, London: Prison Reform Trust.
Fair Access to Justice?, prepared by Jenny Talbot for frontline staff in the criminal justice system and the NHS. The document explains how people with a learning disability who have to appear in court as a victim or witness are given extra support or 'special measures' to help them understand and cope with the process. This does not cover deaths in custody.

Prison Reform Trust (2011) New facts and figures reveal impact of august riots on prisons, London: Prison Reform Trust.
This Bromley Briefings Prison Factfile reveals how the August riots, as well as causing harm and distress in communities, propelled an extra 846 people into already overcrowded prisons. There are facts and figures related to mental health and to deaths in custody but not linked.

Prison Reform Trust (2010) Factfile December 2010: Time for a fair and effective criminal justice system, London: Prison Reform Trust.
This briefing provides facts and figures relating to prison suicides and mental health but not linked.

Corston, J (2007) The Corston Report: a review of women with particular vulnerabilities in the criminal justice system, London: The Home Office.
This report is a review of the treatment of women offenders. The Home Secretary commissioned the report in 2003, after a number of deaths at Styal prison. The report calls on the government to develop a strong, consistent message in support of its policy that prison is not the right place for women offenders who pose no risk to the public. Chapter 3 *Life and Death* discusses the relationship between mental health, distress, prison conditions, drug abuse, depression, self-harm and suicide. 13 out of 19 women (studied by Safer Custody Group (SCG)) died by their own hand in prison in the years 1999 – 2001: one woman was on medication for depression, two had histories of depression, and two had been diagnosed with schizophrenia or psychotic symptoms in prison. One was reported as having a personality disorder. The majority had self-harmed or attempted suicide during their lives and one of them was recorded as having 37 injuries, most of them self-inflicted. Many of these women had multiple anxieties in the days prior to their deaths, including suffering from withdrawal, missing their families, experiencing deaths of loved ones, relationship problems within the prison, being bullied and worrying about losing their accommodation. Three were located in healthcare and two in segregation units when they died. Most of them had recently been relocated, either within a prison or between prisons.

House of Commons Justice Committee (2013) Women offenders: after the Corston Report Second Report of Session 2013–14, London: House of Commons.
This is a report of the Committee enquiry five years after the March 2007 publication of Baroness Corston's report. This report has a section that discusses self-harm and deaths in custody and mental health.Since the Corston Report was published in March 2007, the number of deaths of women in prison have fallen but there have been a further 35 deaths, 14 of which were self-inflicted. The report suggests that too many cases of women, some of whom were clearly mentally ill, serving very short prison sentences which served little purpose except to further disrupt sometimes already chaotic lives. Furthermore there continues to be women in prison for whom the system does not seem able to provide appropriate treatment and conditions.

Department of Health (2001) Changing the outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons, London: Department of Health and HM Prison Service.
This document includes information on suicide prevention in prisons and mental health based on evidence that, with a few notable exceptions, the way mental health services are currently organised, in terms of volume, range and quality, do not meet prisoners' needs. The strategy is intended to set the direction of travel, show how the National Service Framework for Mental Health and the NHS Plan can relate to prisoners, and identify some of the issues which will need to be considered in developing services.

HM Inspectorate of Prisons (2007) The mental health of prisoners A thematic review of the care and support of prisoners with mental health needs, London: HM Inspectorate of Prisons.
This report describes the conditions and treatment of the large number of mentally disordered people in prison. Chapter 6 examines the different experiences of women and black and minority ethnic (BME) prisoners in terms of patterns of drug use, and mental health need and prisons' responses to those needs. Chapter 7 examines the gaps in information sharing and care between mental healthcare and other disciplines with responsibilities for prisoners' welfare; those supporting suicidal and self-harming prisoners; residential staff; those working with substance misusers; forensic psychologists; and those providing resettlement services.

Although the report does not say that all those who are suffering mental health symptoms are at greater risk of suicide, it does quote research that has found in around 20% of self-inflicted deaths, the prisoner had

declared (sometimes to staff, sometimes to other prisoners) that (s)he had heard voices or was suffering from auditory hallucinations. The research and the statistics on self-inflicted deaths reveal that foreign nationals may be becoming increasingly emotionally and mentally vulnerable and an emerging theme from inquests into deaths in prison is the danger of segregation for those with mental health problems.

Brooker C, Ullman B, and Lockhart G, (2008) Out of Sight, Out of Mind, London: Policy Exchange.
This report looks broadly at the state of mental healthcare in prison. It also explores the rates of self-harm and attempted suicide in prison, mental illness, clinical depression, psychosis and personality disorder. It reports that rates of self-harm and attempted suicide in prison are high. And although suicide and self-harm is not necessarily associated with mental illness, both are highly correlated with clinical depression, psychosis and personality disorder. There were 67 prison suicides in 2006 and 22,324 incidents of self-harm were recorded during 2005-06. Attempted suicide over a 12-month period ranged from 7% (in male sentenced prisoners) to 27% (in female remand prisoners). The greatest risk of suicide or self-harm is among newly arrived prisoners in their first seven days in prison. The report goes on to quote that the massive increase in prison suicides of almost 40% in 2007 is a result of the pressures of chronic overcrowding across the prison estate.

Durcan, G et al (2008) From the Inside: experiences of prison mental health care, London: Sainsbury Centre for Mental Health.
TheSainsbury Centre for Mental Health conducted a review of five prisons in the West Midlands to assess the provision of and need for mental health care. The review included interviews with 173 people (98 of them prisoners) who were either imprisoned in, worked in, managed, commissioned or provided services for the five prisons. Additional information was drawn from statistical data, audits of case notes and in the region of 150 hours of observing the daily routines within the five establishments. The report explores self-inflicted deaths, mental health and overcrowding. A key finding in the report states there are key periods during and after incarceration when the risk of suicide is at its greatest. These are during the first seven days of entering prison and in the days following release; with male offenders recently released having an eight times greater risk than other men, and women having a 36 times greater risk. Most of those who take their lives have had a history of mental illness.

MOJ (2013) Safety in Custody Statistics England and Wales Update to December 2012, London: Ministry of Justice Statistics bulletin.
The safety in custody statistics cover deaths, self-harm and assaults and briefly discusses the impact of care in the community on mental illness and the higher number of self-inflicted deaths in the 1980s.

MOJ (2011)Statistics on Race and the Criminal Justice System 2010 A Ministry of Justice publication under Section 95 of the Criminal Justice Act 1991, London: Ministry of Justice Statistics bulletin.
The report includes information on deaths in prison custody and ethnicity but no information on mental health or mental illness.

MOJ (2010) Statistics of Mentally Disordered Offenders 2008 England and Wales, London: Ministry of Justice Statistics bulletin.
This bulletin provides information about mentally disordered offenders admitted to, detained in or discharged from hospitals in England and Wales between 1998 and 2008 under mental health legislation but no information on deaths in custody.

National Policing Improvement Agency (2012) Association of Chief Police Officers Guidance on The Safer Detention and Handling of Persons in Police Custody Second Edition, London: National Policing Improvement Agency.
This guidance sets out the legal framework within which the police must operate to tackle crime, and the protections and safeguards for the public. It focuses on practical issues and aims to provide a definitive guide on how police forces should put in place strategic and operational policies to help raise the standards of custodial care for those who come into contact with the police. This guidance has been compiled primarily to help minimise deaths and reduce the number of adverse incidents while people are in police custody.

All Party Parliamentary Group on Prison Health (2006) The Mental Health Problem in UK HM Prisons, London: House of Commons.
The report explores mental health care in prisons but does not discuss deaths in custody.

Brooker, C., Gojkovic, D. & Shaw, J. (2009) The Second National Survey of Prison Inreach, London: Department of Health.
The first survey of prison in-reach teams was undertaken by Brooker etal. (2004) as part of a project commissioned by National Forensic R&D Programme, England. This, the second national survey (part of the same project), aimed to capture a variety of data including workforce, team functioning, relationship with prison primary care, role of in-reach, barriers to operation, and the relationship to the wider NHS (emphasising pre-release planning). The report explores the link between the prevalence of mental health in prison and the risk of suicide; and role of in-reach in self-harm and suicide prevention.

Findings include: prison populations have high levels of suicidal and deliberate self-harming behaviours, and prisoners are at far greater risk of suicide than the general population; the prison environment and regime can be contributing factors to the high rates of self-harm and suicide in prison; and primary care mental health services require development and investment to ensure that prisoners with common mental health problems receive appropriate, skilled and timely care.

NIJ (2011) Study of Deaths Following Electro Muscular Disruption, Washington: National Institute of Justice.
This report provides findings concerning death investigation, CED use, CED-related health effects, and medical response. The report explains that a number of individuals have died after exposure to a CED during law enforcement encounters. Some were normal, healthy adults; many were chemically intoxicated or had heart disease or mental illness. These deaths have given rise to questions from both law enforcement personnel and the public regarding the safety of CEDs. It should be noted that arrestees who are involved in use-of-force incidents are by nature at higher risk for serious complication and death relative to the overall population. These individuals are more likely to be drug-intoxicated, be mentally ill or have serious underlying medical conditions.

Department of Justice (2009) Report of the Panel of mental health and medical experts' review of excited delirium, Halifax, Nova Scotia, Canada: Department of Justice.
The panel conducted a review of various forms of restraint (chemical irritants, neck restraints and other holds, and CEDs) and examined the evidence of injuries/deaths associated with the use of these restraints. The report suggests that given the current scientific understanding of the complex physiological processes at play in a situation where a person demonstrates symptoms of 'autonomic hyperarousal state' it is frequently not possible to determine the role (if any) that restraint (including the CED) played, if sudden death occurs.

However the report also states that it is reasonable to consider that, when further stressed by physical struggle or the application and continuation of physical restraints (including the CED), an individual exhibiting the syndrome of excited delirium may be at increased risk for sudden death. Similarly, the pre-existence of a medical or psychiatric condition (such as a psychotic illness, pre-existing cardiac condition, delirium with or without the use of psychostimulant drugs) may increase the risk for sudden death in an individual showing signs and symptoms consistent with excited delirium. Individuals who are in 'autonomic hyperarousal state' are reported to be extremely difficult to restrain. The process of restraint may result in a prolonged struggle as police attempt to bring the individual under control. In some cases, sudden death may occur.

A detailed list recommendations, such as, de-escalating strategies of verbal engagement and negotiation is provided in the report.

IAP Themes from the independent advisory panel (IAP) on deaths in custody review of rule 43 reports, narrative verdicts and investigations reports where restraint was identified as a direct cause of contributory factor in the death, London: IAP.
This document covers themes and issues based on the examination of 29 individual deaths in custody drawn from the summary analysis of 22 IPCC cases, and the seven reports from the PPO, HM Coroners Rule 43 Reports and narrative verdicts and Mental Health Act Commission Post Inquest Reports to which the IAP had access. In 12 of the cases, individuals had mental health problems at the time of their death. Five individuals had been diagnosed as suffering from schizophrenia and two individuals were diagnosed with paranoid schizophrenia. Five individuals had been restrained whilst being detained by the police under Section 136 of the Mental Health Act (MHA). In two of these deaths, the use of prone restraint was noted with significant concern in their inquests. The deaths of Azrar Ayub and Geoffrey Hodgkin in 2004, both patients detained

under the MHA, occurred after the recommendations from the Rocky Bennett inquiry were made public. Nine of the deaths were Black and Minority Ethnic individuals where restraint was either a direct cause or contributory factor in their death.

Caring Solutions (UK) University of Central Lancashire (2011) Review of the Medical Theories and Research Relating to Restraint Related Deaths, London: IAP.
The report states that throughout the literature there is evidence that certain groups are more vulnerable to risks when being restrained, whether because of biophysiological, interpersonal or situational factors or attitudinal factors. These groups are: those with serious mental illness or learning disabilities; those from Black and Minority Ethnic (BME) communities; those with a high body mass index; men age 30-40 years and young people (under the age of 20). Reviewing the comparisons of restraint-related deaths in the UK from 1999 to 2010 with the literature available, it can be seen that those in vulnerable groups when restrained in a prone position, or in a basket hold, for a prolonged period and who are agitated and resistive, are most at risk. The fatality may occur during restraint, immediately after, or, as in the case of Roger Sylvester, some considerable time after. The report also found a consensus that there was a gap in reporting restraint-related deaths.

In the period of 2010-2011 seven people fell ill or were identified as being unwell at the point of arrest. Of these seven cases, two were restraint-related deaths where police had contact with the individual; in both these cases the police were called to a mental health hospital to assist staff with a patient.

Since David Bennett's death after being restrained in 1998 there are still complaints of racism in healthcare. According to IAP (2010) since 1999, 8 out of 22 restraint-related deaths involved individuals from BME groups, with five classified as Black, two as Asian and one as Mixed Ethnicity.

Docking, M Grace, K & Bucke, T (2011) Police Custody as a "Place of Safety": Examining the Use of Section 136 of the Mental Health Act 1983, London: IPPC.
This report examines the extent and use of police stations as places of safety under section 136 of the Mental Health Act. The study sought to identify good practice and makes a series of recommendations for the police, health and social care organisations and other relevant bodies which may help to minimise the use of police custody as a place of safety in the future.

Approximately half of all deaths in or following police custody involve detainees with some form of mental health problem. The Independent Police Complaints Commission (IPCC) have continued to repeat this concern, as a significant number of the most serious cases referred to the IPCC have involved people with mental health issues. It has long been accepted that police custody is not a suitable place of safety. It has the effect of criminalising people who are in need of medical attention, can exacerbate their mental state, and in the most tragic cases can lead to deaths in custody.

The majority of detainees (2005/2006) were White – 78%. Of the remainder 4% were Black, 3% were Asian, 1% were Chinese/Other ethnic group, 1% were of Mixed ethnicity, and the ethnicity of 14% was unknown/not stated. When compared to local population data, Black people were almost twice as likely as White people to be detained. Mental health issues have been linked to a number of controversial deaths of Black people who were being restrained by police officers. These deaths have fuelled the perception of a disproportionate number of Black and minority ethnic people dying in police custody.

Grace K, (2013) Deaths during or following police contact: Statistics for England and Wales 2012/2013, London: IPPC.
Mental health continued to be a key factor in deaths in or after police custody in 2012-13, according to statistics published in this report. Deaths in police custody remained at 15, the same as the previous year, and fewer than in earlier years. But almost half (7 out of 15) of those who died were known to have mental health concerns, the same proportion as in 2011-12. Four of those who died were known to have been restrained by police officers. This does not necessarily mean that the restraint contributed to the deaths. In one incident, a Taser stun gun was discharged at a man. In another case, a man was physically restrained with fast straps and an emergency response belt. One man who had been detained under the Mental Health Act was known to have been restrained by officers with leg straps and incapacitant spray.

There was a considerable rise in the number of apparent suicides within two days of release from police custody, with 64 such deaths, the highest number recorded over the last nine years. Almost two-thirds were known to have mental health concerns, an even higher proportion than in 2011-12, and seven had previously been detained under the Mental Health Act.

21 other deaths followed police contact and were subject to IPCC independent investigations only.

IAP (2011) Independent Advisory Panel on Deaths in Custody Report of the cross sector restraint workshop, London: IAP.
This is a report of a workshop that brought together training leads on restraint from each of the custody sectors in order to identify common approaches to restraint. The report provides an overview of each custodial sector's policies and guidance around the use of physical restraint; a summary of the key discussions from the day; and a series of recommendations.

Some workshop attendees highlighted concerns that there appeared to be a disproportionate number of restraint incidents involving Black and Minority Ethnic (BME) prisoners. According to the NOMS 'Race Review' (2008), Black prisoners are consistently more likely than White British prisoners to be on basic regime, to be in the segregation unit for reasons of Good Order or Discipline and to have force used against them. The review also found that the use of force on BME prisoners between April 2008 and September 2008 was well above the expected ranges. However, whilst detention rates have remained higher than average among BME groups detained under the MHA, out of 31,786 patients surveyed as part of the 2009 'Count Me In' census, the only ethnic difference on the use of restraint observed was the 28% lower than average rate among Black Caribbean groups.

IAP (2011) Independent Advisory Panel on Deaths in Custody IAP E-Bulletin April 2011 Issue 4, London: IAP.
This E-bulletin from the Independent Advisory Panel (IAP) on Deaths in Custody provides an overview of our National Stakeholder Consultation Event, which was held in March 2011. It briefly mentions deaths in custody and mental health.

Hannan, M. Hearnden, I. Grace, K. & Bucke, T. (2010) Deaths in or following police custody: An examination of the cases 1998/99 – 2008/09, IPCC: London.
This report examines deaths in or following custody over an 11 year period. It identifies trends in the data, the nature of the deaths, and identifies the lessons that can be learnt for policy and practice to prevent future deaths from occurring. Between 1998/99 and 2008/09 17 people died after being detained under Section 136 of the Mental Health Act 1983 and being taken to a place of safety. Chapter 5 looks at the extent to which the deaths involved people who were mentally vulnerable. It considers the sources of evidence available to suggest mental health issues, whether the evidence was available to the police at the various stages of arrest and detention, and the extent to which the police identified any mental health issues. It looks at people who were detained under Section 136 of the Mental Health Act and subsequently died, and the extent to which suicide featured in the deaths.

IPCC (2004) Inquiry by Joint Committee on Mental Health Bill Memorandum from the Independent Police Complaints Commission, IPCC: London.
This document is a response to the then Government's Mental Health Bill. It does not contain information regarding deaths in custody and mental health.

Keogh, S. (2012) Deaths during or following police contact: Statistics for England and Wales 2011/12, IPCC: London.
This publication is the eighth in a series of statistical reports on deaths in custody published annually by the IPCC. In 2011/12, the following number of fatalities occurred within each category: 18 road traffic fatalities; 2 fatal police shootings; 15 deaths in or following police custody; 47 other deaths following police contact; and 39 apparent suicides following police custody. Fifteen people died 'in or following police custody' (2011/12) of which seven were identified as having mental health issues. Of the 15 cases, eight involved some form of restraint by the arresting officers. In five cases the pathologist mentions 'excited delirium' as a cause of death and in one of the cases the pathologist specifically stated that restraint was a contributory factor in the cause of death. The report also includes statistics on 'other deaths following police contact' of which many individuals are reported to have mental health issues of died following committing suicide.

Grace, K. (2010) Deaths during or following police contact: Statistics for England and Wales 2009/10, IPCC: London.
This is a statistical report on deaths in custody published annually by the IPCC. In 2009/10 there were 86 deaths during or following police contact, of which:

- 29 were road traffic fatalities;
- 2 were fatal police shootings;
- 17 were deaths in or following police contact; and
- 38 were other deaths following police contact.

Seventeen people died 'in or following police custody' of these four people were identified as having mental health issues. The report also includes statistics on 'other deaths following police contact' and suicides where individuals were reported to have mental health issues.

Grace, K. (2011) Deaths during or following police contact: Statistics for England and Wales 2010/11, IPCC: London.
This report presents figures on deaths during or following police contact which occurred between 2010 and 2011. During that time period the following number of fatalities occurred: 26 road traffic fatalities; 2 fatal police shootings; 21 deaths in or following police custody; 46 apparent suicides following release from custody; and 52 other deaths following police contact. Seven of the 21 deaths in or following police custody were identified as having mental health issues. The report also includes statistics on suicides and 'other deaths following police contact where individuals were reported to have mental health issues.

IPCC (2009) Deaths during or following police contact: Statistics for England and Wales 2008/09, IPCC: London.
This document presents the figures on deaths during or following police contact which occurred between 1 April 2008 and 31 March 2009. It includes information on deaths of individuals reported to have mental health issues/needs.

IPCC (2008) Deaths during or following police contact: Statistics for England and Wales 20007/08, IPCC: London.
This document relates to deaths during or following police contact which occurred between 1 April 2007 and 31 March 2008. It includes information on deaths of individuals reported to have mental health issues/needs.

Docking, M. and Menin, S. (2007) Deaths During or Following Police Contact: Statistics for England and Wales 2006/07, IPCC: London.
This report is based on those incidents referred to the IPCC. It presents figures on deaths during or following police contact which occurred between 1st April 2006 and 31st March 2007. It includes information on deaths of individuals reported to have mental health issues/needs.

Teers, R. & Menin, S. (2006) Deaths During or Following Police Contact: Statistics for England and Wales 2005/06, IPCC: London.
This report is based on those incidents referred to the IPCC. It presents figures on deaths during or following police contact which occurred between 1st April 2005 and 31st March 2006. It includes information on deaths of individuals reported to have mental health issues/needs.

Teers, R. & Bucke, T. (2005) Deaths During or Following Police Contact: Statistics for England and Wales 2004/05, IPCC: London.
This report is based on these referred incidents and presents figures on deaths during or following police contact which occurred between 1 April 2004 and 31 March 2005. It includes information on deaths of individuals reported to have mental health issues/needs.

Coles, D. & Edmundson, A. (2012) Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?, London: Prison Reform Trust and INQUEST.
This report examines the experiences and treatment of children and young people who died in prison custody in England and Wales between 2003 and 2010. The research found that some of the children that died in prison custody had experienced problems with mental health, self-harm, were placed in prisons with unsafe

environments and cells; experienced poor medical care and limited access to therapeutic services in prison; had been exposed to bullying and treatment such as segregation and restraint; and were failed by the systems set up to safeguard them from harm. The report also includes are range of recommendations.

Care Quality Commission (2011) Count me in 2010, Care Quality Commission: London.
This is the sixth and last national census of the ethnicity of inpatients in NHS and independent mental health and learning disability services in England and Wales, conducted on 31 March 2010. The information was obtained for patients 32,799 (including 2,959 outpatients on a CTO) on the day of the census of whom 23% were from Black and minority ethnic groups. Although it does not report on deaths in custody its finding include: higher than average rates of referral from the criminal justice system for some Black and White/Black groups; higher than average rates of detention under the Mental Health Act on admission for the Black Caribbean, Black African, Other Black and White/Black Caribbean Mixed groups, White Irish, Other White and Other Mixed groups. Higher than average rates of self-harm for the White British group and conversely lower than average rates for the Black and South Asian groups. Few ethnic differences were apparent in rates of hands-on restraint and physical assault.

Equality and Human Rights Commission (2010) How fair is Britain? The first Triennial Review Executive Summary, EHRC: London
This is a summary of a larger 700 page report which looks broadly at equality in the UK. The summary document reports: a disproportionate number of people who die following contact with the police are Black; people with mental health conditions are more likely than those without to die during or following police custody; and self-inflicted deaths (which include unintentional death for example through drug use) are more common among pre-sentence prisoners than across the rest of the prison population. It is likely there is more detailed information within the full report.

Coles, D and Shaw, H (2012) Learning from Death in Custody Inquests: A New Framework for Action and Accountability, London: INQUEST
This report identifies and explains why inquest reports (both the narrative verdicts and rule 43) have proved to be largely ineffective tools for harm prevention. The analysis identifies trends and patterns in deaths in custody that require improvements in custodial practices and procedures. For mental health the report states there is a lack of communication/information sharing between: prison staff (at shift handovers etc); police and prisons; prisons and prison units; prisons and prison staff; prisons and prisoners; prison Service and external agencies (i.e. Probation Service, NHS); youth Offending Teams (YOT) and Youth Justice Board (YJB); social workers and YJB; and police and attending psychiatrists. The report also mentions the use of restraint of those with mental illness and/or behavioural disorders and training of police and NHS staff to use the techniques.

Of the 42 'rule 43' reports in the sample that relate to deaths in prison, 10% raise poor mental health care as an issue.

A recommendation from the report states that there should be a central oversight body tasked with the duty to collate, analyse critically and report publicly on the accumulated learning from coronial narrative verdicts and rule 43 reports.

Coles, D. & Shaw, H. (2007) Unlocking the truth: families' experiences of the investigation of deaths in custody - Executive Summary and Recommendations, London: INQUEST
Unlocking the Truth describes the experiences of families bereaved by deaths in custody from the time of death to the conclusion of the investigation and inquest. It situates their experiences within the political, recent historical and legal context. Deaths in custody and mental health is not covered in the executive summary.

JCHR (2004) Deaths in Custody: Third Report of Session 2004-05, London: House of Lords/House of Commons Joint Committee on Human Rights.
This report examines the causes of deaths in custody, and considers what may be done to prevent these deaths. The report assesses the provision of physical and mental healthcare in detention, and the human rights implications of inadequate healthcare. It also raises concerns about the detention of mentally ill people in inappropriate forms of detention, whether in prison, in police cells, or in immigration removal centres. The report examines policy and practice in the use of physical restraint in all forms of custody, and the use of

seclusion in Mental Health Act detention in light of patients' human rights. The report also examines homicides in prison and mentions the case of Zahid Mubarek, killed by his mentally-ill cellmate Robert Stewart at Feltham Young Offender Institution in March 2000.

Browne, D. Durcan, D. & Sunders, A. (2013) Black and minority ethnic (BME) communities, mental health and criminal justice, London: Centre for Mental Health.
This report is an appraisal of best practice provision of those services working with BME communities at critical points of the criminal justice pathway. The report does not cover deaths in custody.