

PATIENTS OR PRISONERS: IMPLICATIONS OF OVERLOOKING MENTAL HEALTH NEEDS OF FEMALE OFFENDERS

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Abstract

Since the publication of the Corston report in 2007, there has been little implementation of the recommendations for helping women in prison with mental health needs, despite research providing a better understanding of mental health requirements and a recently developed Female Offender Strategy (Ministry of Justice, 2018a). Evidence has also been brought to light in terms of offender pathways and the complex interplay between offending, mental health and other factors. Therefore, a fresh understanding of mental health among female prisoners is required, as prevalence and need in relation to this cohort is likely to have changed in the intervening years. The short prison sentences that many women are serving can be counterproductive in reducing recidivism and often exacerbate the circumstances that result in many women reoffending. To date, the recommendation of replacing women's prisons with smaller custodial centres has only been implemented at one establishment; therefore, its impact cannot be fully determined. Evidence supporting existing interventions, including the recent liaison and diversion programme, is inconclusive due to a lack of research and inconsistent programme implementation. Therefore, a review of the Corston report (2007) and a re-evaluation of the mental health needs of women prisoners is required to support the development of a much-needed 'new' model of rehabilitation.

Keywords

Mental health; women in prison; offending; rehabilitating offenders

Background

The Corston report (2007), a research and recommendations paper commissioned by the government and led by Baroness Corston, was instrumental in bringing to light the issues confronting female prisoners, such as physical and mental health, education, and family relationships. Two years after the report was published, research by Fair (2009) reported that physical and mental health issues were still more likely to affect female than male prisoners, with the Prison Reform Trust restating this finding as recently as in 2015.

Despite evidence emphasising that comparatively, female prisoners suffer more mental health issues, it has been suggested that because women represent only a small percentage of the overall prison population, prisons struggle to appropriately address their needs and continue to disproportionately cater to the needs of male prisoners (Fair, 2009). More than ten years since the publication of the Corston report (2007), a number of its recommendations around mental health have not yet been implemented.

Mental health issues and prevalence in female prisoners

A systematic review published by the Ministry of Justice (2009) reported that observational studies had discovered that the percentage of offending among participants (both male and female) with mental health issues ranged from 15 per cent to 45 per cent. Although the variance may be accounted for by differing definitions of 'offending' and 'mental health', what could be concluded was that the rate of offending was higher in this population than in the general population.

The Corston (2007) report illustrated that many female prisoners, both on remand and in prison, suffer poor mental health and substance abuse problems on a scale that is disproportionately larger than in male prisoners. Research by Plugge et al. (2006), which was cited in the Corston report (2007), found that female prisoners were over five times more likely to have a mental health concern than women in the general population. Plugge et al. (2006) also reported that mental health issues were likely to impact on women throughout their time in prison: 78 per cent of women displayed some psychological problems when they arrived in prison, and 40 per cent of female prisoners had received help for mental health issues in the 12 months prior to their imprisonment. Although the Corston report (2007) was pivotal in identifying that mental health was a bigger issue for female prisoners, it did not explicitly identify the types of mental health issues commonly experienced by female prisoners, what help was being offered to women or how effective that help was.

In the years since the publication of the Corston (2007) report, research has progressed and has started to present evidence identifying the types of mental health problems that female prisoners and offenders experience. For example, research comparing a sample of incarcerated young women and non-offending young women on a range of mental health diagnoses reported that female prisoners showed increased levels of conduct disorder, substance abuse disorders, depression and post-traumatic stress disorder (PTSD), with 78 per cent of the offender sample meeting the criteria for three or more disorders (Dixon et al., 2004). It is likely that the prison environment can both exacerbate existing mental health problems and trigger mental health issues in those who were not experiencing them

previously, as research presented by Byrne (2003) found that the mental health needs of female prisoners increased during their time in prison.

The link between offending, mental health and other factors

The reasons underpinning women entering the criminal justice system (CJS) are as multi-factorial and complex as the reasons for men entering the CJS. Research has confirmed positive interdependent associations (one factor causing another) between housing issues, material deprivation, alcohol and substance use, mental health issues and offending (Green and South, 2005). Figures also suggest that as many as 42 per cent of women involved with the probation service have emotional and relationship-based well-being issues (Royce-Greensill, 2016), while other literature implies that mental health and addiction are factors related to offending and subsequent contact with the CJS (see, for example, Phillips, 2000; Molero, Larsson, Larm, Eklund and Tengstrom, 2011; Wareham and Boots, 2012; Walters and Urban, 2014). The Corston (2007) report itself established that women in the prison system were likely to have experienced sexual or physical abuse, but it only reported the 'likelihood' of a link between these experiences and mental health.

The aftermath of such abuse can manifest itself in many ways. Qualitative interviews with 96 incarcerated adolescent women showed that a large percentage of them had been exposed to multiple types of trauma or abuse, 65.3 per cent reported to have had experienced PTSD at some time in their lives, 48.9 per cent were currently showing symptoms of PTSD and a further 11.7 per cent were currently showing partial PTSD symptoms (Cauffman et al., 1998). Similar results were obtained in a more recent study, which aimed to document the prevalence of PTSD symptoms and comorbid psychiatric disorders in female juvenile offenders; this study also supports the link between trauma, PTSD and further development of psychopathology amongst young female offenders. Later research using the Diagnostic and Statistical Manual criteria to establish PTSD symptoms from interviews found smaller percentages of incarcerated women in China had current or lifetime PTSD (10.6 per cent and 15.9 per cent of 471 prisoners, respectively) and that 86 per cent had experienced at least one traumatic event (Huang et al., 2006).

The same research (Huang et al., 2006) identified that predictive factors for lifetime PTSD included the experience of the sudden death of a close friend or a loved one, childhood physical and sexual abuse, physical assault (during childhood or adulthood), witnessing family violence, and experiencing more than five traumatic events. Based on this and other evidence, abuse has been linked to the development of anxiety disorders, including PTSD (Byrne and Howells, 2002). Such findings should be considered when working with female offenders with a history of trauma, as this may be useful in improving diagnoses and making appropriate referrals for treatment.

Research on co-morbidities has highlighted a relationship between serious mental illness, substance abuse and a history of trauma (Butler et al., 2011; Lynch et al., 2012). This link is further supported by Nowotny et al. (2014), whose research looked at data to determine the risk profiles of women in prison with a serious mental illness. Their study found that one in five of the women had a current co-occurring disorder (a mental illness in addition to substance abuse issues). The findings also revealed that significantly more women with a current co-occurring disorder had been exposed to violence and drugs at a young age.

Although the research findings of Plugge et al. (2006) reported that 40 per cent of female prisoners had received help for mental health issues in the past year, Nowotny et al. (2014) found that approximately one-third of the women with a current co-occurring disorder had received no treatment in the past year, highlighting a substantial unmet need.

A risk factor linked to mental health problems and offending in both men and women is alcohol and substance misuse (Brekke et al., 2001; Sheldon et al., 2006). Substance abuse is also reported to be a bigger problem in female prisoners than in male prisoners (Prison Reform Trust, 2015). Research by Plugge et al. (2006) showed that in the six months before imprisonment, 58 per cent of women had used drugs daily, 75 per cent had taken an illicit drug and 42 per cent drank excessive amounts of alcohol. The Social Care, Local Government and Care Partnership Directorate (2014) also confirmed that people with mental health problems have higher levels of alcohol misuse and that these difficulties are exacerbated by poverty, poor social networks, and more difficulties accessing housing, employment, education and other opportunities: factors that the Corston report (2007) implicated in the offender pathways of women.

A report by Byrne and Howells (2002) stated that substance abuse issues are related to physical and/or sexual abuse and being unable to manage distress. Based on the understanding that substances are known to be used by female prisoners to manage both abuse and mental health issues, and the established link between mental health, substance abuse and offending, there is a possibility that some prisoners who have substance abuse issues in addition to a history of abuse also have undiagnosed mental health issues. Although the Corston report (2007) concluded that drug addiction plays a disproportionately large role in female offending, the report did not address the concern that drug addiction may also represent a coping mechanism used by incarcerated women to mask existing mental health issues and trauma.

Applying the knowledge gained from existing research findings and commissioning further research into the links between mental health and offending would allow for a more in-depth understanding of the complex issues that exist. This understanding could then be incorporated into treatment programmes.

Corston recommendation: sentencing

Creating better practices that do not needlessly sentence women to custodial terms when they could be rehabilitated outside prison was another recommendation in the Corston report (2007). Corston (2007) put forward the case that many problems listed in female offending pathways (addiction, mental health, unemployment, unsuitable accommodation and debt) could be better resolved through casework, support and treatment than through prison. This is because for many women, the prison environment is particularly tough: it punishes women with existing issues for non-violent crimes by imprisoning them for a time so short that they are unable to receive the help and support they need to address any short- or long-term issues, but for long enough to have a negative impact on their lives and on their families.

This can be particularly pertinent for the two-thirds of women who lived with their children prior to their imprisonment, as they are unable to provide care for their children and,

therefore, cannot ensure that they have stability (Corston, 2007). This negative impact is reflected in findings stating that only 5 per cent of children of incarcerated mothers remain in their home, with many being cared for by relatives or friends and 12 per cent being put into care or foster care (Corston, 2007). A concerning finding of the Revolving Doors Agency (2004) survey is that of 1,400 female prisoners, 42 per cent did not know for certain how their children were being taken care of. Additionally, the Prison Reform Trust (2015) stated that on average, female prisoners were imprisoned 60 miles away from their families, making visiting and maintaining family relationships more difficult. These factors run parallel with the stigma of being an incarcerated woman and the attached notions of being a bad wife, partner or mother (Corston, 2007), and they contribute to a woman's prison experience: one which may be hard for a woman to leave behind once she is released.

The Corston report (2007) strongly suggested that the short prison sentences many women serve do not successfully deter future offending. David Cameron's prison reform speech in 2016 stated that 60 per cent of short-sentenced offenders (both men and women) would reoffend within a year of release (2016). What was not addressed in his speech were some of the reasons behind this statistic. Women who have lost their children, family and home as a result of their imprisonment may purposely try to re-enter prison due to having nowhere safe to go after their previous release. Qualitative data from Green and South (2005) suggested that issues such as lack of accommodation relate to a person's likelihood of not only being put in prison but also returning to prison, with some women seeing prison as a safer option than a lack of stable accommodation. Green and South (2005) described the experience of offenders with mental health problems as a detrimental cycle, as those who received a custodial sentence of 13 weeks or more lost their local authority tenancy and so may have returned to prison as a result of their reduced access to stable housing.

For some women, their short time in prison does not provide the level of support required to address the issues that led to their offending and incarceration, which may result in further offending. A report by the All Party Parliamentary Group on Women in the Penal System (2016) stated that dealing with women in this way is an ineffective and expensive way of trying to reform women who come into contact with the CJS. Although David Cameron (2016) did state that there was a strong case for dealing with women with children in a different way, there is an equally strong case that short sentences can be the catalyst for further reoffending. This has been recognised by the recently published Female Offender Strategy (Ministry of Justice, 2018a) which is looking to shift emphasis from custody to the community with non-custodial sentences in place tackling the causes of offending such as substance misuse.

Corston recommendation: replacing women's prisons with custodial centres

A further recommendation made by the Corston report (2007) was that women's prisons should be replaced with suitable, geographically dispersed, small multi-functional custodial centres within the next 10 years. Despite the recommendation being re-emphasised in a subsequent paper that contemplated the achievements made in the years since the report (All Party Parliamentary Group on Women in the Penal System, 2011), there have been limited instances of its implementation.

One recent example of its implementation was adopted in Scotland when Cornton Vale prison was closed. The prison was replaced with a smaller prison and five small custodial units that intended to support and treat women with mental illness, drug and alcohol issues and other problems and were located closer to the women's families (Saner, 2015). Although it is too early to assess whether this approach will reduce offending in the long term, as the process is still being implemented (Scottish Parliament, 2018) the implementation was described in the media as a fresh approach (BBC News, 2015). However, in England, the Ministry of Justice (2018a) has decided to scrap plans to build five new community prisons for women and instead increase the use of non-custodial sentences.

Barriers to implementing alternatives to prison for offenders with mental health issues

Mental health appears to be a problem that prisons and criminal justice services are failing to adequately address, prompting yet more governmental focus. One of the main issues in trying to address the mental health concerns detailed in the Corston report (2007) is that the report was published 10 years after the Office for National Statistics (ONS, 1997) survey of psychiatric morbidity among prisoners in England and Wales was conducted. Between 1997 and 2007 no other study on prison mental health was conducted, so part of the picture of female prisoner mental health shown in the Corston report (2007) was already 10 years old and could have been considered outdated even then. In 2014, the Social Care, Local Government and Care Partnership Directorate produced a policy paper covering the current picture of mental health in general, which led to research by Public Health England being commissioned and the Mental Health Intelligence Network being set up with a view to gathering evidence and understanding mental health needs and well-being in the UK.

Although initiatives to address mental health in prisons did arise from this policy, a current picture has still not been established. As mental health does not have the same level of stigma attached to it as it did in 1997 (when the last ONS survey of psychiatric morbidity among prisoners in England and Wales was conducted), it would be expected that a higher percentage of prisoners would report having issues with mental health. From there, the resources required to manage the problem could more accurately be considered.

Despite there historically being an incomplete understanding of mental health needs in prison, in recent years there has come to be an acceptance that prison is not an appropriate place of rehabilitation for many prisoners – particularly women. However, alternative options are not available with the level of support required to make them successful. This was emphasised in the All Party Parliamentary Group on Women in the Penal System (2016) report, which stated that effective women's centres and diversion schemes had insufficient and unstable funding allocated to them. The 2018 Female Offender Strategy (Ministry of Justice, 2018a) has recognised the vulnerability of women offenders and prisoners, especially in terms of mental health needs, and the strategy is recommending increasing the use of community sentence treatment requirements rather than custodial sentences. However, as the strategy is so recent, it is difficult to measure its impact.

It would seem that because of this historical lack of alternatives to prison, the number of female prisoners serving short sentences has not been significantly reduced in the 10 years since the Corston report (2007) was published. The All Party Parliamentary Group on Women in the Penal System (2016) reported that the number of female prisoners had fallen by less than 500 women (from 4,350 in March 2007 to 3,889 in May 2015); and when women on remand are considered, there were almost twice as many women behind bars in 2013 as there had been in 1993.

The number of women in prison has slowly fallen from 4,350 in March 2007 to 3,889 in May 2015 (Ministry of Justice, 2016). However, this is still almost double the number twenty years ago when the female prison population stood at 1,979 (Ministry of Justice, 2014).

Another issue that prevents alternatives to prison from being utilised is the lack of knowledge about successful intervention, rehabilitation and diversion strategies. The Social Care, Local Government and Care Partnership Directorate's (2014) policy on mental health stated that it had commissioned Public Health England to develop an evidence base to determine the mental health services and treatments that are most effective. To date, however, this evidence has not been published.

As part of their systematic review, the Ministry of Justice (2009) evaluated the known intervention schemes that are used in the USA and the diversion schemes that are currently used in the UK. As the Ministry of Justice (2009) only found intervention schemes from the USA, this impacts on how easily best practice can be applied to a UK context, due to the differences between the two CJSs.

One of the methods used in the USA is the specialist mental health courts (SMHCs). After a hearing, the defendant is able to access mental health treatment services that are available in the community or as hospital in-patient services. Findings reported that the percentage of people who received treatment was higher among SMHC participants (83 per cent) than among those trying to access services through the traditional court route (52 per cent) (Boothroyd et al., 2005). SMHCs were also found to reduce re-arrest rates and the severity of such re-arrest amongst those with poor mental health, compared with those who followed the traditional court route (Moore and Hiday, 2006). Although these services are increasing in number, there is a lack of research into the effectiveness surrounding the intervention beyond access and recidivism figures once the SMHC has reached a verdict. One reason for this may be that the review did not include a description of a definitive, nationwide model of what processes are carried out in SMHCs or the type of mental health services female offenders will gain access to. It is also unclear what treatment services are available to individuals, the quality of those services, how appropriate they are for those referred, how they are staffed, and patients' experiences of and perspectives on these treatments.

Compulsory outpatient treatment (COT) is another intervention used in the USA that was evaluated in the review (Ministry of Justice, 2009). The evaluation generated mixed results when the findings were compared. A randomised control trial of COT for offenders with mental health problems found that the longer clients spent in COT, the less likely they were to be arrested (Swanson, 2001). The same study also found that routinely taking

medication, reducing misuse of substances and lower levels of violent behaviour were also significantly linked to lower rates of recidivism among those receiving COT. However, a review paper did not find any significant differences in arrest rates between those who were involved in COT and those who were not (Kisely and Preston, 2005). What should be considered is that this discrepancy in findings may be due to the research methodologies or because Kisely and Preston were unable to detail the interaction of the intervention and outcomes across several studies (particularly if different samples and methodologies were used). Therefore, this is not definitive evidence that the intervention is ineffective. However, further research is required to generate more informed conclusions.

The evidence base for UK diversion schemes is not favourable. Court-based diversion schemes in the UK, such as criminal justice mental health teams (CJMHTs), in which mental health assessments are conducted, were found to result in referrals to mental health services in only 12 per cent of those assessed (Green and South, 2005). The same research found that 'court ordered referrals' or 'community referrals' were more likely to occur if an individual met the criteria for a severe mental illness. These findings are problematic, as there is no information confirming whether accurate diagnoses are made (and in what percentage of cases). This is an important consideration for two reasons. The first is that CJMHTs can vary from a full team of health-care professionals to just one community psychiatric nurse carrying out the assessment (Ministry of Justice, 2009) and, as such, diagnoses may not be consistent. The other consideration addressed by the review paper (Ministry of Justice, 2009) is that individuals could be prevented from accessing treatment if they are not considered to have a severe mental illness (such as schizophrenia, bipolar disorder or schizoaffective disorder), making accurate diagnosis crucial.

When comparing community-based referrals with court-ordered referrals for psychiatric admission, it appears that there were no significant differences in completion rates for those accessing treatment through a court-ordered or a community-based referral (James et al., 2002). The assessment of recidivism for diversion schemes was complicated due to the ways in which offending was reported. However, the reconviction rates of court-ordered psychiatric patients were less than half those of offenders given prison or community disposals (James et al., 2002). It was stated that this may be due to the impact of hospitalisation and the close monitoring, which reduces opportunities to offend (Ministry of Justice, 2009).

The Ministry of Justice (2009) review stated that increased recidivism could be explained by secondary offences, such as non-payment of a fine or failure to attend. To date, there is no strong evidence available to support the use of one intervention or diversion strategy over another. Further research and evaluation of these strategies would be required to provide an evidence base that could be cited as a rationale for implementing specific alternatives to prison.

Current initiatives for offenders and prisoners with mental health needs

Despite the varied results and mixed feelings about court diversions, a programme was trialled in the UK for two years starting in April 2014. Following initial discussion in the Social

Care, Local Government and Care Partnership Directorate's (2014) policy on mental health, the government stated that it wanted to assess the individual needs of anyone who came into contact with the CJS as part of a new liaison and diversion service at police interview and custody suites.

A pilot programme was rolled out in 10 areas in April 2014. The Social Care, Local Government and Care Partnership Directorate (2014) policy stated that the aim of the liaison and diversion service was to identify individuals in the CJS with mental health needs (and other vulnerabilities), assess them and potentially refer them to appropriate support services. Further objectives were to improve access to services, divert individuals out of the CJS and into other supportive services (NHS, social services), and reduce reoffending.

An evaluation of the pilot programme was published by Disley et al. (2016) and provided limited results. The evaluation stated that data were available for only four of the ten areas due to geographic changes in the areas covered by the programme before and after implementation. Another methodological issue identified by Disley et al. (2016) was that a control group could not be used for a 'before and after' comparison; nor could an evaluation be done to compare the pilot areas with areas that had no liaison or diversion services (due to a lack of data on who would have accessed the service had it been available). Due to these limitations and the short amount of time for which data had been collected, no data on reoffending was available; therefore, uncertainty exists around how the programme impacts on offending behaviour.

Although analysis of the four sites found that more adults who could benefit from the diversion scheme had been identified through the programme, this did not result in a proportionate increase in the number of identified needs. This may be because these areas were reported to have liaison and diversion services in place prior to the pilot, or because the extent to which the programme was implemented varied between sites (Disley et al., 2016). Further analysis by Disley et al. (2016) revealed that information about individuals with vulnerabilities could increase or decrease the chances that a case would be prosecuted rather than diverted.

The data from the study by Disley et al. (2016) suggests that housing and benefit services were perceived as being the most difficult to refer to. Issues with monitoring were also reported in the evaluation, as practitioners were not always aware of whether service users continued to engage with the services or what their outcomes were. It was interesting to note that there was a discrepancy between the data from the four sites and the data from stakeholder interviewees, judges and magistrates. The data from interviews, judges and magistrates suggests that the model did have an impact on sentencing decisions, despite this not being reflected in the data from the four sites (Disley et al., 2016). Only 18 service users provided feedback about the model; as such, their experiences may not be applicable to all who have been referred, as the people who provided feedback were the ones who were likely to have engaged with the service (Disley et al., 2016). The feedback stated that service users could develop a rapport with liaison and diversion staff, that the service could be reassuring, that practical support to access referrals was provided, and that being able to talk to the staff was as important as the practical support that was offered (Disley et al., 2016).

It is difficult to make any concrete conclusions from this evaluation. The impact of the pilot on reoffending and on identifying needs was inconclusive due to a lack of data. The short amount of time the pilot had been in operation may be the reason for a lack of meaningful data or conclusions. However, as the programme was in various degrees of operation throughout the 10 sites, this may also have contributed to the lack of consistency in the findings. What is apparent is that issues with resources meant that the staffing levels for the pilot did not meet the aims. A result of this was that staff were not always aware of what had happened beyond a person being referred to services. Further to this, the aim of diverting vulnerable people away from the CJS was not achieved, as it was found that vulnerabilities could increase the chances of prosecution. Despite the evaluation findings, Nacro (2016) has announced that it will provide funding so that the scheme can be rolled out across England by 2020.

What should happen next vs. what is proposed to happen next

Considering that many sources, including the Corston report (2007), highlight the vulnerabilities of women in prison, it is apparent that the prison environment is an unsuitable one in which to establish a rehabilitation system that will support a variety of complex needs. This becomes apparent when female prisoners receive short sentences and are often released before the work of gaining trust and creating the foundations to help the individual has occurred, sometimes resulting in recidivism due to the impact that incarceration has on women's lives outside prison. Existing interventions and diversion strategies designed to provide access to mental health services are not supported by enough research evidence to enable them to be put forward as useful strategies for women in prison who need referrals for their mental health and other issues. However, these initiatives should be trialled and evaluated with female prisoners to see if they are effective in this population.

The announcement that there will be a move towards full co-commissioning for governors and NHS England so that prison leaders can allocate a budget for implementing mental health services for prisoners is flawed, as it does not consider the admission that there is not a full picture of mental health in general or in prisons (Social Care, Local Government and Care Partnership Directorate, 2014). Therefore, allocating funding to services without a thorough understanding of mental health within prisons would be inadvisable.

The suggested reforms appear to overlook many of the recommendations made in the Corston report (2007) and the evidence in favour of these recommendations. A possible reason for this oversight is the complex balance between the need to treat a person for underlying issues (e.g. mental health) and the need to prosecute and punish individuals for the offences that they committed in order to show the public that justice is being done (Home Office and Department of Health, 1995). Historically, the reporting of cases where newly released offenders with mental health issues have gone on to commit serious offences, such as murder, has led to a reluctance to treat offenders in the community, which has resulted in an influx of offenders with mental health problems in prison (Ministry of Justice, 2009). However, as the recent Female Offender Strategy (Ministry of Justice, 2018a) recommends viewing custody as the last resort and instead states that the focus should be on addressing offending and underlying causes in community settings, it is possible that Corston's recommendations made in 2007 are finally being actualised. To do so, the

government intends to invest £5 million over the next two years to address the provision of services in the community for women as well as to develop a pilot for at least residential centres in England and Wales. This strategy has also driven guidance for police forces to raise awareness of the particularities of the needs of female offenders (Ministry of Justice, 2018b). While this is a positive step towards a more evidence-based practice, the strategy also calls for local solutions, which hinders clarity on how consistency on treatment options and their evaluation is going to be embedded throughout the pilot.

When considering how best to address mental health needs in female prisoners, a finding from James et al. (2002) should be acknowledged: an influx of prisoners with mental health problems will result in more people being denied access to treatment, as prisons are not equipped to treat mental health problems. This sentiment was reflected in the Corston report (2007) and should be kept in mind when creating future policies.

In conclusion, there is still limited understanding of current rates of mental health needs in prisons, despite progressive research into the types of mental health issues that impact on women who offend and the links between offending and mental health. This, combined with a lacking evidence base for intervention, liaison, diversion and treatment services, and few firm examples of the Corston report's (2007) mental health recommendations being implemented, presents a compelling case for re-evaluating how to deal with women in the CJS who struggle with mental health issues. It would seem appropriate and sensible for a relevant model, which considers the current prevalence of mental health needs in female prisoners, to be developed with some urgency.

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