Has the management of mentally ill criminals by the UK justice system improved or deteriorated over the past fifty years?

Abstract

Following the commencement of the Deinstitutionalisation Drive in 1960, several state psychiatric hospitals were closed forcing psychiatric patients on the streets to fend for themselves, resulting in these patients becoming increasingly desperate and encountering police officers and courts more often. Nowadays, the situation has continued and is said to be aggravated by inappropriate sentencing, a lack of staff training, and delayed transfers to hospitals from prisons. This essay identifies and evaluates these three main factors that contributed and inevitably led to the mistreatment of prisoners with mental health disorders. It will lead to the conclusion that over the past fifty years, the handling of criminals with mental health disorders in the United Kingdom (UK) has drastically deteriorated and is in dire need of change. Relevant analyses and evaluations are made based on many secondary sources such as academic journals, websites, newsletters, and official government documents. Considering the prevalence of mental illnesses within secured prisons, it is vital to reassess the current management systems and implement attainable solutions to supply a higher quality of care to enhance the wellbeing of criminals during their sentence.

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Introduction

Despite accounting for socio-economic status, age, and other important social factors, the proportions of mental health disorders in UK prisons are much higher than in the general population. In 2017, 12% of incarcerated inmates met the criteria for psychosis; 53.8% for depressive disorders; 26.8% for anxiety disorders; 33.1% were dependent on alcohol and 57.1% on illegal drugs; 34.2% had some form of personality disorder; and 69.1% had two disorders or more (Bebbington et al. 2017). This has led to the prison service system having the highest drug-related suicide rates ever recorded in history (Revie and Mais, 2023) and being described as a "breeding ground for poor mental health" (Brooker and Ullmann). According to the World Health Organisation (WHO 2022), a mental disorder is a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour, usually associated with distress or impairment in important areas of the brain. Over 300 of these disorders are listed in the Diagnostic and Statistical Manual of Mental Disorders (ICD-11) and are arranged into multiple groups such as anxiety, personality, and psychotic (HealthDirect, 2023).

Since the Deinstitutionalisation Drive (Montenegro et al.) formally began in the 1960s, the United Kingdom (UK) has seen gradual changes in the legal and medical systems over time aimed to make mental healthcare more accessible for offenders, following in the footsteps of other countries such as Norway in terms of their focus on rehabilitation (Iversen, 2022). These changes have had far-reaching outcomes on the sense of community in British society: affecting the happiness of millions of prisoners, the safety of the public, and the quality of life of family and friends of the prisoners. However, significant amounts of evidence have suggested that either an overestimation of the changes' effects or the plain ignorance of stakeholders has resulted in deteriorating care that, in the long-term, could have negative consequences including a lack of trust in the criminal justice system and the National Health Service's (NHS) mental healthcare system: a critical drawback for British society to progress.

This essay will analyse the current state of justice for mentally ill prisoners in three different respects: the impact of the Deinstitutionalisation Drive on the UK, sentencing, and quality of staff training. Each of the following three sections will begin by examining aspects that have arguable improved over the past fifty years. However, these will be followed by a critical analysis of the areas in which deterioration has occurred, along with proposed recommendations for improving this area of justice in the future. It will ultimately be shown that, despite countless attempts to improve the situation, the current systems should be seen as worsening for the prisoners themselves and the members of the public, and that further research must be done so that the process of punishment can be more unbiased and streamlined for all parties involved.

Impact of Deinstitutionalisation Drive

The first aspect to consider is the impact of the Deinstitutionalisation Drive on prisoners. During this period, the focus shifted from large-scale psychiatric institutions, commonly known as asylums, to community-based care (Koyanagi and Bazelon, 2007). It has arguably played the most major role by influencing costs and management styles in prisons to this day.

But to begin with, an understanding of the Deinstitutionalisation Drive is needed to establish some context. Beginning in the 1960s and gaining momentum throughout the 1970s and 1980s in the United Kingdom, it was a transformative movement that shifted the care of individuals with mental illnesses from large, centralized psychiatric institutions to community-based settings (Fakhoury and Priebe, 2007). It served as a reaction to the substandard living arrangements and care given to patients in psychiatric hospitals that were often overcrowded (Craig and McCarthy, 2022). These patients were also subjected to cruel treatments such as lobotomy and electroconvulsive therapy which directly infringed their civil rights (Cuncic, 2022). This led to the closure of many long-stay psychiatric hospitals in the UK and the development of community mental health teams, outpatient clinics, and supported housing options (Torrey, 1987). It prompted important discussions on mental health care reform and highlighted the importance of comprehensive community-based services in promoting mental well-being and recovery.

Advocates of deinstitutionalization sought to provide a more humane and personalized approach to mental health care, emphasizing the importance of integrating mentally ill individuals back into society. By closing large psychiatric facilities, it was believed that patients would receive better care and support in smaller, community-based facilities and outpatient programs (Killaspy, 2007). While deinstitutionalization brought significant advancements in mental health care, it also faced numerous challenges. The closure of psychiatric institutions sometimes outpaced the development of adequate community-based services, leading to issues of homelessness and inadequate support for prisoners who were discharged. As a result, some individuals did not receive the comprehensive care they needed, and some ended up in the criminal justice system or living in suboptimal conditions (Holloway, 2018).

Despite these challenges, the Deinstitutionalization Drive marked a crucial shift in mental health care philosophy, promoting community-based care and emphasizing the importance of individualized treatment. Today, ongoing efforts continue to strike a balance between community-based care and the provision of appropriate resources to ensure that individuals with mental illnesses receive the best possible care while fostering their inclusion and participation in society.

To some extent, most patients experience significant positive outcomes from this transition. Transitioning prisoners from expensive correctional facilities to community-based care can result in substantial cost savings particularly in the movement of staff. By switching from nursing to residential care, local health authorities have the potential to achieve significant cost reductions. In fact, studies indicate that in one year alone, these authorities can save up to 20% of their total staff budget (The King's Fund, 2015). Maintaining large prisons can be financially burdensome, and reallocating funds towards community mental health services and support programs can provide more cost-effective options. These savings can be reinvested in prevention efforts, diversion programs, and comprehensive re-entry services to address the underlying causes of criminal behaviour. By treating individuals within appropriate mental health settings, there is a greater likelihood of long-term rehabilitation. This approach may reduce the risk of reoffending and, consequently, the future need for costly incarceration or intensive rehabilitation services.

Deinstitutionalisation has also brought about improvements in mental health care by prioritizing community-based services. This shift has allowed individuals with mental health conditions to receive

treatment and support tailored to their specific needs, promoting a more patient-centred approach. An example of this was the introduction of Assertive Community Treatment (ACT) which, in summary, is an evidence-based approach to mental health care designed to provide comprehensive and intensive support to individuals with severe mental illness who are involved in the criminal justice system (CWRU, 2021). In several observational studies involving 5,775 subjects, Assertive Community Treatment (ACT) has consistently shown greater improvements in psychiatric symptom severity when compared to standard case management treatments (Coldwell and Bender, 2007). ACT delivers a wide range of services directly to individuals in their own communities, helping them manage their symptoms and achieve their personal goals – aiding them in regaining their independence. Programmes such as ACT provide opportunities for prisoners to participate in decision-making regarding their treatment, housing, and employment options (Cuncic, 2022). This sense of empowerment has positively impacted their self-esteem and motivation to change for the better. This could be because individuals who might otherwise be institutionalized are given the opportunity to live independently and regain their autonomy.

However, despite all its merits, this historical change has created massive delays in transfers to hospitals from prison upon initial referral. Over the past decade, half of the prisoners in England referred for psychiatric treatment are not transferred to hospital (Robins, 2022). The analysis of Freedom of Information responses from 22 NHS trusts has revealed that, for the first time, slightly over half of the 5,403 prisoners assessed by prison-based psychiatrists in England between 2016 and 2021 were not transferred to appropriate mental health facilities. This figure represents an alarming 81% increase compared to the number of prisoners denied a transfer in the preceding five years. (Wall, 2022) The primary cause behind these delays is the scarcity of available beds in admissions wards within secure hospitals, which are specifically designated for the treatment of sentenced prisoners. One of the key disadvantages of such delays is the potential for exacerbation of mental health conditions. When individuals do not receive timely access to appropriate treatment and support, their mental health can deteriorate rapidly. Symptoms may worsen, leading to increased distress, risk of self-harm, or violence towards others.

Additionally, extended delays in transfers raise ethical and legal concerns. Recent data reveals a trend in England's high and medium security hospitals, as they consistently operated above the recommended maximum bed occupancy rate of 85% set by the Royal College of Psychiatrists (RCPSYCH, 2022). Despite NHS guidelines stipulating that inmates should be transferred within 28 days of an initial referral, the available figures, obtained from the Ministry of Justice, revealed instances where prisoners have been made to wait as long as 104 days after the department received a formal transfer application (Wall, 2022). As established guidelines and recommendations by healthcare organizations and regulatory bodies are being contradicted, ethical concerns arise. The denial of timely access to necessary mental health care violates prisoners' rights to receive appropriate medical treatment. This is not only crucial for prisoners' well-being but also for fostering their chances of successful rehabilitation and reintegration into society. Addressing these challenges requires collaborative efforts among healthcare providers, correctional systems, and policymakers to ensure the provision of timely and adequate health care for incarcerated individuals.

It is understood that psychiatric institutions provide long-term care for a secure recovery. The closing of these hospitals also led to an increase in the number of individuals with mental health illnesses living in the community. Consequently, this lack of transitional planning and available resources resulted in a significant number of prisoners facing homelessness upon their release. According to data from the Ministry of Justice, the years 2018 and 2019 witnessed 11,435 individuals who were released from prison directly into homelessness. Simultaneously, a minimum of 3,713 of these individuals were under the supervision of the National Probation Service, which is responsible for high-risk offenders – risking public safety (HMIP, 2020). The recent introduction of wide-scale early release schemes has intensified these pressures. Under reforms, prisoners serving standard

determinate sentences are now eligible for release after serving only 40% of their term as part of the drive to ease prison overcrowding (Georgia Poncia, 2024). The Independent further reveals that homelessness among released prisoners has soared by 30% in a single year despite government efforts to provide housing support. In 2024, 9,210 individuals were released into homelessness or rough sleeping. This is up from 7,055 the prior year representing about 13.1% of all prison releases. Experts partly attribute this increase to the “chaotic” emergency early release scheme (Andy Gregory, 2024).

Recent evidence has suggested that individuals released into stable accommodation are about 50% less likely to reoffend than those without housing (GovUK, 2023). Without a stable address, individuals face numerous challenges in resettling back into the community, finding employment, accessing financial services, and utilizing local support networks (UN). According to inspectors, numerous offender-specific programs have ceased operations or merged with general homelessness services, resulting in a reduced likelihood of acceptance for higher-risk individuals.

The His Majesty's Inspectorate of Prisons (HMIP) noted that the housing register generally did not prioritize most offenders, and certain individuals were excluded due to factors such as previous behaviour, rent arrears, being classified as "intentionally homeless" or lacking a local connection (Burke and Raynor, 2020). This apparent stigmatisation has created significant barriers for offenders in accessing suitable housing. Homelessness poses a major issue as they may impede compliance with probation or parole requirements. For example, having no fixed address can make it difficult to receive official correspondence, attend appointments, or maintain regular contact with probation officers (The Probation Service, 2015). These challenges can lead to possible violations, potentially resulting in legal consequences making them more vulnerable to mental health challenges or engaging in risky behaviours to meet their basic needs. To disrupt the cycle of re-offending among former prisoners, it is imperative for the government to prioritize two key areas: addressing the housing crisis and reinvesting in a robust, publicly funded probation services.

Sentencing

Another important aspect of justice to consider is the way that the mentally ill are treated by judges when pronouncing sentence. Due to the lack of understanding about mental illness in the criminal justice system, mentally ill offenders are often punished more harshly than others (CJJI, 2021), which can exacerbate their condition and lead to further negative consequences. It is also likely to lead to a cycle of reoffending (Boseley, 2015) as convicts may be unable to receive the necessary treatment to address their mental health issues, causing them to continue to engage in criminal behaviour. To further support this claim, a 2017 report by the Ministry of Justice stated that approximately 46% of offenders with mental health issues reoffend within one year of release from prisons (House of Commons, 2017) - this is much higher compared to the general reoffending rate of 29.4% (Statista, 2017).

As a result, there have been attempts made over the past few decades to specialise sentencing approaches in a way that better considers the unique circumstances and needs of mentally ill offenders – some of which have at least partially achieved their objectives. These include the relatively successful introduction of Community Sentences under the Criminal Justice Act of 1972 (Hussain et al. 2012). Community Sentences aimed to combine traditional punishment with activities to benefit the community for convicted offenders. In addition to a community sentence, they may be provided with a Community Sentence Treatment Requirement (CSTR) (NHS) to help them with any problems that may have contributed to the crime. One CSTR that is up for salient discussion is the Mental Health Treatment Requirement (MHTR) (RCPSYCH 2021) which was introduced after the amendment of Section 27 of the Criminal Justice Act 2003. The MHTR service plays a crucial role in identifying and offering psychiatric interventions to sentenced adults who may have a history of

trauma but have not received prior treatment within the community (Scott and Moffatt, 2012). They have been available to courts in the United Kingdom for crimes committed after 4 April 2005 and have usefully provided treatment plans to hundreds of offenders (National Offender Management Service).

The overall positive effect that MHTRs have had is palpable: community sentences with MHTRs have reduced re-offending rates more than short custodial sentences (Centre For Justice Innovation). Not only has this had a positive impact on the criminals' lives, but it would also be better for the wider society because it finally disrupts the illness-offending cycle (RCPSYCH 2021) which led to the influx of mentally ill offenders to begin with. In addition, in a cohort study of 7030 individuals with psychosis who had committed offenses, the results from a 2-year follow-up revealed a correlation between heightened engagement with community mental health services within 30 days following an offense and a decline in recidivism rates among male offenders (Adily et. al, 2020). This is most likely because treatment requirements can help individuals develop coping mechanisms and strategies to manage their mental health condition effectively. They can also help offenders regain and enhance their ability to perform daily activities, engage in meaningful work or education, and maintain healthy relationships. By providing appropriate care and support, treatment requirements can contribute to ensuring the safety and well-being of both the individual and the broader community.

Furthermore, the use of MHTRs have significantly reduced spendings. To keep someone in prison, mentally ill or not, for a one-year sentence, costs an average of £35,000 (Citizen's Advice). It was estimated, however, that 30 MHTRs saved a total of 17 years of custody, thus saving a minimum of £595,000 (RCPSYCH 2021). The proven decrease in reoffending rates leads to a decrease in costs related to arrests, court proceedings, incarceration, and probation or parole supervision. Moreover, the economy is benefitted by an increase in mental wellbeing, with the increased participation of employees resulting in increased tax revenue and reduced reliance on social welfare programs (Kundi et. al, 2020) – simultaneously saving money on the need for costly emergency room visits, hospitalizations, or intensive care. This vast sum of money has been spent effectively to benefit taxpayers and offenders.

However, other sentencing approaches have not met their purpose and have had an overall negative effect on the rehabilitation of offenders with mental illnesses. One of which is Hybrid Orders which are listed under Section 45A of the Mental Health Act 1983, amended in 2007, stating that a judge can mandate that an offender must be placed in prison after receiving hospital treatment and recovering or if the treatment has not benefited the patient (Alexandra Blackman, 2022). These can enforce strict conditions including limitations on social interactions, geographical restrictions, technology access, and control over an individual's behaviour within their own residence (JUSTICE, 2023). These circumstances have been called into question, resulting in a multitude of issues within the medical system.

One example of such an issue is aftercare, which has been considered insufficient under the Hybrid Order. Aftercare is defined as the additional support provided by community providers (College of Policing 2017) after a prison-based treatment programme, a hospital-based treatment, or a community sentence. The Hybrid Order does not guarantee acceptable mental healthcare after release, even though, other sections of the Mental Health Act such as Sections 37 and 41 (Rethink 2022) offer long-term psychiatric supervision and a follow up for their mental illness which has proven to be useful as 31% of prisoners who completed aftercare reoffended compared to a predicted reoffending rate of over 70% (Politics, 2021). It was suggested that release from the Hybrid Order did not provide appropriate protection to the public as the minimum aftercare provided is supervised by probation officers within the penal system rather than mental healthcare professionals (GCN 2018). Consequently, ex-inmates with mental disorders have relapsed, increasing the rates of suicide, self-harm, and drug abuse or they have re-offended, risking the safety and wellbeing of the public and

themselves (Chang et al. 2015). This system is vital to further aid prisoners' integration back into society, decrease the risk of reoffending and suicide, and provide mental healthcare that they could not afford immediately after their verdict (Fox et al.).

On top of that, deterrence to recovery could limit the progression of rehabilitation. Forensic psychologists would suggest that if a patient learns that their recovery means an immediate return to prison then this would demoralise them from seeking out purposeful recovery during their time in hospital. This was proven in a 2019 qualitative study of the Hybrid Order's use in forensic practice through interviewing 12 forensic psychiatrist with an abundance of experience in psychiatric sentencing recommendations: "I think it's very hard for people to truly engage in treatment if [when] they get better, they're going to prison..." (Blackwood et. al, 2019). This hidden motivation may cause a massive drop in the effectiveness of forensic therapy or hospital treatment, therefore delaying their recuperation.

To conclude, the evolution of sentencing styles has undergone significant changes over time, reflecting shifting societal attitudes and priorities. However, the overall impact of these changes on the well-being of prisoners has regrettably been negative. While there have been efforts to address issues such as harsh punishment and economic spendings, the criminal justice system still grapples with many challenges, including the perpetuation of cycles of recidivism due to a lack of programmes to aid reintegration into society. To truly promote the welfare of prisoners, it is essential to continue re-evaluating sentencing policies and prioritizing rehabilitation, with a focus on providing individuals with the support and opportunities they need to lead productive, fulfilling lives.

Quality of Training of Staff

Once incarcerated, the prisoners' mental well-being is the responsibility of prison officers and other staff. Nonetheless, the mental health training provided to these staff members has been deemed inadequate. According to an experienced prison officer, the extent of his training on mental illness consisted of a single talk and some online training modules using a "click-through PowerPoint" format (Wall, 2022) and, out of 380 prison officers, only a mere 4% had received sufficient training to address these mental health challenges within the prison environment (Inside Time Reports, 2022). This use of anecdotal and secondary research has been used to inform government programmes about the lack of high-quality mental health education for staff members.

As a response, new connections between mental health professionals and officers were established. For individuals with mental health issues living in the community, police officers are often the first point of contact during mental health crises. Introduced in June 2013, a telephone 'triage' system is an initiative that involves mental health nurses accompanying officers to incidents where immediate mental health support is deemed necessary by the police (UK Parliament, 2015). The service's awareness levels were notably high: in a survey of 256 officers from the Thames Valley Police, an impressive 92% of these individuals found the service to be helpful (Kirubarajan et. al, 2018). Officers acknowledged that the introduction of this service was "long overdue" and regarded it as "one of the best decisions made by Thames Valley Police and NHS in recent years." A particular comment highlighted the necessity of the service, emphasizing that "mental health is a specialist area, and police officers are not mental health specialists." (Puntis et. al, 2018).

By offering this immediate link to mental health experts, telephone triage systems play a pivotal role in addressing such distressing situations promptly. The correctional environment can be particularly challenging for incarcerated individuals, and many prisoners may encounter moments of emotional distress or crisis during their time behind bars (Lamb and Weinberger, 1998). Early identification and intervention of mental health issues are crucial in preventing the exacerbation of symptoms and

reducing the risk of crisis situations. In the correctional setting, where access to mental health care may face limitations, telephone triage bridges the gap and enables mental health professionals to promptly assess and address prisoners' needs. By addressing issues early on, mental health professionals can engage in targeted interventions and support, potentially alleviating distress and fostering a sense of stability and well-being for the prisoners. Moreover, telephone triage systems offer an avenue for continuous monitoring and follow-up care. Prisoners' mental health needs may evolve over time and being able to promptly identify these changes allows for the necessary adjustments in treatment and support. Regular contact with mental health professionals via telephone provides a valuable platform for prisoners to express their concerns, feelings, and progress, facilitating a more comprehensive understanding of their mental health journey.

The telephone triage system also reduces stigma on mental health issues. In the prison environment, seeking help for mental health concerns may be viewed as a sign of vulnerability, leading to potential social repercussions (Quandt and Jones, 2021). Having a system that prioritises the care of others demonstrates that seeking mental health support is a routine and accepted aspect of overall health care (Søvold et. al, 2021) By providing a confidential platform for communication, telephone triage systems remove some social barriers, making it easier for prisoners to prioritize their mental health without concerns about negative perceptions from others. Addressing the stigma surrounding mental illness in the correctional setting, telephone triage systems contribute to a more compassionate and supportive environment. They promote open dialogue about mental health concerns, encourage help-seeking behaviour, and empower mentally ill prisoners to prioritize their well-being, ultimately fostering a healthier and more conducive correctional atmosphere for rehabilitation and reintegration into society.

More recently, the introduction of the Right Care, Right Person (RCRP) initiative (College of Policing, 2023) has begun to reshape how mental health-related incidents are handled in the British community. Launched by the UK government in 2023 and now being rolled out across police forces, RCRP seeks to ensure that people experiencing mental health distress are supported by the most appropriate service rather than being defaulted to a police response. Under the new national framework, non-emergency calls involving mental health or welfare concerns are, where appropriate, redirected to NHS crisis teams, ambulance services, or social care professionals, rather than police officers (West London NHS Trust, 2023). Early evaluations have shown reductions in the time police spend on health-related incidents, and some forces have reported fewer detentions under the Mental Health Act because of improved triaging and referral (Home Office, 2024). The policy aims to reduce unnecessary police involvement, free up policing resources, and improve outcomes for vulnerable individuals by ensuring they receive care from trained professionals.

Although these connections have been found, the lack of fundamental mental health training for prison officers (Metropolitan Police, 2022) has led to numerous influential issues. The first problem was that a lack of education would lead to mental health issues not being identified. It should be noted that since 2018, a mandatory first-day and follow-up screening requirement has been implemented for every adult entering the correctional system (Hard and Watson, 2021) and is completed by primary care nurses or healthcare social workers (House of Commons, 2021). This follow-up screening holds significant importance as it is often during this time that individuals, especially those experiencing custody for the first time or on repeated occasions, may experience changes in drug misuse, increased anxiety, medication needs, or psychosis. However, there is no standardized mandate for mental health training within the prison workforce (NHS). As a result, these healthcare practitioners may have inconsistent or even non-existent levels of experience in mental health. Consequently, due to their lack of familiarity with evidence-based practices and therapeutic techniques essential for managing and addressing mental health conditions, inmates may be deprived of the vital support, counselling, and medication required to address their concerns.

Furthermore, the situation is exacerbated by the personal biases that some of these healthcare professionals may hold. This analysis examines the prominent themes of stigmatization related to race, sex, and mental illness, delving into each topic individually. The Lammy Review revealed that there is a concerning disparity in the identification of learning difficulties among Black, Asian, and Minority Ethnic individuals compared to other prisoners (The Lammy Review, 2017). Racial disparity is proven further by real testimonies such as a prisoner from the East Midlands who had been the victim of segregation and consistent humiliation from officers: “My co-defendant saw what was happening and mentioned something to the guard and said I was being racially abused, to which his reply was ‘good, tell someone that cares.’” (T2A, 2016). Another form of stigmatisation is the gender-based disparity in access to appropriate care. Concerns were raised about discriminatory gender-specific offenses, inadequate financial resources to prevent incarceration, and a prison system primarily designed by and for male prisoners (Lang, 2021). A common problem in prisons is the limited access to hygiene products including sanitary items and hot water. For many decades, there has been a significant absence of provisions addressing the specific needs of women, even though the failure to provide a sanitary environment that fulfils basic health requirements violates their rights to health and dignity (Woodall et al., 2021). The potential consequence of this situation is the emergence of behavioural problems since physical deficiencies are directly linked to mental health issues.

Finally, people with mental illnesses, in general, often encounter discrimination by experiencing negative perceptions and treatments (HealthDirect, 2021). Research findings imply that police officers can harbour negative attitudes towards individuals with mental health problems, often perceiving such cases as incongruent with what they consider as "proper police work." (Bittner, 1967). In spite of the Equality and Diversity Laws (UK Parliament, 2010), multiple studies have highlighted the allegations of individuals who have experienced mental health challenges, revealing that they often feel undervalued by the police service (Jones and Mason, 2002) . Therefore, untrained staff members who hold stereotypes on race, sex, and mental health can result in the neglect of the prisoners’ needs, denial of appropriate care, or disciplinary actions that exacerbate their conditions rather than addressing them in a compassionate and rehabilitative manner. Due to a lack of understanding, untrained staff may inadvertently escalate situations involving inmates with mental health issues, resulting in heightened tension, conflicts, and physical harm affecting both staff and inmates. The HM Prison and Probation Service should collaborate with mental healthcare experts within the prison system to create training programs for prison officers and operational staff.

Conclusion

As demonstrated by the arguments presented above, the justice system in the United Kingdom has become more open-minded in their practices with mentally ill offenders, leading to an improvement in the quality of their care. However, substantial evidence suggests that the faulty medical system led by the National Health Service has worsened, especially for prisoners who are not able to receive adequate medical care – causing an increase in suicide and reoffending rates. The safe keeping of criminals with mental health disorders has significantly deteriorated, for reasons including unwise sentencing decisions, insufficient staff training, and the scarcity of high-security psychiatric beds. Although all three of these factors contribute to the modern humanitarian crisis, it can be concluded that delayed or poor-quality medical treatment, due to the shortage of staff and resources in high security psychiatric hospitals, and the racial disparity integrated within mental health screening on arrival to prison, should be labelled as particularly fatal. Despite the reopening of some forensic hospitals, the fact remains that without any medical intervention in prisons, vulnerable prisoners with mental disorders will never improve or reintegrate back into society smoothly, which increases the risk of re-offence.

Due to a lack of space and time, this essay does not exhaustively discuss the myriad of social factors involved in this complex issue such as social stigma or the influx of mentally ill criminals to begin with. Only a multidisciplinary approach that spans beyond the scope of prison healthcare would sufficiently address the faults with its management; but the discussions made in this dissertation would hopefully reveal aspects within the literature and system that should be afforded more attention. It would perhaps be beneficial if future research could be undertaken into ways to prioritise cost and quality services within the NHS and ways to educate not only the staff in jail but the public and those involved with the final sentencing decisions on mental healthcare to ensure that all people in these sectors would find the motivation to address the multitude of problems discussed.

While the justice and medical system has made progress in handling mentally ill offenders, then, the inadequate medical care in prisons remains a pressing issue that needs to be addressed urgently. The identification and assessment of mental health needs, collaboration between the criminal justice system and mental health professionals, and the provision of wrap-around services are all essential components of effective management of mentally ill criminals. It is crucial for the government to allocate more resources to improve the quality of healthcare in prisons, particularly for those with mental health issues, to ultimately promote the well-being of prisoners as well as the society. Through these concerted efforts, we can build a more just and compassionate system that nurtures the potential for rehabilitation, healing, and reintegration into society. Only then can we begin to fulfil the promise of a fair and equitable justice system for all, including those with mental illness.

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