The mental health of prisoners

A thematic review of the care and support of prisoners with mental health needs

October 2007

ISBN: 978 1 840990 107 9
Published by:
HM Inspectorate of Prisons
1st Floor Ashley House
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LONDON
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With thanks to: The Healthcare Commission Prison Working Group; Eddie Fletcher, Offender Health; Kate Lawrence, Healthcare Commission; Neil McIntosh, Offender Health; Dave Spurgeon, Nacro

Introduction

'There is particularly urgent need for increased provision for the care of those with mental health problems, who make up a larger proportion of the prison population than they would of any other group in the community. What is more, prison can exacerbate mental health problems, which has a long-term impact on the individual concerned and the community into which he or she may be released.'

HM Chief Inspector of Prisons, *Patient or prisoner?*, 1996

'Since the late 1980s the proportion of the prison population who show signs of mental illness has risen seven-fold. For them, care in the community has become care in custody […] But I do have what I see as the cavalry coming over the hill in the form of 300 psychiatric nurses from the NHS coming into prison hospitals to offer in-reach services to those who are ill. But the problem is near overwhelming.'

Martin Narey, then Director-General of the Prison Service, at the British Institute of Human Rights, 2002

This report describes the conditions and treatment of the large number of mentally disordered people in prison, 10 years after the Inspectorate published its seminal healthcare report, *Patient or prisoner?,* and five years after Martin Narey's 'cavalry' – NHS mental health in-reach nurses – began to ride over the hill and into prisons.

There can be no doubt that, over this period, the quality and extent of treatment available to mentally ill prisoners has improved. The presence of trained healthcare professionals, and the direct involvement of the National Health Service, has had a direct effect on the care of patients, and an indirect effect on the better understanding of mental illness among prison staff as a whole. But, in a sense, this infusion of skilled personnel has acted as a marker: establishing beyond doubt not only the scale but also the complexity of the need.

Two findings stand out starkly from this report. The first is that there are still too many gaps in provision and too much unmet and sometimes unrecognised need in prisons. The second, equally important, is that the need will always remain greater than the capacity, unless mental health and community services outside prison are improved and people are appropriately directed to them: before, instead of, and after custody. Those are the two parallel tracks that must be followed if the initial gains are to be built on.

It is clear that when mental health in-reach teams rode to the rescue of embattled prison staff they found a scale of need which they had neither foreseen nor planned for. Those who end up in our prisons have complex and long-standing mental health needs: often linked to substance misuse, and ranging from acute psychosis, through personality disorder, to high levels of anxiety and depression. Some prisoners also, or alternatively, have learning disabilities. And these needs are themselves only part of a more complex picture of multiple disadvantage and social exclusion, which may fall through the net of community health, social care, housing and drugs agencies.

Mental health in-reach teams in prisons have in practice ended up dealing almost exclusively with the 'severe and enduring' conditions that are the focus of secondary mental health services in the community. For those patients, the care programme approach (CPA) can offer considerable benefits: a managed approach that is capable of offering joined-up care between the community and prison. Equally, the presence of mental health professionals has undoubtedly assisted the speedier transfer of patients assessed as needing secure NHS care: though they remain a minority, and there are still delays before assessment.

However, as this report shows, four out of five mental health in-reach teams felt that they were unable to respond adequately to the range of need. There was no clear blueprint for delivering mental healthcare in prisons, based upon the assessed needs of the prison population. There is, in particular, a gap in the organisation and provision of specialised primary mental healthcare, appropriate to the complex and challenging needs of those in prison who fall beneath the threshold of severe and enduring illness, and who may be particularly at risk of suicide or self-harm. In addition, we found that mental health in-reach teams were often working in isolation – lacking the governance and support structures that their colleagues in the community have, with little opportunity to evaluate their work, or share best practice. Equally importantly, they were rarely well-integrated with other services being provided to their clients within prisons. Our research showed serious weaknesses in the essential links with residential staff providing day-to-day care, those supporting suicidal and self-harming or segregated prisoners, forensic psychologists offering cognitive behaviour programmes, and resettlement teams. It was of particular concern, given the well-established connection between substance misuse and mental illness, that joint work between mental health and substance misuse teams was in general weak; nor did the initial clinical management of drug and alcohol dependent prisoners provide enough psycho-social support at this critical time.

One of the key messages of this report is the need, five years on, to develop a clear blueprint for the delivery of mental health services in prison, including appropriate external support and governance, and internal integration with other prison staff and services.

However, care and support for those with mental and emotional needs should not be seen as the exclusive province of mental health professionals. It requires a holistic approach, as developed by this Inspectorate in its model of a 'healthy prison' – one where prisoners are safe, treated respectfully, able to engage in purposeful activity, and prepared for resettlement. Notably, it was activity and support from staff and other prisoners that were the two things thought to be most helpful by prisoners with mental health and emotional problems, and the absence of these crucial elements was thought most likely to make things worse. In overcrowded, under-resourced prisons, these essential elements of care are, however, at a premium.

The report identifies other gaps. Reception screening is failing to pick up the extent or diversity of need. This is partly because it is not always well done, or properly followed up, by appropriately skilled staff. But it is also partly because the screen itself is not sensitive enough to pick up real, and particularly unacknowledged, need. Our own screening processes picked up higher levels of need throughout, but particularly so in the case of black and minority ethnic (BME) prisoners, who are much less likely to access mental healthcare in the community, and also male prisoners, who are less likely to acknowledge need. A more effective, and consistently implemented, screening process is needed.

In general, we found that services were insufficiently responsive to diverse needs. Neither substance use nor mental health services were sufficiently alert to the different needs of BME prisoners; nor were they monitoring access effectively. Women had the highest levels of emotional and psychological distress, often related to past abuse and exacerbated by distance

from home and children. Primary mental healthcare, relationship support, and survival counselling are particularly important to meet their needs. Finally, and importantly, the needs of learning disabled prisoners were neither properly identified nor adequately met.

These are important findings for those delivering and funding mental health services in prisons. But there is an even more important prior message: that prison has become, to far too large an extent, the default setting for those with a wide range of mental and emotional disorders, which may themselves only be part of a spectrum of disadvantage. Our research found significant weaknesses and inconsistencies in court diversion and liaison schemes, established to identify and divert those who should properly be cared for in mental health settings. Only two out of the 23 primary care trusts in our sample knew of the existence of such a scheme. The best diversion schemes had good links with health, social care, and access to forensic skills; the worst operated only occasionally and without any clear accountability or clinical governance. All were short of funds. We recommend that there should be a clear service specification for the delivery and focus of diversion schemes, and resources allocated to them.

However, this essentially brings the argument back full circle. For, even if there were more and improved diversion schemes, there simply are not enough secure places for those who could appropriately be diverted there; nor is there sufficient community provision for those with complex needs, including mental health needs. Indeed, the failure to identify need, and provide support, at an early stage is the reason why some people offend in the first place.

Our final, and perhaps most important, key message is therefore to those commissioning and providing services outside prisons. This requires the same holistic, multi-agency approach within the community as we have recommended in prisons, and which is suggested in the most recent report from the Social Exclusion Unit[1]. Prisons can provide better and more focused care for those who need to be there; but they will only do so effectively if there is sufficient alternative provision for those who should not be there, and effective community support for those who leave prison. Unless those gaps are filled, mentally ill people will continue to fall through them, and into our overcrowded, increasingly pressurised prisons.

Anne Owers
HM Chief Inspector of Prisons

[1] Social Exclusion Unit (2007)

1. Executive summary and recommendations

Recent developments

1.1 In 2001, before healthcare commissioning as a whole passed to the NHS, funding began to be provided for mental health in-reach services in prisons through the NHS. The aim was to implement the National Service Framework standards that applied in the community and to ensure that all prisoners with severe and enduring mental illness would be subject to the care programme approach. Community mental health teams (CMHTs) began to operate in prisons as mental health in-reach teams (MHIRTs), targeting those with severe and enduring mental illness who were not so ill as to require being sectioned. They were also expected to contribute to primary care, wing-based services, day care, transfer arrangements and suicide prevention.

1.2 By the time of this review, 80% of prisons had nurse-led MHIRTs, consisting of a core team of psychiatric nurses with varying access to other professionals such as psychiatrists, clinical psychologists, occupational therapists, drugs workers and counsellors. Mental health awareness training was also made available to prison staff.

1.3 Mental health services were largely commissioned by primary care trusts from mental health trusts, accustomed to working in the community, and focused on secondary mental health need. However, studies show that those who end up in prisons have higher and more complex levels of psychiatric morbidity, with significant primary mental healthcare needs, and links to substance misuse. The service specification did not reflect those needs, nor did it provide for links with services already working in prisons to tackle substance misuse or to reduce reoffending. Moreover, mental health has a lower priority and awareness within the primary care trusts which now commission all prison healthcare.

1.4 Commissioning did not consider the needs of those with learning disability, whose prevalence in prisons has recently been identified as at least three times that in the community. They are also missed in court diversion and prison reception screenings. Some have the double jeopardy of learning disability and mental illness.

1.5 There has been some reduction in the delays experienced in transferring those sectioned from prisons to a secure health setting, though prisoners can wait some time for an assessment.

1.6 Despite these changes a recent parliamentary report concluded that the mentally ill are still being inappropriately criminalised, and that the structure of mental health services in prison is currently not meeting the full range of prisoners' needs.

Diversion/liaison schemes

1.7 Court diversion and liaison schemes, introduced in 1989, have no ring-fenced funding, no service blueprint and no clear accountability. A 2002 study established that diversion from court to hospital can result in successful outcomes. A 2005 Home Office/Department of Health review identified a wide variation in funding and organisation, and suggested that the most effective were those jointly funded by health and social care.

1.8 The lack of NHS secure beds and insufficient community provision continues to be a barrier to successful diversion. Community services tend to operate in silos and may not be able to provide early interventions, or meet the complex needs of offenders. They also fail to pick up early mental health problems among black and minority ethnic (BME) communities; black patients are over-represented in secure care and more often compulsorily admitted from the courts than from the community.

1.9 Only two of the 23 primary care trusts surveyed knew about diversion schemes in their area. The six schemes examined during fieldwork had a wide variation in funding, scope and effectiveness. They mostly operated in magistrates' courts during the times that the court sat and accepted referrals from any source, but one operated mainly in police custody suites and one provided cover on only two days a week. The quality of the links with prisons varied.

1.10 The schemes focused on meeting practical need, and there was little monitoring or evaluation, including the impact on diverse groups, such as BME communities. Frustrations were caused by a lack of sufficient resources for the task and by a shortage of community placements, particularly for sex offenders and those with learning disabilities.

1.11 There was no blueprint for a diversion/liaison service. The most effective schemes had strong working links and lines of communication between health and social care, as well as with voluntary sector organisations. This enabled them to respond well to clients' needs and access a range of services on their behalf. Schemes needed to be able to assess risk of harm to the public as well as mental health need, and those that were not forensic-led needed to have access to those services.

On arrival: pathways into care

1.12 Reception screening for new prisoners usually asked about self-harm, substance misuse, medical needs and previous mental health contact, but did not seek to identify learning disability. Initial reception screening was reliably carried out in local prisons. Around 45% of the 252 prisoners sampled were identified as having used drugs or alcohol, but the level of alcohol dependency was not reliably assessed.

1.13 About 17% of the 237 new prisoners sampled disclosed a psychiatric history but further information from outside prison was requested in few of these cases; under half received a secondary health screen, and less than a third were referred to MHIRTs. For a quarter of these prisoners no response to their disclosure was recorded in their clinical records. There was no recorded action in the clinical records for a quarter of those disclosing both a history of self-harm and current thoughts of self-harm.

1.14 A formal measure of psychological wellbeing (GHQ12) showed much higher levels of mental distress than the currently-used reception screen: 50% of the 220 prisoners who completed the GHQ12 scored at levels that indicated primary or secondary mental health needs. Women scored more highly than men, though they were much more likely to recognise that they needed emotional support. A substantial number of those prisoners were not referred to primary or secondary care. Worryingly, those with a high level of need were less likely to be followed-up appropriately by healthcare staff than those with less need. A quarter of the 237 prisoners surveyed said they wanted mental health support and there was some dissatisfaction with the lack of follow-up to needs expressed in reception.

1.15 Half of the new arrivals who disclosed substance misuse on reception said they had not had a urine test, a third had not had a full history taken and only half were referred to drugs services. Women were most likely to have received clinical treatment for dependency, and young adults

least. Very few prisoners were offered alcohol detoxification. Prisoners commented that detoxification was too little, too fast and too late, though they were more positive about CARATs staff in this respect. Mental health problems were both obscured and exacerbated by drug-taking, yet little psycho-social or mental health support was offered to those withdrawing from drugs: only 43% said they were given any emotional support, usually from CARATs rather than healthcare.

1.16 Reception screening on transfer to other prisons was not as comprehensive as on first entry to custody, and not as reliably completed. Initial reception screens were often missing from clinical records and information about mental health needs and self-harm was missing in about half of the sample examined. There was some evidence that continuity of care was disrupted on transfer.

Mental healthcare in prisons

1.17 The boundaries between primary and secondary mental health need were not clear cut, and secondary need was in general prioritised, rather than the more predominant primary need. Only 19% out of 84 MHIRTs thought they could meet the needs of prisoners. However, where there was effective primary healthcare, the co-location of the two services could result in a more responsive and flexible service than was possible in the community.

1.18 GPs are responsible for primary care in prisons, but the nine we interviewed lacked specialist training in the care of prisoners or their complex mental health needs. It is known that many male prisoners are distrustful of doctors and fear the label of mental illness. From inspections in general, few GPs appear to have any specific responsibilities for clinical team leadership or direction, and they work largely in isolation. From our interviews, relationships with MHIRTs were good, but GPs said they had little direct contact with psychiatrists or input into multidisciplinary meetings. They described a shortage of talk therapies and therapeutic interventions for primary mental health and substance misuse problems.

1.19 MHIRTs were mainly nurse-led and staffed by RMNs, with variable access to other health professionals from their trusts. Most lacked the support they would have had in the community and some felt professionally isolated. A third of the 84 MHIRTs surveyed preferred to receive referrals from healthcare staff and almost a fifth were reluctant to receive referrals from prison staff who had no mental health awareness training. Few prisons had RMNs in the primary care team who could screen referrals or deliver primary mental healthcare, and links with primary care teams were not always good. The average number of referrals to MHIRTs was 51 a month, and most were dealt with quickly: the average caseload was 33 clients per practitioner, though numbers were higher in local prisons.

1.20 We interviewed 66 MHIRT clients. Nearly half were suffering from depression or self-harm, with some incidence of schizophrenia and psychosis. Personality disorder and learning disability occasionally featured as a co-morbid condition but not as a single diagnosis, and there were some anxiety disorders and anger management problems. Three-quarters of the clients had received some psychiatric care in the community before prison, but contact with previous providers had been made in only 59% of cases. Half had physical health problems and 70% had substance misuse needs.

1.21 About two-thirds of the clients in our sample had a care plan, though only about a third appeared to know about it. Over half had regular appointments with a mental health professional. Targets were mainly health focused and included few social or custodial elements, although these came high in the lists of things that prisoners believed would help them. Over half (57%) claimed they had been given some choice about their treatment, though

less than half had been asked what had worked for them in the past. Most had been given information about their medication, and 72% felt their treatment had helped them.

1.22 Hearing voices was an obvious indicator of distress, but was not always considered treatable by MHIRT staff. Yet research from Safer Custody Group has shown that hearing voices is associated with 20% of self-inflicted deaths.

1.23 Only 58% of the 66 MHIRT clients sampled had a key worker or regular contact with families. Prison staff had facilitated contact in emergencies, but involvement of families in care planning was rare. Prisoners' comments confirmed the importance of a holistic approach to mental and emotional wellbeing, identifying the positive impact of activity out of cell, supportive wing staff, and support from other prisoners, even more than contact with healthcare staff and family. Some clients had become at least psychologically dependent on their medication and there were insufficient other therapies to overcome this, where appropriate and necessary.

1.24 Only a quarter of MHIRT leads believed they had sufficient interventions to meet the extent of prisoner need. The most common interventions were cognitive behavioural therapy, medication and counselling. There was some evidence of new therapies, including occupational and art therapy, but their impact was not effectively recorded. Many of the interventions overlapped with those provided by other prison specialists. There was little quality control or evaluation of therapies and a lack of coordinated case management integrating the work of mental health staff with other disciplines.

1.25 Prison officers' awareness of mental health problems had increased. All 66 wing staff recognised that a proportion of prisoners were mentally unwell and felt that they managed them quite well though they lacked confidence that what they were doing was right. Only about a quarter of those interviewed had received mental health training though most wanted it, or wanted more. Over 70% said they would refer to the MHIRT, but there was frustration when difficult to manage prisoners were returned to the wing, and confusion about the distinction between personality disorder and mental illness.

1.26 New practice guidance for the management of segregated prisoners requires healthcare staff to screen prisoners on arrival and to provide input to monthly reviews. The Prison and Probation Ombudsman has highlighted the vulnerability of mental health patients in segregation. Of the five MHIRT clients in our sample who were in segregation, only one, a woman, was being effectively monitored or supported by the MHIRT, who were not advising and involving segregation staff on their management and care planning.

Diversity of mental health need

1.27 From our reception sample, women had higher levels of drug use than men or young adults, though lower levels of alcohol dependency. Almost a third of the 80 women prisoners were referred to the doctor for substance misuse problems on arrival. Women also had higher levels of both previous and current mental health problems, including self-harm, yet were less likely than other prisoners to receive a secondary health screen. Two-thirds of women exhibited signs of psychological distress, higher than men or young adults. This was exacerbated by separation from children and distance from home. For women with emotional problems, unlike men, the most important need was for interventions to support relationship skills.

1.28 This profile confirms the importance of good quality primary mental healthcare for women. We did not find significant differences in the delivery of services between women, men and young adults, but there were high levels of medication. Some clinical notes and interviews confirmed at least a psychological dependency on medication, arguably exacerbated by the absence of

alternative treatments, and other studies suggest a higher level of medication for primary mental healthcare needs. There did, however, appear to be a somewhat wider range of interventions available for women than for male prisoners.

1.29 The aggregated experiences of BME clients in prison are largely unknown because of a lack of monitoring and evaluation. Our findings suggest a lower level of engagement with and referral to MHIRT services in prison for adult BME and foreign national prisoners. BME prisoners in general reported higher levels of satisfaction with immediate healthcare needs than white prisoners, though fewer understood their medication. However, our examination of reception screens showed that issues identified in reception were adequately followed up for fewer BME than white prisoners.

1.30 On reception, the 121 BME prisoners in our sample presented with a different pattern of substance misuse from white prisoners. Fewer were referred to the doctor or underwent detoxification. This may have been because services were not appropriate to their need or were not sufficiently culturally aware.

1.31 There was no difference in levels of reported psychological distress between the BME and white prisoners in our sample on entry to prison, or in the extent to which they felt they needed support from healthcare staff, but fewer were referred either to the GP or to the MHIRT. This may well reflect, and stem from the same causes as, the well-documented under-use of mental health services in the community by people from BME groups, and argues for a more effective reception screening tool, and more culturally sensitive mental health services. Ethnicity was not reliably recorded on clinical records and awareness of different racial need among primary and secondary mental health teams was low. Only one MHIRT had specific services for different ethnic groups, and many said they needed more training.

1.32 Our research and the statistics on self-inflicted deaths suggest that foreign nationals may be becoming increasingly emotionally and mentally vulnerable. In practice, healthcare staff were finding considerable needs which they were unable to meet.

Missing links

1.33 Fourteen per cent of the MHIRT clients in our sample were being managed on assessment, care in custody and teamwork (ACCT) procedures, as prisoners at risk of suicide or self-harm. Only two-thirds of 84 MHIRTs said that they contributed to reviews of such prisoners. The evidence suggested that at-risk prisoners were managed more comprehensively when mental healthcare staff and residential staff planned their care together, to include both healthcare and custodial care. There was also scope for the involvement of primary healthcare professionals in this area of work in general.

1.34 The involvement of residential staff in the management of prisoners subject to the care programme approach (CPA) was limited, in spite of guidance from the Department of Health. Only a minority of MHIRT clients' wing records contained any comment from healthcare staff, CPA reviews rarely involved residential staff, and only 12% of MHIRT leads reported genuinely cooperative working. Where joint working did happen, the results were very positive; by contrast, when it was not, prisoner care could suffer. There remained a widespread but erroneous belief among both healthcare and residential staff that clinical information could not be shared.

1.35 Just under two-thirds of MHIRT leads claimed they had a degree of cooperative working with substance misuse teams, either in prison or the community, but only 11% had a specialist dual diagnosis service. Only a third of the records of the 14 MHIRT clients who were CARAT (drug

treatment) clients showed any evidence of information received from healthcare, and any protocols concerned referrals between teams rather than joint working.

1.36 There was no evidence of shared working between MHIRTs and forensic specialists, such as psychologists and probation staff in the prison. Prison psychologists have been working with mental health issues for many years, but commissioning had not considered how this would dovetail with the new mental health arrangements, which was a serious omission. This could result in confusion about where responsibility for clinical care lay, to the detriment of prisoner care.

1.37 Mental health is part of the third resettlement pathway, in the national reducing reoffending action plan. Risk assessments show a correlation between emotional wellbeing and criminogenic needs[2]. However, from general inspection those with primary mental health needs had rare communication with resettlement teams prior to release, and referral to GPs in the community was variable. Links were also variable for the 31 clients in our sample who were approaching release. Only half recorded contact with community mental health teams within three months of the date of release, clients were not routinely involved and kept informed about resettlement planning, and information about ongoing mental healthcare on release was not routinely shared with other disciplines with resettlement responsibilities.

1.38 There were no patients on MHIRT caseloads because of their learning disability alone, and no evidence of any engagement with learning disability services for those with a suspected learning disability, as well as mental health problems.

Main recommendations

1.39 The Department of Health, through the Care Service Improvement Partnership (CSIP), should issue commissioning guidance to local PCTs with the aim of ensuring that there is sufficient proactive support, case management and care in the community for those with multiple needs that include mental health, as well as provision of sufficient secure and acute mental health beds.

1.40 There should be a national service specification for court diversion and liaison schemes that specifies funding, governance, services, staffing, location and accountability, and that requires monitoring by ethnicity, disability and gender.

1.41 There should be a blueprint for delivering mental healthcare in prisons, which ensures appropriate support and governance for mental health staff and which specifies the services required, based on the complex needs of those in prison, including the specific needs of women and black and minority ethnic prisoners, drawing on the detailed recommendations in this report.

1.42 The Department of Health and the National Offender Management Service should ensure that commissioning arrangements, protocols and guidance to staff emphasise and support joint working between mental healthcare services and other services and staff in prisons, to ensure the delivery of coordinated care and management for each individual prisoner.

[2] From O-DEAT data (OASys Data Evaluation and Analysis Team) 2006.

1.43 Reception screening in prisons for mental health needs should be improved and consistently implemented, so that those who may have previously undisclosed mental or emotional problems, and those with learning disabilities, can be professionally assessed and appropriate mental health and/or other interventions put in place.

Other recommendations

Diversion/liaison schemes

1.44 PCTs, in commissioning services from mental health trusts, should ensure that court diversion/liaison schemes are in place that are capable of assessing mental health need and risk of harm. A range of alternatives to custody should be available, including sufficient secure and acute beds and packages of non-residential support capable of meeting offenders' mental health and social needs and of protecting the public.

On arrival: Pathways into care

1.45 All staff should be reminded of the need to complete the Grubin screening form accurately, including the number of units of alcohol consumed in the week prior to custody.

1.46 Reception screening should include screening for learning disability.

1.47 Following the initial health screen, all prisoners should have a further health assessment carried out and recorded by trained staff no later than 72 hours after their arrival in custody.

1.48 Where it is identified that a prisoner has had previous mental health contact in the community, a referral to the MHIRT should always be made and information about previous history actively sought and subsequently used.

1.49 An ACCT should always be opened for those prisoners with a history of self-harm who also disclose current thoughts of self-harm in reception.

1.50 Reception staff should be aware that male prisoners in particular will often not disclose their true level of distress, because of either their distrust of healthcare staff or lack of insight. Requests for help should always be responded to, and if a healthcare response is not appropriate then help should be sought from elsewhere.

1.51 Treatment for drug dependency in men's prisons and YOIs should equate to that available in women's prisons. A full history should always be taken and a urine test should precede any prescribed clinical management.

1.52 All substance dependent prisoners should be provided with symptomatic relief at the earliest opportunity, following screening and testing; whether in police custody or prison.

1.53 Detoxification for alcohol should always be offered in cases of extreme dependency, and treatment for alcohol and drug misuse should tackle alcohol dependency before drug use.

1.54 Psycho-social support should accompany any clinical detoxification.

1.55 All prison healthcare departments should have an electronic clinical information system and the ability to confidentially transfer clinical records electronically between establishments and other healthcare providers.

1.56 On transfer to another establishment, prisoners should receive a comprehensive reception screen, including a review of all previous interactions with health service personnel.

Mental healthcare in prisons

1.57 There should be sufficient resources in primary care teams to meet the high level of primary mental health need in prisoners, and greater coordination between them and MHIRTs to ensure that referrals are appropriately allocated and managed.

1.58 GPs should receive specific training for delivering primary mental healthcare in prisons, and should take responsibility for the clinical management of primary mental healthcare.

1.59 There should be a greater range of primary mental health services to treat the high level of depression and anxiety, and reduce psychological dependence on substances.

1.60 Primary mental health services should include guided self-help programmes based on cognitive-behavioural models and psychological treatments as specified in NICE guidelines.

1.61 Mental health practitioners in prisons should be trained to understand the specific mental health needs of prisoners and should adopt an ethical approach that respects their wishes and feelings without compromising public protection, and that specifies the limits of medical confidentiality.

1.62 Mental health practitioners in prisons should also have access to psychiatrists trained in the specific competencies required to meet prisoners' psychiatric needs.

1.63 All mental health practitioners should receive regular clinical supervision and opportunities for professional development.

1.64 Interventions should be subject to clinical audit and other NHS reviews, and where appropriate should operate under the supervision of a psychologist.

1.65 All discipline staff should receive mental health awareness training, with at least bi-annual updates. The training should be quality controlled.

1.66 MHIRTs should accept referrals from prison officers and include them in multi-disciplinary care planning and review.

1.67 All interventions with prisoners should be agreed with the individual after options have been discussed and the effects of any medication fully explained.

1.68 Interventions should be planned by a multi-disciplinary team and coordinated by a named key worker, to ensure coordination and to avoid duplication or undermining of work carried out elsewhere.

1.69 Care plans should be integrated documents with contributions from all disciplines as appropriate. They should include health, social care, custodial and resettlement needs.

1.70 There should be an auditable trail to evidence that all care plans are regularly reviewed, updated and shared with the prisoner.

1.71 Family involvement in CPA case reviews should be rigorously pursued and all family contact should be documented in the multidisciplinary care plan.

1.72 Staff with expertise in mental health should work in conjunction with segregation unit staff to ensure that prisoners held in segregation are supported and provided with appropriate distracting activities.

1.73 Complaints by prisoners that they are hearing voices should always be taken seriously and every effort made to alleviate this as quickly as possible.

1.74 Interventions for prisoners with personality disorder should be developed in cooperation with forensic psychologists.

Diversity of mental health need

1.75 There should be a wider range of mental health interventions available in women's prisons to meet their high levels of primary and secondary mental health need. Particular emphasis should be placed on emotional management and relationship skills.

1.76 There should be a high level of coordinated work between substance misuse teams and MHIRTs in women's prisons.

1.77 Clinical audits should monitor the prescribing patterns for psychotropic medication, including by ethnicity and gender.

1.78 The ethnicity of patients should be recorded on all clinical records and the uptake and outcomes of mental health services in prison by ethnicity should be audited.

1.79 The outcomes for BME mental health patients in prisons should be included in future Department of Health 'Count me in' mental health ethnicity audits.

1.80 The provision of both primary and secondary mental health services should be assessed for their impact on different ethnic groups and nationalities to inform the development of more culturally sensitive services.

Missing links

1.81 An enhanced primary care team should provide RMN input to multi-disciplinary self-harm assessments and reviews.

1.82 There should be a formal documented procedure for briefing wing staff when an inpatient is discharged back to a residential wing.

1.83 All establishments should have an inter-agency information-sharing protocol, which satisfies legal requirements and clearly sets out procedures for both disclosing and receiving information as set out in PSI 25/2002.

1.84 There should be specialist dual diagnosis services for prisoners who experience both mental health and substance-related problems.

1.85 The arrangements for the commissioning of mental health services should take into account, and include where appropriate, existing input from forensic psychiatrists, psychologists and probation staff, and specify how new services will complement existing services.

1.86 MHIRT clients should all be referred to mental health services in the community, either by means of a GP letter or by direct contact with community mental health teams in the area to which they are released. Such actions should be reliably communicated to resettlement staff and included in individual resettlement plans.

1.87 Prisoners' mental health needs should be part of any resettlement planning, and as a minimum this should ensure that a letter to the community GP is provided in all cases.

1.88 Where prisoners are identified with learning disability, this information should be shared with the disability liaison officer, and the prisoner referred for assessment to a specialist learning disability service.

2. Recent developments

2.1 This chapter examines developments in mental health services in prisons and their impact. It includes reference to other relevant reviews of practice and proposed changes to legislation, which provides the current context of prison mental healthcare.

A major shift in the organisation of prison healthcare

2.2 Over a decade ago this Inspectorate published a thematic review[3] that drew attention to major deficiencies in the healthcare provided for prisoners, including mental healthcare. Subsequently, the Government accepted the key recommendation made in that review and in a joint Department of Health (DH) and Home Office review, that the NHS should assume responsibility for providing healthcare in prisons and implement, among other initiatives, the seven standards of the National Service Framework for Mental Health.

2.3 In 2000[4] the DH committed to ensuring that by 2004 all prisoners with severe and enduring mental illness would receive treatment, and none would leave prison without a care plan and a care coordinator. Five aims were identified:

- prison health services should be delivered according to general NHS standards
- screening should be improved to identify mental ill health more effectively
- the care programme approach (CPA) should be strengthened using in-reach services
- prisoners should receive an equivalent level of healthcare in prison to that which they would receive in the community
- policies should support effective communication between prisons and the wider health and social care service.

2.4 A five-year strategy document, *Changing the Outlook*, published in 2001, set the direction of travel, though the detail of how the service should be commissioned and delivered was left to individual primary care trusts (PCTs). Funding was provided for services to be developed in partnership with prisons, in accordance with the recommendations of the NHS Plan and the National Service Framework for Mental Health. Community mental health teams (CMHTs) were established to operate in prisons as mental health in-reach teams (MHIRTs), in order to address generic mental health problems rather than any link between mental health and offending. They were to target those with severe and enduring mental ill health, but who were not so severely ill that they required transfer out of prison under section to an NHS facility. In addition to meeting secondary mental health need MHIRTs were expected to contribute to primary care, wing-based services, day care, transfer arrangements and suicide prevention. In practice, most have confined themselves to providing a service to prisoners with severe and enduring mental illness.

Healthcare commissioning

2.5 The commissioning of healthcare by the NHS was phased in between 2003 and 2006. By the time of this review we were informed by Offender Health (previously known as Prison Health) that there were 102 MHIRTs and 360 mental health professionals working in prisons across

[3] HM Inspectorate of Prisons (1996)
[4] DH (2000)

the country who had been recruited since 2001. Teams comprised between one and three whole time equivalent staff, consisting largely of psychiatric nursing staff, with variable access to psychologists, psychiatrists, drugs workers, learning disability nurses, counsellors and occupational therapists.

2.6 Under the new arrangements, prisons were able to benefit from the support available from the Care Services Improvement Partnership (CSIP)[5] within DH which delivered mental health awareness training to 20% of all prison staff in 2006/7, and aims to train 20% each year on a rolling programme. Core awareness-raising training now includes dual diagnosis, substance misuse, sexual health, communicable diseases, resuscitation, learning disability and personality disorder.

2.7 The mental health aspect of the new healthcare service was commissioned on the basis of general prevalence studies, and rarely by local needs assessments. The 1998 Office for National Statistics' (ONS) survey of psychiatric morbidity in prisons identified much higher levels of morbidity than in the general population. The claim that 90% of prisoners have at least one mental health disorder is commonly quoted, though this is inflated by the inclusion of substance misuse as a mental disorder. In fact the ONS morbidity study found substantial levels of neurotic disorder, personality disorder, drug use and hazardous drinking, and of co-morbidity, but relatively lower levels of severe and enduring mental illness, albeit still higher than in the community.

2.8 Further analysis of the ONS data[6] identified a strong association between severe dependence on cannabis and psychostimulants and psychosis, suggesting that much of the severe mental illness seen in prisons is linked with substance misuse, and needs to be treated alongside it in a coordinated approach. However, mental health services were commissioned without reference to the care, assessment, referral, advice and throughcare services (CARATs) introduced in 1998 to address prisoners' substance misuse, and failed to make explicit how the two services should work together.

2.9 Subsequent studies have confirmed high levels of co-morbidity between neurotic disorder, personality disorder and substance misuse in prisoners. A 2007 study in Kent and Medway found that 33% of a mixed population from nine prisons reached a threshold for three or more disorders[7]. This mix of needs is often accompanied by poor personal and social adjustment, distrust of authority, and by challenging behaviour such as violence and/or self-harm. A study commissioned by the Prison Service Safer Custody Group identified that half of those with current thoughts of self-harming also had a psychiatric history.[8]

2.10 This profile of needs is different from that of non-offenders in the community, from where MHIRTs were drawn, not only in the level of disorder but also in terms of complexity, treatability and manageability. The original strategy of targeting services at severe and enduring mental illness therefore overlooked the less severe but no less challenging combination of primary mental health need, personality disorder, and substance misuse that predominates in prisoners. A number of reviews have been critical of this mismatch of services and need at primary care level. The Sainsbury Centre for Mental Health has reported that all of the London prisons' MHIRTs receive a large volume of referrals for clients falling below their threshold for severe and enduring mental illness, and the CSIP has been particularly critical of

[5] www.csip.org.uk/about-us.html
[4] Farrel et al (2002)
[7] Sheeran and Swallow (2007)
[8] Care of at-risk prisoners project (COARP) research, Jenny Shaw, Manchester.

the lack of high quality primary mental healthcare in their review of services for women in prison.[9] [10]

2.11 Currently, primary care in prisons is provided by GPs and prison nursing staff with a mix of mental health and general nursing qualifications. They are expected to fulfil a range of roles in order to meet prisoners' physical and psychiatric health needs. Those with mental health training are generally not able to work in a dedicated mental health role under supervision and with access to continuing professional development in a way that would allow them to maintain their specialist skills.

2.12 Further, when services were initially commissioned, consideration was not given to how the new mental health service would contribute to the goal of reducing reoffending. The Social Exclusion Unit identified a link between health deficits and offending, and the 2004 National Reducing Reoffending Delivery Plan subsequently identified prisoners' health as the third resettlement pathway[11]. Yet the driver for the commissioning of mental health services was parity of treatment between offenders and non-offenders, so it was not made explicit how mental health staff might work alongside resettlement teams, probation staff and forensic psychologists to contribute to broader offender management objectives.

2.13 The Healthcare Commission, in a shared memorandum of understanding with this Inspectorate, routinely assesses the commissioning arrangements for health services operated by the relevant primary care trust (PCT) for directly managed prisons. By the time of this review, these assessments formed a database covering 23 PCTs and 26 prisons and showed that mental health was a low priority for PCTs. When asked to identify their priorities in respect of prison healthcare only three mentioned mental health at all.

2.14 The Health Service Journal routinely surveys mental health trust chief executives on a number of confidence measures, most of which have steadily increased, despite mental health budget cuts in 2006/7. However, their confidence in PCT commissioners' understanding of the mental health needs of communities has consistently been the lowest of the eight measures.[12]

2.15 At the same time the merger of PCTs, which began in October 2006, has had the effect of disrupting the developing relationships between PCTs and the prisons in their community as they absorb the challenge of a major reorganisation.

Learning disability

2.16 Learning disability is a psychiatric and nursing specialism, and the advent of MHIRTs has exposed a level of learning disability in prisons that was previously hidden. This review did not set out to explore services for learning disability, but a gap in such services became apparent in the context of diversion schemes, reception screening and consultation with MHIRT leads.

2.17 Learning disability has a prevalence of less than 2% in the community, but until recently its prevalence in prisons was unknown. A 2007 paper from the Prison Reform Trust documented the gap in knowledge and services that currently exists for this group of prisoners[13]. Strictly, learning disability is defined as an IQ of 70 or below, but wider definitions of learning difficulty

[9] CSIP (2006)
[10] Durcan and Knowles (2006)
[11] Home Office (2004)
[12] Health Service Journal, 12 October 2006, 3 May 2007
[13] Talbot (2007)

include dyslexia and autistic spectrum disorders. A study in three prisons in the North West[14] identified a prevalence of learning disability of 6.7%, and of learning difficulty of 25.4%, which together equates to almost a third of the prison population. For women the proportions were higher, with a total of 40% assessed as either learning disabled or experiencing learning difficulty. A Kent and Medway study[15] confirmed these findings with an overall prevalence for learning disability of 7.2% and for learning difficulty of 22%. Although those with learning disability were no more likely than other prisoners to report mental health problems, 39 (15%) of the total sample of 264 prisoners in this study were deemed to warrant further assessment on the basis of learning difficulty and mental health need.

2.18 There was no mention in any of the early commissioning strategy documents of the needs of those with learning disability, though the CSIP has since published a handbook for professionals in the criminal justice system who work with prisoners with learning disabilities, and incorporated a module on learning disability in its training for prison staff (see 2.6)[16]. The handbook acknowledges the lack of any routine assessment of learning disability, either before custody or during reception health screening, but it points out that generic arrangements for managing disability under PSO 3050 apply also to learning disability, as do the provisions for effecting transfer to appropriate provision outside prison. But for these frameworks to be used appropriately it is necessary for learning disability to be reliably identified and contact made with community learning disability teams.

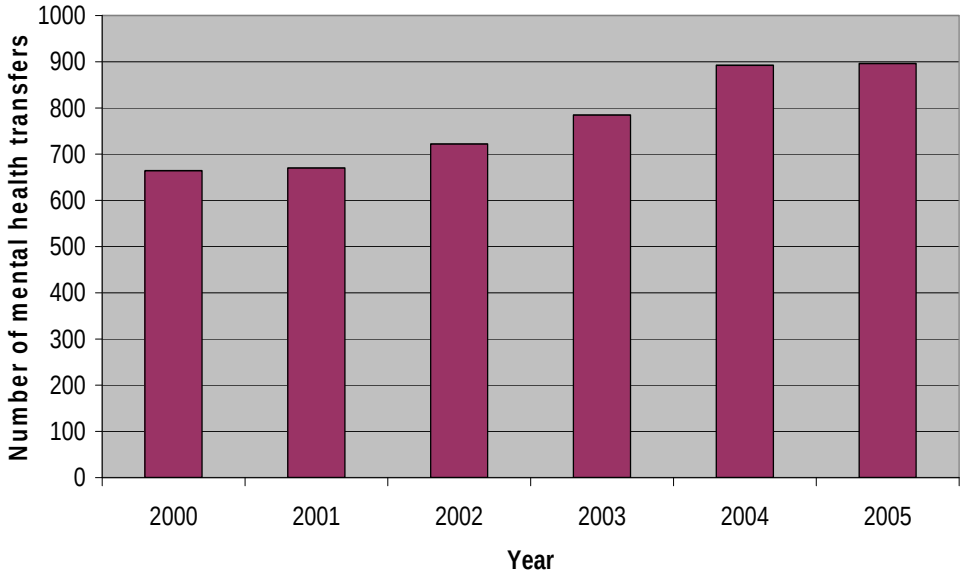
The legislative and parliamentary framework

2.19 As service delivery developed in prisons, debate on a draft Mental Health Bill published in 2002 continued. In March 2006, the Bill was dropped and replaced, at the time of this review, with a Bill to make a series of amendments to the 1983 Mental Health Act (MHA). The Bill has since become the Mental Health Act (2007). The amendments include removing the so-called 'treatability test' for certain forms of detention in hospital, in the hope of making it easier for people with personality disorders (including prisoners) to obtain the mental health services they are deemed to need. It will also allow more patients who have been transferred from prison to hospital to be discharged subject to supervised treatment in the community, with the possibility of recall.

2.20 Under the Mental Health Act, prisons are not considered a health setting and therefore prisoners can only exceptionally be treated without their consent[17]. In the past transfers to NHS secure beds have been subject to long delays during which prisoners' prospects of an eventual recovery diminish. Offender Health reports jointly to DH and the new Ministry of Justice and is now in a better position to expedite such transfers. Information about the length of time that prisoners wait for assessment and subsequent transfer to an NHS secure bed shows a 20% decrease in the number of people waiting for transfer for more than 12 weeks from assessment, though prisoners can wait a long time to be assessed. Routine inspections have prompted some concerns that assessments appear to be delayed until a bed becomes available. Nevertheless, Figure 1 shows a steady increase in the number of mental health transfers under sections 47 and 48 of the Mental Health Act since 2000:

[14] Mottram (2007)
[15] Sheeran and Swallow (2007)
[16] CSIP (2007)
[17] A duty of care applies that must take account of human rights law.

Number of mental health transfers under section 47 and 48 since 2000



2.21 There was also an increase of 7.7% in the number of mental health transfers in 2006, but as this information includes transfers under more sections of the Mental Health Act[18] it is not directly comparable with the data from previous years, so has been omitted from Figure 1. A national pilot scheme for the transfer of acutely mentally ill prisoners under the Act, which began at the end of 2006, aims to continue this improvement by achieving an ambitious transfer target waiting time standard of 14 days between assessment and transfer.

2.22 A list of principles to inform good clinical practice was proposed by the Royal College of Psychiatrists during the passage through the Lords of the proposed amendments to the Mental Health Act, and has been used as a touchstone for good practice in this review. The principles are that interventions should:

- respect patients' past and present wishes and feelings
- minimise restrictions on liberty
- involve patients in planning, developing and delivering care and treatment appropriate to them
- avoid unlawful discrimination
- consider the effectiveness of treatment
- consider the views of carers and other interested parties
- consider patient wellbeing and safety
- consider public safety

2.23 Despite the significant changes in the organisation and resourcing of prison healthcare, the All Party Parliamentary Group on Prison Health concluded in November 2006 that a 'fundamental shift in thinking' was still required to decriminalise the mentally ill and shift the burden of care for many from prisons to the NHS. Their report identified failures at all stages of the patient's journey through mental health and criminal justice services. In prisons specifically, they

[18] Sections 35, 36, 37, 38, 47, and 48 of MHA 1983.

identified the lack of a clear, stepped system of mental healthcare equivalent to that in the community, with sufficient input at preventive, primary and secondary levels.

Summary

2.24 In 2001, before healthcare commissioning as a whole passed to the NHS, funding began to be provided for mental health in-reach services in prisons though the NHS. The aim was to implement the National Service Framework standards that applied in the community and to ensure that all prisoners with severe and enduring mental illness would be subject to the care programme approach. Community mental health teams (CMHTs) began to operate in prisons as MHIRTs, targeting those with severe and enduring mental illness who were not so ill as to require being sectioned. They were also expected to contribute to primary care, wing-based services, day care, transfer arrangements and suicide prevention.

2.25 By the time of this review, 80% of prisons had nurse-led MHIRTs, consisting of a core team of psychiatric nurses with varying access to other professionals such as psychiatrists, clinical psychologists, occupational therapists, drugs workers and counsellors. Mental health awareness training was also made available to prison staff.

2.26 Mental health services were largely commissioned by primary care trusts from mental health trusts, accustomed to working in the community, and focused on secondary mental health need. However, studies show that those who end up in prisons have higher and more complex levels of psychiatric morbidity, with significant primary mental healthcare needs and links to substance misuse. The service specification did not reflect those needs, nor did it provide for links with services already working in prisons to tackle substance misuse or to reduce reoffending. Moreover, mental health has a lower priority and awareness within the primary care trusts which now commission all prison healthcare.

2.27 Commissioning did not consider the needs of those with learning disability, whose prevalence in prisons has recently been identified as at least three times that in the community. They are also missed in court diversion and prison reception screenings. Some have the double jeopardy of learning disability and mental illness.

2.28 There has been some reduction in the delays experienced in transferring those sectioned from prisons to a secure health setting, though prisoners can wait some time for an assessment.

2.29 Despite these changes a recent parliamentary report concluded that the mentally ill are still being inappropriately criminalised, and that the structure of mental health services in prison is currently not meeting the full range of prisoners' needs.

3. Diversion/liaison schemes

3.1 This chapter examines schemes designed to identify and divert the mentally ill from custody to treatment, recognising that the number of mentally disordered people in prison is in part determined by the decision-making of criminal justice professionals upstream of prisons, in police stations and courts.

Court diversion/liaison schemes

3.2 Court diversion schemes were introduced in 1989, with joint Home Office and Department of Health (DH) funding, to divert mentally ill people coming into contact with the criminal justice system into acute mental health services or to liaise with other services in order to provide care in the community. Where diversion was not appropriate or possible, many schemes focused on a liaison function, signposting people to mental health services in the community or in prisons.

3.3 The performance of these schemes has been mixed. Funding was not ring-fenced, and there was no blueprint for a service, no systematic measurement of performance and variable local audit or accountability. A survey of schemes carried out by Nacro in 2004[19] found that coverage was incomplete and schemes varied in their organisation, staffing and operating times, with a third consisting of a single staff member. A year later, more schemes had closed. A 2005 review of 10 schemes by the Home Office and DH[20] concluded that their effectiveness depended on adequate resources and an appropriate structure that met both mental health and social care need. However, few schemes were based on needs analyses or delivered jointly by health and social care. Targets, performance management, and outcome analysis were generally not in place.

3.4 The lack of NHS beds continues to be a barrier to successful diversion. Between 1993 and 2004 there was a reduction of 56% in the number of people remanded to hospital for a report, and of 44% in the number admitted to hospital for treatment from the courts. The All Party Parliamentary Group on Prison Health, in their 2006 examination of mental health provision in the criminal justice system,[21] identified a common complaint among judges that they were provided with no real alternative to imprisonment as a source of treatment for prisoners. The silo nature of services in the community and their criteria for service provision also means that it is hard to find services that can meet the complexity of offenders' needs. With a shortage of both secure and acute beds and sufficient community provision, prison has become the default setting for many with mental health problems.

3.5 A 2002 study into psychiatric admissions through the courts identified that court diversion schemes can significantly improve the recognition of mental illness and expedite admission to hospital. It also showed that the outcomes in psychiatric care for those admitted following court diversion were comparable with those admitted from the community: and that, of those successfully diverted, there was a reoffending rate of only 28% within two years, significantly lower than the general reoffending rate.[22]

[19] Nacro (2005)
[20] Home Office and DH (2005)
[21] www.scmh.org.uk/80256FBD004F3555/vWeb/flKHAL6VBJQE/$file/allparty_prison_health_report_nov06.pdf
[22] James et al (2002)

3.6 The 2006 national census of mental health and learning disability in inpatients confirms the long-standing finding that black and black/white mixed race patients are over-represented in secure care, and more likely to be detained under the Mental Health Act on admission. The study also showed that this is largely attributable to the fact that they are more likely to be admitted from court than by GPs or mental health teams in the community.[23]This suggests that the first contact of many black people with mental health professionals occurs in the context of the criminal justice system, where their mental health needs are first identified. This would be consistent with the documented distrust black people have for mental health services in the community and the consequent fact that they are less likely to be picked up and treated in the early stages of mental health difficulty.[24]

3.7 Better provision of mental health liaison and diversion might have been expected with the advent of commissioning by PCTs. However, when asked about court diversion schemes as part of a general commissioning review only two out of 23 PCTs provided specific information regarding a diversion scheme in their area. Others stated that they were not involved in schemes in their areas or did not respond to the question at all. It was not clear if there were no schemes operating in the areas covered by the remaining 21 PCTs, or if PCTs were unaware of them.

Fieldwork

3.8 We visited six diversion/liaison schemes between August 2006 and February 2007. There was wide variation in organisation, funding, operation, numbers and the skills mix of staff. All were nurse-led and included at least one registered mental nurse (RMN). Those serving more than one court had up to five nurses. There were different levels of medical input, ranging from none to a few sessions each week from a psychiatrist, and with one exception, all included at least one social worker and administrative support.

3.9 Schemes were mostly accommodated within court buildings, but two also had office accommodation in local NHS premises. Another scheme operated mainly from police stations where it received referrals from custody nurses. Input at this stage meant that referrals from court were rare. All the others operated mainly in magistrates' courts where defendants were making their first court appearance. Cover was variable but most schemes operated Monday to Friday while the courts were sitting. Two also covered Saturday morning sittings on a rota, but one provided cover on only two days a week, despite the fact that the courts sat for six days a week. This scheme appeared not to have been developed since its inception. There were no measures of success and no clinical governance structure. Often the recommendation was for clients to be remanded in custody to be seen by the team's psychiatrist at a later date; which appeared to defeat the object of the scheme.

3.10 Referrals were generally accepted from anyone, including court staff, escort staff, solicitors and drug and alcohol services. Two schemes said that individuals could self refer. Two teams checked the names of all those in court cells against the community mental health team (CMHT) database, and one checked all referrals against their ever-expanding client database to identify anyone already known to the service. All kept some form of record of their contact, but only one had an electronic database. The schemes' focus was on meeting practical needs on a case by case basis and there was little monitoring or evaluation.

[23] Count me in (2007)
[24] Keating and Francis (2002)

3.11 Clients' ethnicity information was recorded, but appeared not to be used in any way. This was an omission, given the evidence that the first contact with mental health professionals for many black people with mental health problems may be the criminal justice system, and that sectioning from court largely accounts for the higher detention rate of black patients in hospitals (see 3.6).

3.12 If a client was sent to prison, all the schemes claimed they would pass on the information they had to prison healthcare staff. The strength of these links varied. One scheme was just beginning to develop links with its local prison. Another had well-established links and in another the lead nurse attended the prison for two sessions a week. Some schemes also passed information concerning patients to community GPs.

Good practice: A generic mental health team was based in Liverpool Magistrates' Court and provided a comprehensive throughcare service for clients with serious mental health problems in the criminal justice system. It was able to divert clients away from the criminal justice system when appropriate and liaised with community services and prisons to ensure good aftercare. It was the link for many parts of the criminal justice and health services and provided training to the police.

3.13 All the diversion/liaison schemes appeared to have difficulty measuring their success, although some could identify indicators that their service was recognised and valued. One stated that judges would not deal with some clients until scheme staff arrived in court. Continued funding was also taken as a sign of success, as was the lack of any complaints. There were frustrations, such as not having the resources to meet the level of demand and the immediacy of the need, and the difficulty of finding suitable places for those with learning disability and also for sex offenders, for whom there was a shortage of community provision.

3.14 Two of the schemes were provided by forensic services rather than CMHTs, and this level of specialism enabled risk of harm to others as well as mental health need and risk to self to be assessed. As part of a county-wide forensic service they could access low and medium secure beds more easily, both in and out of area, or refer to CMHTs. Non-forensic teams experienced more difficulty making these referrals to forensic care. Both of the forensic teams had input from forensic psychiatrists, psychologists and social workers, and had good links with the MHIRTs in their local prisons. Their specialist skills in risk assessment meant that they were well placed to contribute to multi-agency public protection meetings, priority offender schemes and anti-social behaviour order (ASBO) meetings. One scheme also acted as a source of training and advice for police, probation staff and magistrates, and offered mental health placements to RMN and social work students.

3.15 In our view, it was important that schemes were able to assess both mental health needs and risk of harm to the public in clients who came into contact with police or the courts. This requires good links between forensic and generic mental health practitioners. We saw examples of apparently successful schemes that were forensic-led, but able to refer to community mental health teams where appropriate, as well as those that were led by generic mental health practitioners with the capacity to refer to forensic services if they had concerns about risk.

Good practice: If a client was sent to prison, which might in itself increase the level of risk, the Chelmsford Criminal Justice Mental Health Team contacted healthcare staff in the prison to advise whether an inpatient bed was required, and to fax reports and other information to the prison directly. Because it was an established forensic clinical team with a consultant psychiatrist, the team could keep the client on its caseload and open the care programme approach if they were bailed, or refer to the

relevant community mental health team. Because of the team's links with forensic services and good relationships with local commissioners it could also refer directly to low or medium secure beds, even out of area.

Summary and recommendations

3.16 Court diversion and liaison schemes, introduced in 1989, have no ring-fenced funding, no service blueprint and no clear accountability. A 2002 study established that diversion from court to hospital can result in successful outcomes. A 2005 Home Office/Department of Health review identified a wide variation in funding and organisation, and suggested that the most effective were those jointly funded by health and social care.

3.17 The lack of NHS secure and acute beds and insufficient community provision continues to be a barrier to successful diversion. Community services tend to operate in silos and may not be able to provide early interventions, or meet the complex needs of offenders. They also fail to pick up early mental health problems among BME communities; black patients are over-represented in secure care and more often compulsorily admitted from the courts than from the community.

3.18 Only two of the 23 primary care trusts surveyed knew about diversion schemes in their area. The six schemes examined during fieldwork had a wide variation in funding, scope and effectiveness. They mostly operated in magistrates' courts during the times that the court sat and accepted referrals from any source, but one operated mainly in police custody suites and one provided cover on only two days a week. The quality of the links with prisons varied.

3.19 The schemes focused on meeting practical need, and there was little monitoring or evaluation, including the impact on diverse groups, such as BME communities. Frustrations were caused by a lack of sufficient resources for the task and by a shortage of community placements, particularly for sex offenders and those with learning disabilities.

3.20 There was no blueprint for a diversion/liaison service. The most effective schemes had strong working links and lines of communication between health and social care, as well as with voluntary sector organisations. This enabled them to respond well to clients' needs and access a range of services on their behalf. Schemes needed to be able to assess risk of harm to the public as well as mental health need, and those that were not forensic-led needed to have access to those services.

Recommendation

3.21 PCTs, in commissioning services from mental health trusts, should ensure that court diversion/liaison schemes are in place that are capable of assessing mental health need and risk of harm. A range of alternatives to custody should be available, including sufficient secure and acute beds and packages of non-residential support capable of meeting offenders' mental health and social needs and of protecting the public.

4. On arrival: pathways into care

4.1 This chapter examines how the mental health needs of new prisoners were identified and responded to on arrival at prison. A random sample of 237 new receptions was surveyed by means of a specially designed questionnaire as well as a formal health screening questionnaire (GHQ12) that measured psychological wellbeing. Clinical records were examined in order to determine the prevalence of primary and secondary mental health need and substance misuse problems in prisoners who had recently arrived, and the extent to which these needs were met by existing services.

Reception screening

4.2 It is standard practice that prisoners are seen in reception by a member of healthcare staff and screened for any immediate health needs that require a first night response. MHIRT staff are not targeted at reception, and this task usually falls to prison nursing staff, many of whom are not trained in mental health or substance misuse, and are poorly equipped to elicit the necessary information in these areas. In local prisons, a standard reception screen is used[25].

4.3 New prisoners are asked, among other things, about any medication they are taking, their use of alcohol and drugs, whether they have had any contact with mental health services in the community, whether they have previously self-harmed and whether they currently feel like self-harming. There are no screening questions to establish whether the prisoner is suffering from a learning disability. This Inspectorate's expectation is that a further secondary screen to obtain a fuller past medical history should take place within 72 hours of the first.

4.4 It is important to note that prisoners on remand can be received into prison several times during their remand period. Because of population pressures, they may be returned after a court appearance to a different prison from the one they left, often after several hours' delay. With the national prison population at record levels, some prisoners may have been locked out in police cells at critical times for their health and wellbeing, with variable clinical input. For those with mental health problems and drug or alcohol dependency, these disruptions make it very hard for them to achieve continuity of medical care. Many prisoners arrive late in the day, especially women and young adults who usually have longer journeys, and this puts their reception screening under particular pressure.

4.5 In training prisons, to which prisoners are moved if they are serving longer sentences, screening on reception is less comprehensive as prisoners are already under the care of prison health services and are transferred with a current clinical record that should contain the initial reception screen. In these circumstances healthcare departments often devise their own screening questions, and some MHIRT leads told us in our national survey that they had added some mental health screening questions to the reception screen in use at their prison.

4.6 Reception screening remains in most places a paper process. A small number of healthcare centres are linked with their trust or PCT systems, but coverage is not national and there is no way of transferring clinical information confidentially in an electronic format.

[25] The Grubin Screen

4.7 These findings are taken from a survey of 237 prisoners, men and women, from two male local prisons, four young offender institutions (YOIs), and four women's prisons, all of whom had been in the prison for less than a month, and from an examination of their reception screens in clinical records. We selected equal proportions of white and BME prisoners from each establishment. Our sample was:

- 68% male and 32% female
- 30% aged under 21, 50% aged 22 to 39 and 20% aged over 40
- 53% white, 23% black, 10% Asian, 11% mixed race and 2% of other ethnicity.

4.8 In our survey, most (over 80%) said they were asked about self-harm, substance misuse and other medical needs in reception. Sixty-eight per cent said they were asked about emotional wellbeing. From 252 clinical records[26], only two were missing a reception screen, but half were missing a fuller secondary health screen.

4.9 Almost half (47%) of new prisoners in our survey disclosed problems with drugs and/or alcohol, with 7% reporting problems with alcohol only, and 15% with both alcohol and drugs (see Table 1). The clinical records of these prisoners broadly concurred with their self-report, with substance misuse problems recorded in 45% of all reception screens. The level of alcohol misuse was hard to determine as the actual amount consumed in the week prior to custody was recorded in only 42% of the records we examined. The reception screen prompts the interviewer to ask for this information, to determine whether detoxification is required, but in 49% of screens it was recorded simply as 'social drinking' or 'binge drinking', which did not quantify the level of dependency. This was a serious omission, and suggested that those carrying out the assessment did not understand the importance of the question. From the information available we estimated that 31 prisoners or 12% of our total reception sample were alcohol dependent and in need of detoxification. Twenty-four were men and seven women, with only three from a BME group.

Table 1. Prevalence of drug and alcohol use from self-report and reception screen

Source of data	Drugs	Alcohol	Drugs and alcohol	Total
Self-report	25% (59)	7% (17)	15% (34)	47% (110)
Reception screen	36% (91)	3% (8)	9% (23)	45% (122)

* NB. The reception screen data includes those who refused the survey

4.10 Similar gaps occurred in the recording of mental health history. The relevant questions in the reception screen were not answered for between 10% and 15% of new prisoners. Where information was recorded, 38 (17%) were documented as having received previous mental healthcare in the community and 32 (14%) reported being on medication for mental health problems on arrival in custody. A similar proportion reported previous self-harm, and about a third of these reported current thoughts of self-harm. Despite 17% of prisoners being recorded as having a mental health history, the 'further information required' box was ticked in only 3% of screens, and in less than half (45%) of these prisoners' clinical records was there any evidence of a secondary health screen (see Table 2).

[26] There were more records than prisoners as 15 prisoners declined to complete the survey.

Table 2. Prevalence of mental health need from reception screens

Previous mental health contact in the community	38 (17%)
On medication for mental health problems on arrival	32 (14%)
History of self-harm	40 (16%)
Current thoughts of self-harm	13 (5%)

4.11 In response to the identified mental health needs of the 38 prisoners who had had previous mental health contact, 20 (53% of those with a psychiatric history, and 9% of the total sample for whom mental health information was recorded) were referred from reception to the MHIRT. But 10 of the 38 (26%) were left with no response, despite guidance stating that any previous mental health contact, however historical, should prompt a referral to the MHIRT.

4.12 The risk of self-harm is particularly high on reception into prison[27], and any lack of vigilance in this area is a serious omission. One health screen was marked 'no evidence of current self-harm' but there was a self-harm warning form in the record which had been completed by the escort contractor that day. Of the 13 prisoners in our sample who disclosed in reception that they currently felt like self-harming, five were placed on an assessment, care in custody and teamwork (ACCT) monitoring form, three were referred to the MHIRT and one was both on an ACCT and an MHIRT patient. No action was recorded in the clinical record for the other four. It was difficult to see why an ACCT was not always opened for prisoners with a history of self-harm who also disclosed current thoughts of self-harm at a high-risk time.

Lack of wellbeing

4.13 Those prisoners reporting previous mental health contact were not the only ones who needed support. In our own survey, new prisoners were given the option of filling in a section on general wellbeing if they had needs in this area, and a quarter of our sample of 237 did so.

4.14 We also administered the GHQ12[28], a formal measure of psychological wellbeing to the reception sample. Responses suggested an even higher level of distress, with 50% scoring four or above, a threshold that in the community prompts further mental health assessment. More women than men or young adults scored over this threshold. However, it was also evident that women were more likely to acknowledge their needs than were men. In our GHQ12 assessments, 65% of women scored four or above and 46% in our prisoner questionnaire said that they needed support from healthcare for their emotional wellbeing needs. Among the men surveyed, 52% scored over four in the GHQ12, but only 15% acknowledged the need for support for emotional wellbeing. This, and the fact that current prison reception screening tends to pick up most easily those who have had previous mental health contacts in the community – which women are also more likely to have accessed – suggests that a significant amount of mental health need among men is likely to be missed under present screening arrangements.

[27] Shaw et al (2003)
[28] The General Health Questionnaire 12

Table 3 .The number and percentage of women, young adults and men reporting that they needed emotional support

	GHQ12 more than 4		Needing support	
	N	%	N	%
Women	46	65	31	46
Men	50	52	15	15
Young adults	14	27	9	17

4.15 Table 4 shows that GHQ12 scores corresponded with other indicators of mental health disturbance, with above-threshold scorers reporting higher levels of both past and present mental health need, and current thoughts of self-harm. The table indicates that to some extent these increased needs were picked up by reception screens, as above-threshold scorers were more likely to have been referred to the doctor, and a little more likely to have been referred for further physical and mental health screening and to drugs services. High scorers were also more likely to report a psychiatric history and current thoughts of self-harm.

Table 4. Differences between high and low GHQ12 scorers on various indicators of need and outcome, from initial reception screens

	GHQ12 less than 4		GHQ12 more than 4	
	N	%	N	%
Previous mental health contact in the community	12	14	22	23
Previous inpatient	1	1	11	12*
Medication in the community	10	14	28	36*
Medication on arrival	9	11	23	25*
History of self-harm	11	12	23	23
Current thoughts of self-harm	0	0	10	10*
Received a secondary health screen	51	47	61	57
Seen by doctor	63	64	80	79*
Seen by the MHIRT	11	10	15	14
Referred to drugs services	12	11	22	20

* indicates statistical significance, p=<.05

** Figures exclude respondents who did not complete the GHQ12

4.16 Table 4 also indicates, however, that a substantial number of prisoners identified as distressed from our own measure were not picked up in reception, where this screen is not routinely used. Forty-three per cent of new prisoners with high GHQ12 scores did not receive a secondary

health screen, and 21% were not referred to primary care. Worryingly, our examination of clinical records revealed that, in our judgement, issues identified in reception had been appropriately addressed for fewer of the more needy high scorers (71%) than the less needy low scorers (84%).

4.17 These findings suggest that the current prison reception screen, even if properly applied, is not a sufficiently reliable mechanism to be able to pick up those who have mental health needs, and who are unaware of this, or have not accessed mental health services in the community.

4.18 In our survey of the 237 new prisoners, 55 (23%) indicated that they wanted mental health support. Sixteen of these commented that they were not receiving treatment or were still waiting to see someone. Some of those prisoners not being seen commented:

'Having suffered from depression severely before, I think unless you're suicidal or a drug addict you're left feeling very isolated.'

'Healthcare doesn't listen. I want to talk to someone about what I need.'

'*Some staff are OK and are doing their job's worth 100%, others dismiss anxiety and depression and forms of bullying. Seek help and the situation has to escalate where you have to become a discipline problem, thus the situation can't be resolved as the behaviour shown is then concentrated on and not the cause behind it.*'

Co-morbidity

4.19 Seventy per cent of those interviewed from current MHIRT caseloads also had substance misuse problems, often accompanied by depression and anxiety. In psychiatric reports in clinical records mention was often made of personality disorder, and it was apparent that mood disturbance, exacerbated by drugs and alcohol, could be taken as evidence of both borderline personality disorder and bi-polar disorder. Diagnosis was often obscured further by the presence of drug-associated psychosis and paranoia. Survival issues following earlier trauma appeared to manifest themselves in self-harming behaviour and/or violence, the former more prevalent in women and the latter in men.

Substance misuse

4.20 From clinical records, of the 114 (45%) prisoners in our sample who were identified as having problems with substance misuse in reception, 61 were referred to the prison GP and 42 were referred for clinical management or to a dedicated treatment service (CARATs). Clinical management of those withdrawing from drugs is provided by the primary care team and other drugs services to support long-term change provided by the CARAT service. Some were referred to both, but 45 (39%) were not referred at all. The CARAT service is voluntary, and a referral is only made if agreed with the prisoner. Some prisoners would not have wanted to be referred, particularly cannabis users, as there is no clinical detoxification for cannabis use.

4.21 What drugs were taken was recorded in most (94%) records, but frequency of use (62%) and when drugs were last used (58%) was recorded in fewer. Only 46% were recorded as having been given a urine test, which is an essential precursor to any prescribed clinical management.

4.22 In our survey, of those reporting substance misuse problems (110), 64% said they had a full history taken, 50% were referred to CARATs, and 50% said they had received a detoxification. A further 14% claimed they were put on a maintenance programme and 3% that they had been

slowly withdrawn from prescription medication such as benzodiazepines. Thirty-four per cent overall said they had received no clinical treatment for their drug dependency, and these were more often young adult or adult men, reflecting what we commonly find in inspections, that substance misuse services are less well developed in men's prisons and YOIs than in women's prisons.

Table 5: Action taken in response to prisoners reporting substance misuse problems in reception from the prisoners' survey

	Women %	Men %	Young adults %	Total %
Urine test undertaken *	74	41	0	46
A full history taken	70	65	46	64
DIPs involved in care	58	55	23	50
Undertaken detoxification	48	60	21	50
Maintenance	33	6	0	14
Slow reduction	6	2	0	3
No treatment	12	31	79	34

*from clinical records
NB: Percentages are rounded up and may not add up to 100%

4.23 Table 5 indicates that there were substantial gaps in the action taken once prisoners disclosed substance misuse. The pattern of response to the needs of young adults is considerably at variance with that of adults, though this is likely to be in part a result of a different pattern of drug use. Young adults use mainly cannabis, ecstasy, and alcohol, but not to the level of physical dependency, and they require clinical support less often than adult prisoners. However, a full history should always be taken where substance misuse is disclosed.

4.24 It is difficult to know whether all those who would have benefited from prescribed clinical management and wanted it were offered it, as not all withdrawals can be treated in this way, and such treatment is voluntary. Urine tests and a full history are only essential as a precursor to some form of clinical management, and the prisoner could have indicated that s/he was reluctant to go down this route. However, some of the comments made by prisoners in the survey suggested that treatment options fell short of their needs:

'Cannabis and alcohol – no detox programme.'

'I was in a terrible state due to withdrawing and DTs coming off the alcohol. I have had no treatment at all for the drink or my benzo [benzodiazepine] addiction.'

4.25 GPs in local prisons prescribe for detoxification and symptom control until the extent of dependency can be established, at which point methadone can be prescribed. In practice we find that methadone is rarely prescribed on the first night, except in women's prisons, without confirmation from the prescriber in the community, because of the importance of getting the dose right. In women's prisons it is common practice for those testing positive for methadone to be given a low first night dosage, which is then adjusted depending on the results of urine screening, which accounts for the higher proportion, in Table 5, of women reporting a urine test after disclosing substance misuse.

4.26 From the clinical records of our sample, very few prisoners were offered detoxification from alcohol, though this is clinically advised in cases of extreme dependency. It was difficult to determine whether this reflected low levels of dependency or oversight, as the information recorded during the reception screening process was imprecise. Clinical guidelines state that alcohol detoxification should precede detoxification for drugs. In our survey, only 8 (24%) had been offered detoxification from both alcohol and drugs; one said that drugs were tackled first, five that they were tackled together and only one[29] that he was detoxified, appropriately, from alcohol first.

4.27 Of the 36 comments prisoners made about their detoxification, 32 were critical. A common complaint from prisoners was that the process to establish what drugs they had been taking, either from a urine test or from checking records in the community, meant that they were left for the first night in prison without any symptomatic relief.

'You are left to withdraw for the first night no matter what your condition.'

4.28 Given that new prisoners had often spent some time in police custody before coming to prison, this was not necessarily their first night of withdrawal.

'You should be started straight onto either subutex[30] or methadone especially if you are on maintenance on outside and haven't had it due to being in police station.'

4.29 Many of the comments referred to the inadequacy of the detoxification medication in providing relief from symptoms given the extent of their dependency, or of the programme being too rapid.

'If I have been drinking for 8/9 years every day heavily, I fail to see that a detox of one week is going to: (1) take away my need for alcohol (2) deter me on release from relapsing. Medication and support in my opinion are vital during the first 6-8 weeks for sleeping patterns, depression etc.'

'Been on methadone four years. Detoxing me in 19 days – never been so ill.'

'The detox was too fast. I also think that once the detox has been completed we should be put on a long-term maintenance programme as the temptation to use drugs in prison is very great. Also medication for depression should be prescribed to all prisoners who need it.'

4.30 Mental health problems were both obscured by and exacerbated by drug-taking. Clinical experience shows that many prisoners use substances as a form of self-medication to help them deal with the depths of depression or the overwhelming effects of anxiety associated with traumatic early life experiences, and they are anxious about these feelings returning once the drugs are stopped. In these circumstances, clinical detoxification alone does not stop a habit that meets psychological needs. It is precisely at this point that the underlying mental health issues may be manifested. However, the psychological aspect of detoxification was rarely considered. In our reception sample, only 43% of those undergoing detoxification said they were given any emotional support, and from comments this was more often from the CARATs team than from healthcare staff, except for those who were on the MHIRT caseload, most of whom claimed their mental state was monitored at this time.

[29] One respondent did not state which detoxification happened first.
[30] Bupenorphrine, an opiate-based drug used for detoxification from heroin.

'CARATs have been good.'

'CARATs have been helpful.'

'I think the detox in this prison is appalling because you are not offered any support or information about anything. This prison detoxes you way too fast, plus they don't listen to you about how you feel.'

'I have a history of steroid misuse and it's more difficult to treat. Though it's very stressful, I overcame this on my own. I feel there should be a bit more on offer (support wise), emotions are all over the place and I had no support network.'

'It was a nightmare and I thought of suicide.'

Reception screening on transfer

4.31 On transfer to another prison, the initial reception screen remains in the prisoner's clinical record and should be available to the receiving healthcare staff. In eight training prisons visited we examined 135 subsequent reception screens completed when a prisoner transferred. Transfer is a high-risk time for prisoners with mental health problems when any existing support networks are disrupted, and continuity of care can be jeopardised. The reception screening was often carried out by means of locally-produced forms rather than the standard screen used on first entry and they were neither as comprehensive as the initial screen nor as reliably completed. Information about alcohol and drug use was missing in about 15%, and about mental health needs and self-harm in about 50%. In only 59% had the screen been fully completed, and there was evidence that the previous screen had been consulted in only 26% of cases. We rated continuity of care as satisfactory or good in only 48% of the screens examined. We came across the following example:

Case study: A male prisoner was picked up by the MHIRT at Preston where he was seen by a psychiatrist and prescribed medication. He was subsequently transferred to Wymott where the reception screen picked up the previous contact with mental health services and made a referral to the GP. The prisoner did not attend his appointment and he was not followed up. He was later seen by the GP regarding an eating problem, but the mental health issues were not picked up, although the notes of his previous psychiatric review were on the same page as the GP's entries in his clinical record. The MHIRT at Wymott was unaware of this patient.

Summary and recommendations

4.32 Reception screening for new prisoners usually asked about self-harm, substance misuse, medical needs and previous mental health contact, but did not seek to identify learning disability. Initial reception screening was reliably carried out in local prisons. Around 45% of the 252 prisoners sampled were identified as having used drugs or alcohol, but the level of alcohol dependency was not reliably assessed.

4.33 About 17% of the 237 new prisoners sampled disclosed a psychiatric history but further information from outside prison was requested in few of these cases; under half received a secondary health screen, and less than a third were referred to MHIRTs. For a quarter of these prisoners no response to their disclosure was recorded in their clinical records. There was no

recorded action in the clinical records for a quarter of those disclosing both a history of self-harm and current thoughts of self-harm.

4.34 A formal measure of psychological wellbeing (GHQ12) showed much higher levels of mental distress than the currently-used reception screen: 50% of the 220 prisoners who completed the GHQ12 scored at levels that indicated primary or secondary mental health needs. Women scored more highly than men, though they were much more likely to recognise that they needed emotional support. A substantial number of those prisoners were not referred to primary or secondary care. Worryingly, those with a high level of need were less likely to be followed up appropriately by healthcare staff than those with less need. A quarter of the 237 prisoners surveyed said they wanted mental health support and there was some dissatisfaction with the lack of follow-up to needs expressed in reception.

4.35 Half of the new arrivals who disclosed substance misuse on reception said they had not had a urine test, a third had not had a full history taken and only half were referred to drugs services. Women were most likely to have received clinical treatment for dependency, and young adults least. Very few prisoners were offered alcohol detoxification. Prisoners commented that detoxification was too little, too fast and too late, though they were more positive about CARATs staff in this respect. Mental health problems were both obscured and exacerbated by drug-taking, yet little psycho-social or mental health support was offered to those withdrawing from drugs: only 43% said they were given any emotional support, usually from CARATs rather than healthcare.

4.36 Reception screening on transfer to other prisons was not as comprehensive as on first entry to custody, and not as reliably completed. Initial reception screens were often missing from clinical records and information about mental health needs and self-harm was missing in about half of the sample examined. There was some evidence that continuity of care was disrupted on transfer.

Recommendations

4.37 All staff should be reminded of the need to complete the Grubin screening form accurately, including the number of units of alcohol consumed in the week prior to custody.

4.38 Reception screening should include screening for learning disability.

4.39 Following the initial health screen, all prisoners should have a further health assessment carried out and recorded by trained staff no later than 72 hours after their arrival in custody.

4.40 Where it is identified that a prisoner has had previous mental health contact in the community, a referral to the MHIRT should always be made and information about previous history actively sought and subsequently used.

4.41 An ACCT should always be opened for those prisoners with a history of self-harm who also disclose current thoughts of self-harm in reception.

4.42 Reception staff should be aware that male prisoners in particular will often not disclose their true level of distress, because of either their distrust of healthcare staff or lack of insight. Requests for help should always be responded to, and if a healthcare response is not appropriate then help should be sought from elsewhere.

4.43 Treatment for drug dependency in men's prisons and YOIs should equate to that available in women's prisons. A full history should always be taken and a urine test should precede any prescribed clinical management.

4.44 All substance dependent prisoners should be provided with symptomatic relief at the earliest opportunity, following screening and testing; whether in police custody or prison.

4.45 Detoxification for alcohol should always be offered in cases of extreme dependency, and treatment for alcohol and drug misuse should tackle alcohol dependency before drug use.

4.46 Psycho-social support should accompany any clinical detoxification.

4.47 All prison healthcare departments should have an electronic clinical information system and the ability to confidentially transfer clinical records electronically between establishments and other healthcare providers.

4.48 On transfer to another establishment, prisoners should receive a comprehensive reception screen, including a review of all previous interactions with health service personnel.

5 Mental healthcare in prison

5.1 This chapter examines the role of the GP and the primary care team, the treatment of those accepted on the MHIRT caseload and wing staff's perspective of their role with mentally ill prisoners. It reports the results of interviews with nine GPs, 66 MHIRT clients, and 66 residential wing staff. Clinical records, CARATs files and wing history sheets for the client sample were also examined with specific reference to the MHIRT input into the care of five clients who were located in segregation units.

Primary and secondary mental health

5.2 The boundaries between primary and secondary mental health needs were not clear cut, in terms of either diagnosis or service. The incidence of severe and enduring mental illness was comparatively low though consistently higher than in the community, and was complicated by the prevalence of drug-induced psychosis that could mimic the symptoms of schizophrenia. By contrast, the incidence of psychological distress was high. This was often a consequence of the unmasking of underlying depression and anxiety when drugs and alcohol were withdrawn. In addition, many prisoners, removed from their communities and families, and sometimes moved around the country in search of space to hold them, were left anxious and depressed by their situation, leading to a heightened suicide risk. The response of prisons to this array of need varied according to the size and skills mix of the team, the mental health practitioner capacity of the primary care team, and the flexibility of MHIRTs to adapt to the needs of a prison population.

5.3 In response to the question in our national survey of MHIRT leads to ask whether they felt capable of meeting the prisoner mental health need at their establishment, only 19% said they did 'completely'. Some felt that they were able to meet primary problems but not the needs of the acutely unwell, whereas others said that they could meet the secondary need, but not the primary need or the need for mental health promotion. It was our view that secondary need was being prioritised over primary, and that the in-reach resource (primarily focused on severe and enduring mental health need) had made less impact on the bulk of prisoner need associated with psychological distress and lack of emotional wellbeing.

5.4 However, where effective primary mental healthcare services did exist, there were some positive comments that the co-location of primary and mental healthcare staff allowed for greater flexibility than was possible in the community.

The input of GPs

5.5 Since 2001 primary medical care in prisons has been provided by GPs and coverage is all but complete.[31] Sometimes this service is delivered by a local GP practice and shared between GPs from the practice, and sometimes the GP is individually contracted to provide the service.

5.6 During fieldwork, nine GPs were interviewed by a health services inspector who is a qualified GP. All had completed post-professional registration training as GPs, but none had received any specific training in the care of prisoners. Two had previous experience of working in

[31] DH (2001)

prisons, two were also working as forensic medical examiners for the police and one was working for a local drug and alcohol service in the community under the direction of a specialist consultant. One had a special interest in mental health, but none had any formal training in this area. The average number of sessions worked was just over five a week.

5.7 The lack of specialist training was an omission given the particular challenges associated with delivering primary care to prisoners. Comparatively high levels of substance misuse and associated psychotic symptoms, personality disorder, depression, learning disability and physical health problems make for a complex mix of need for which particular skills are required.

5.8 Over and above this combination of need, recent research suggests that prisoners are often distrustful of GPs and reluctant to disclose emotional needs and allow a successful doctor–patient relationship to develop. A recent study involving in-depth interviews with 35 male prisoners[32] indicated that most did not trust their GPs enough to ask them for help, despite experiencing high levels of distress, self-harming behaviour and emotional problems. Some men in the study said that fear of being labelled mentally ill was a reason for not seeking help, either because of the stigma this would bring or because they would then have to confront the problem. Distrust of the 'system' and authority figures in general was linked to adverse childhood experiences. The study reported that prisoners wanted their GP to listen to them, treat them with respect and compassion, and provide appropriate information.

5.9 During routine inspections we find that GPs interpret their role in different ways and often operate in isolation from the rest of the clinical team. Most of those interviewed saw themselves as the providers of primary mental healthcare in prisons, with varying degrees of input from psychiatric nurses or a consultant psychiatrist. All reported good working relationships with the MHIRT, but fewer had direct contact with psychiatrists, from whom feedback was usually received in the form of clinical notes. More specialised referrals to forensic psychiatrists involved a long wait for a response. Only two of the GPs were directly involved in any multidisciplinary meetings, and only one in care programme approach meetings.

Good practice: In Durham, the lead GP was also the medical director for the prison cluster. He had both clinical and administrative responsibilities and had developed excellent relationships with other local health staff.

5.10 Some GPs working in training prisons where initial detoxification had been completed were reluctant to respond to requests for subsequent detoxification as this required them to accept that drugs were available in prisons, despite the most recent national guidelines directing prisons to offer clinical support on the basis of need rather than location. This illustrated the relative isolation of prison GPs from the prison's drug strategy. A new integrated drug treatment service (IDTS) is currently being introduced on a rolling programme that promises to reduce GPs' isolation and improve the clinical management of drug and alcohol users overall, including screening, assessment, treatment options, joint work, secondary detoxification and throughcare. Despite a cut in funding last year, IDTS is expected to make a major contribution to effective and consistent provision.

5.11 When asked how mental health services to prisoners could be improved, GPs suggested that much primary mental healthcare need remained unmet. They made the following comments:

[32] Howerton et al (2007)

- the need for a better understanding of the link between substance misuse and depression, and the need for psychological support for those withdrawing from drugs and alcohol.
- the lack of service for those with personality disorder, which together with substance misuse underlay many of the mental health problems experienced by prisoners.
- limited access to forensic psychiatrists with long waits after referral.
- a lack of mental health expertise in the primary care team.
- a lack of access to psychological talking therapies and an over-reliance on medication.
- a lack of preventive work and advice on mental wellbeing.
- limited communication from community services about what had gone on before and what could be put in place for release.

Mental health in-reach teams

5.12 The majority of MHIRTs were staffed by registered mental health nurses (RMNs), with between one and three whole time equivalent staff. Access to allied health professionals such as drugs workers, clinical psychologists, counsellors and occupational therapists was variable. Most had some links with a psychiatrist but most nursing staff did not experience the ease of contact and professional support they would have had within the NHS. In our survey, some MHIRT leads commented that they felt professionally isolated and lacked opportunities for professional development. They also identified a contrast in professional cultures, restrictions on treatment, the turnover of prisoners and the challenging prison environment as barriers to effective provision.

Referrals

5.13 Two-thirds of MHIRT leads in our survey claimed that anyone could refer to them, and the others appeared to prefer to receive referrals from healthcare professionals. A quarter said that they preferred a self-referral to come through a member of staff, and 18% said that they would only accept referrals from wing staff if they had received mental health awareness training. For our client sample, most referrals had come from healthcare staff in the prison: wing history sheets showed that 13% had been made by prison officers and only 4% were self-referrals.

5.14 Referrals to RMNs and to psychiatrists were generally responded to quite quickly. Two-thirds of MHIRT leads said there was no waiting list at all to see an RMN and 56% said there was no waiting list to see a psychiatrist; only 7% had a waiting list of over 20 to see the RMN or of over 11 to see a psychiatrist. Few prisons had formed primary mental health teams which screened referrals and only passed on to the MHIRT those with a secondary need. Some had no RMNs in the primary care team who could fulfil such a function, and others did not deploy their RMNs in the primary team in a specific mental health role at all.

5.15 MHIRT leads provided figures which indicated that the average monthly number of referrals was 51 prisoners, and the average caseload per practitioner was 33 prisoners, ranging from small numbers in YOIs to over 100 in two local prisons. However, the level of involvement with individual prisoners was variable. Only 58% of the clients we interviewed reported having regular appointments with a mental health professional, and the turnover in local prisons meant that caseloads changed quickly.

5.16 From our survey, most (90%) MHIRT leads stated that they had some input into primary care, with 19% providing the primary care service themselves, or signposting to other services. Very

few claimed to have RMNs working across both primary and secondary healthcare teams, but most (69%) claimed they passed referrals between them and/or had meetings to discuss referrals. Most (71%) MHIRT leads claimed that their records were kept with the main clinical record, and where this was not the case, they described systems whereby notes or care plans were photocopied for the main record, or duplicated in both records. Despite their co-location and ability to share information and pass referrals between them, not all took advantage of this, as we often find in our routine inspections.

Good practice: At High Down, primary and secondary care were integrated into a single service under the direction of the MHIRT. A triage screening tool allocated patients to either a primary or secondary team within weekly meetings. All practitioners were supervised in their clinical practice, and patients could be moved between teams as deemed appropriate.

Clients

5.17 Sixty-six MHIRT clients were interviewed during fieldwork, of whom 68% were white and 32% were from a black and minority ethnic (BME) group. Most (85%) were sentenced. The clinical records of 73 were also examined. Of the mental health needs recorded, 74% were accounted for by depression, schizophrenia and psychosis, which is largely equivalent to the caseloads of community mental health teams:

Depression/self-harm	35 (48%)
Schizophrenia	13 (18%)
Psychosis	13 (18%)
Personality disorder*	11(17%)
Anxiety	8 (11%)
Bipolar disorder	5 (7%)
Anger management	4 (5%)
Attention deficit hyperactivity disorder	3 (4%)
Post-traumatic stress disorder	3 (4%)
Other**	6

*when co-morbid with another diagnosis

**including Asperger's syndrome, obsessive compulsive disorder, possible learning disability, and eating disorder

5.18 During interviews, most of those on active caseloads (76%) told us they had been receiving previous psychiatric care in the community, and their needs had been identified either at reception or soon after by wing staff or the doctor. Most (70%) also disclosed substance misuse needs. From records, half also had other physical health problems. Most (77%) were currently on medication (see Table 6).

Table 6: The health profile of MHIRT clients

Currently on medication	51 (77%)
Previous mental health contact in the community	50 (76%)
Substance misuse needs	46 (70%)
Physical health problems	39 (56%)

5.19 From clinical records, most MHIRT clients (81%) had a completed nursing assessment on file and 64% had a completed care plan; in four cases these were primary care plans. In interviews, not all the prisoners were aware of the existence of these care plans, with young adults less aware than adults. A third (35%) of the sample said they had one but 46% were unsure. Of those who knew they had a care plan, most (83%) said they had been involved in its development, and most (78%) agreed with it. Most (83%) MHIRT leads said that they would issue a copy to the client, but that this was sometimes refused by the client because they had nowhere private to store it.

5.20 Our examination of care plans indicated that they were essentially health-focused documents that included few social or custodial elements. Clients reported the following treatment or support:

Medication	76%
Regular appointments with a mental health professional	58%
Out of cell activity	5%
Therapeutic community	5%
Occupational therapy groups	5%

5.21 Of the current MHIRT clients interviewed who had also been receiving psychiatric care in the community, 49% said that their care coordinator was aware of them being in prison and 15% that they had provided information and/or visited. From clinical records it was clear that contact with previous providers in the community had been made for 59% of these clients, leaving at least 40% of those entering prison with a psychiatric history without any continuity of care.

5.22 In accordance with good practice principles (see 2.22), we asked MHIRT clients whether their wishes had been sought and respected when treatment was discussed. Over half (57%) claimed they had been given some choice about their treatment, though fewer (48%) had been asked what had worked for them in the past. Most (98%) of those on medication said they knew what it was for, 63% knew how long it would take to work and 70% had been told about the side effects (see Table 7).

Table 7: MHIRT patients' involvement and choice in their treatment

Been given some choice in treatment	33 (57%)
Been asked, where applicable, what had helped in the past	21 (48%)
For those currently taking medication:	
Knew what medication was for	50 (98%)
Had been told about possible side effects	27 (70%)
Knew how long medication would take to work	34 (63%)

5.23 We did, however, come across one example of a young man whose wishes for his own treatment had been ignored.

Case study: We interviewed a young life-sentenced prisoner on the MHIRT caseload and checked his clinical record. He was diagnosed as suffering from drug-induced psychosis and hearing voices that he thought were other people on the wing talking to him. He requested an anti-psychotic medication that had worked for him in the past, but he was told that his symptoms did not correspond with genuine psychosis, and it was not prescribed for him. He returned to his wing and complained to his personal officer who encouraged him to ask to see the doctor again. At his next consultation two nurses, one from the primary care team and one from the MHIRT, were present, and he was told again that he was

hearing the 'wrong sort of voices' for medication. Feeling bullied, he lost his temper with the doctor and walked out. At the time of the fieldwork he had still not received any medication or support and was quite distressed.

5.24 Although it would not be appropriate to assert that all those who are suffering such symptoms are at greater risk of suicide, unpublished research from Safer Custody Group has identified that, in around 20% of self-inflicted deaths, the prisoner had declared (sometimes to staff, sometimes to other prisoners) that he had heard voices or was suffering from auditory hallucinations. Such assertions are indicators of distress and merit a response. If there is nothing that MHIRT staff believe they can do, then they should ensure that other forms of support are in place by recruiting the services of the personal officer and residential staff.

5.25 Again, in accordance with the principles of good clinical practice described at 2.22, we enquired whether clients were satisfied with the service they had received and 72% of MHIRT clients felt that they had been helped, but 28% were dissatisfied. Some commented:

'Helps with the voices, but having problems sleeping. It's hard to get up when not sleeping, but they deduct IEPs[33] so have to.'

'I would like long-term counselling.'

'I was on a lot of medication when I arrived and like a recluse, but I have been taken off much of the medication and been helped to mix with others.'

5.26 Social contact is an important source of support for those with mental health problems, but, to their knowledge, only just over half (58%) of the MHIRT clients we interviewed had a key worker at their current establishment. About the same proportion had regular contact with family and friends, and another 28% had some contact with family and friends. Barriers to contact were the distance involved and the expense of telephone calls, though in our interviews, 28% of MHIRT clients told us they had been granted free phone calls or extra phone credit at times of crisis.

5.27 One of the principles of good clinical practice is consideration of carers' views. Fifty-four per cent of MHIRT leads surveyed reported that they had invited family or friends to CPA case reviews where appropriate, but in practice this was rarely achieved due to the distance involved. Most claimed, however, to encourage family contact by helping prisoners to write letters, granting free phone calls, asking residential staff to facilitate phone calls or phoning families themselves, with the client's consent, though some MHIRT leads were concerned about the security implications, and preferred wing staff to make contact.

5.28 From our sample, in just four (8%) cases clients' families had been involved in their care planning. Two had been phoned, one young man's mother attended his CPA review and another's family was planning to come. In the clinical records of those in our sample who were about to be released, just over half mentioned family or partners, though active involvement was limited. This was a very low level of family involvement for a high-risk group of prisoners with multiple needs.

Good practice: In Elmley, there was a dedicated phone line for family members to phone the prison if they had any concerns about a prisoner's mental state and possible self-harm. We tested this number and the call was returned within a few minutes.

[33] IEPs: points associated with incentive and earned privilege schemes.

Good practice: At Reading, family contact was used as part of the support plan for young adults on open suicide and self-harm monitoring forms.

5.29 We asked prisoners with mental health problems what helped and what made things worse. The following helped, in order of importance:

- Keeping busy, including gym, reading or painting
- Support from wing staff
- Support from other prisoners/friends
- Someone to talk to
- Healthcare staff
- Contact with family
- Listening to relaxation CDs

What made things worse, in order of importance, were:

- Having nothing to do
- Wing staff being uncaring
- Healthcare staff not helping
- Time in cell
- The frustrations of prison life, such has having to put in applications for everything, being denied transfers, problems with recategorisation and having to share a cell
- Feeling isolated, lack of contact with family/friends

5.30 These comments confirm the importance of a holistic approach to mental and emotional health. It is not enough to rely on treatment from mental health professionals. The whole environment of a prison needs to support emotional wellbeing. This is something that has long been recognised by this Inspectorate, and is embedded in our four tests of a 'healthy' prison: where prisoners feel safe, are treated with respect for their human dignity, have sufficient purposeful activity, and are prepared for resettlement. It is also confirmed in recent studies of the factors that help prevent suicide and self-harm.

5.31 As recognised in mental health legislation, prisons are not primarily therapeutic environments, and the imperatives of security and control will always create a challenging environment for delivering care to the mentally ill. But the above findings show the importance of contact with people who care and of prisoners having something positive to occupy them. Both isolation and enforced contact with strangers were mentioned as challenges for those with mental health problems, as was the inactivity that is a major feature of prison life. We increasingly find in prison inspections that in overcrowded prisons there are insufficient activity places for the large number of prisoners held. The key role of wing staff in influencing mental state is evident, even above that of the healthcare staff, and it was disappointing therefore that care plans rarely specified a role for wing staff or personal officers.

5.32 Most of the women (90%) and adult men (82%) in our sample of those being treated by the MHIRT were on medication at the time of this review. Many believed that their medication helped them and clinical notes showed that some had resisted coming off medication and were, at the very least, psychologically dependent on it. Many of the women we interviewed spoke about their medication possessively, as if it was a friend they could not live without, and some reported having arguments with the doctor about what medication they wanted. In contrast, a few spoke proudly about the achievement of coming off prescribed medication, often on their own initiative and sometimes without the knowledge of the prescriber. A comment made by several women was that they really wanted to talk about their problems

rather than take medication, which they knew was not getting to the root of their problems. Although the men in our sample did not express the same need, the shortage of talk therapies and an over-reliance on medication was identified as a problem by healthcare staff and it was likely that this applied equally to men and women.

Interventions

5.33 We asked MHIRT leads what interventions were available for clients, and whether they judged these to be sufficient to meet the need. Only 24% of MHIRT leads believed they had sufficient interventions, and the reasons given for this were lack of resources and a need to develop links with other disciplines in order to deliver effective help. The most common interventions identified were:

- cognitive behavioural therapy (62%)
- medication and educating clients about their medication (43%)
- some form of counselling (36%).

5.34 The following were also mentioned, but were not necessarily widespread: signposting to other services; CPA and case management; psychosocial interventions; occupational therapy; anxiety management; anger management; group work; motivational interviewing; coping strategies; health promotion; art/dance therapy; solution-focused brief therapy.

5.35 Our examination of the interventions provided indicated that there were some very imaginative adjunctive therapies being trialled, such as art and movement therapy, acupuncture and dietary advice. There had also been positive input from occupational therapists who were able to advise on therapeutic activities in-cell, and day centres had provided crucial distraction and support. However, it was not possible to determine how structured and focused many of the talk therapies were, as there were no detailed notes on file. Our impression was that much of the ongoing support was relatively superficial and unfocused.

5.36 A number of other non-statutory agencies were also providing counselling to prisoners, particularly in women's establishments, and no doubt made a contribution towards meeting needs that healthcare staff alone could not meet.

5.37 It was also apparent that psychosocial interventions, anxiety and anger management, motivational interviewing and coping strategies in some cases duplicated interventions provided by means of accredited programmes and one-to-one work with psychologists, probation officers and prison discipline staff. These programmes were inter-disciplinary, provided quality control and the outcomes were shared with other staff. Concern was expressed by these specialists that person-centred counselling, which focused on the prisoner's difficulties in isolation, was unhelpful unless it was part of a shared offender management plan that also addressed the offending.

5.38 Forty-two per cent of teams said that they needed to involve other disciplines in treatment to improve their effectiveness. During interviews, MHIRT leads told us that there was little quality control or evaluation of the effectiveness of treatment. One of the principles of good clinical practice is to consider the effectiveness of treatment, but at the time of this review there was a gap in quality control and evaluation of psychological therapies when they were applied by mental health staff as opposed to when they were applied by forensic psychologists. For the former there was no equivalent of accreditation, or evidence of clinical audit.

Good practice: In Whatton, if the mental health nurse assessed the patient as requiring counselling, such as specialist sexual abuse counselling, which was common with this population, he would be referred to a service coordinated by the psychology department. In collaboration, these two disciplines tried to ensure that prisoners who required such specialist counselling received it before they undertook the sex offender treatment programme.

The role of wing staff

5.39 Prison residential staff, of necessity, play a key role in the support and care of mentally disordered prisoners. Dr John O'Grady, a leading consultant psychiatrist, commented

'The role of prison officers must be one of the most frustrating roles in society. They are employed to keep in custody and keep safe people with very complex disabling problems across the whole spectrum of human need. They have virtually no training in the management of people with complex problems. What is astounding is that some, one way or another, learn skills to manage people whom health services, for example, cannot manage and actively reject. [34]'

5.40 There is no doubt there is a greater awareness among residential staff of the existence of mental health problems in the prisoners for whom they are responsible than was the case before the advent of MHIRTs. ACCT training has gone some way to developing this awareness, as has the training delivered under the CSIP programme (see paragraph 2.6).

5.41 In fieldwork we explored the perspective of 66 wing staff, officers and senior officers, and examined the wing history sheets of 55 of our MHIRT client sample. All the wing staff recognised that they had contact with prisoners who were mentally unwell during the course of their work. Overall they believed they managed them quite well, though largely in isolation, but they lacked confidence that what they were doing was right.

'*We are trained to control their behaviour but not the root cause.'*

'We do a lot on experience or just instinct. We do not know if it is right. We need resources and skills to improve our self-confidence.'

'In the past we were commended for managing a mentally ill boy well. We took him to the healthcare inpatient ward for art therapy and yoga once a week and we all looked out for him.'

5.42 About 23% of wing staff had received some form of mental health training. This was more often part of their initial officer training or part of suicide and self-harm training than in mental health awareness sessions. One had received dangerous and severe personality disorder (DSPD) training. Those who had received training generally found it had helped, though they thought it was insufficient. Those who had not received any training generally thought it would help.

'Training very helpful and have put training into practice on many occasions.'

'Training insufficient; gives you an idea but does not equip you.'

[34] John O'Grady, Chair, Faculty of Forensic Psychiatrists, Royal College of Psychiatrists, May 2007, private correspondence.

'Training would be good. We care for them the best we know how, with better training we could do more.'

5.43 Most staff (71%) said they could refer a prisoner to the MHIRT, and would do so, most often because of an abnormal change in a prisoner's behaviour. From wing history sheets it was evident that in 13% of cases staff had in fact made the original referral to the MHIRT.

'When I feel that a viable interaction is no longer possible.'

'If I thought a prisoner was seriously struggling I would refer them to the MHT [MHIRT] or the doctor.'

5.44 There was frustration among wing staff when prisoners who were difficult to manage, because of the risk of violence or self-harm, were returned to the wing. The distinction between primary and secondary mental health need, or personality disorder and mental illness, was not readily understood by prison staff.

'I find it frustrating that people with mental health issues that are deemed "untreatable" are then deemed as not medical concerns, but discipline problem.'

'I have had a difficult experience with the mental health team in another prison. I had a dispute over the assessment of a prisoner who they called a psychopath, not mentally ill, so nothing could be done to help with his management; I saw this as unsatisfactory.'

'There are a lot of mental health problems in the Seg [segregation unit] where this involves violent behaviour. We adapt to their needs. We often keep those with severe mental health problems who are too violent for hospital.'

Segregation: case studies

5.45 Comments made by prisoners with mental health problems point to the need for a caring, supportive and stimulating environment. Yet prisoners with such difficulties can often find themselves in segregation because of the challenges their behaviour poses.

5.46 Since the publication of new practice guidelines for managing prisoners in segregation in 2003[35] any prisoner entering a segregation unit must be assessed within two hours by a member of the healthcare staff using a safety algorithm, which identifies whether there are any concerns about the prisoner's mental state. Healthcare staff are also expected to attend reviews of prisoners held in administrative segregation. We asked MHIRT leads how confident they were that those with mental health problems in segregation units were not missed. Almost two-thirds (64%) were confident or very confident that they were not missed and only 12% were unconfident, though when asked to identify ways that they offered support, only 25% cited weekly visits to segregation units and only 13% cited attendance at segregation reviews.

5.47 An emerging theme from inquests into deaths in prison is the danger of segregation for those with mental health problems. The Prison and Probation Ombudsman criticised in his annual report[36]

[35] PSO 1700
[36] Prison and Probation Ombudsman (2005/6)

'…the failure of prisons to identify specific practical measures to promote and safeguard prisoners' mental health while in the segregation unit. In one case, the required regular reviews were carried out, but there was a failure to set and monitor imaginative targets to help relieve the boredom and isolation. In other cases, prisoners were left in impoverished regimes, without television, radio, reading materials, in-cell hobbies, or any other occupation. Giving vulnerable prisoners something to occupy their time is likely to be a crucial part of ensuring their welfare in segregation.'

5.48 Five of our MHIRT client sample were located in segregation units at the time of our fieldwork: one woman and four men, two of whom were young adults. We followed each of these up.

Case study: The woman had been moved to the segregation unit that day under good order or discipline (GOOD) as a bullying allegation had been made against her. The segregation staff were aware of her obsessive compulsive disorder and her self-harming, and she had all her own belongings with her as well as two budgies. She had been seen twice by the MHIRT even though she had been there for only a day. Her regime was limited but she was speaking to the staff, and one member of staff in particular.

5.49 In this case, the care given to a woman with complex and difficult needs showed an appropriate level of understanding, and of contact with the MHIRT. However, it was not clear that segregation staff had been briefed directly by the MHIRT about the importance of preventing deterioration and of monitoring her mental state.

Case study: One young adult on the MHIRT caseload was being held in segregation at his own request and had been there for a month. The staff were aware of his paranoia and mood swings and had passed on some concerns to the safer custody officer. They were not aware of any MHIRT involvement, and the prisoner said that there had been no contact even though he had requested counselling for post-traumatic stress disorder, was awaiting a psychiatric report, and had been on an ACCT form. He had access to the gym once a week, could exercise outside and had applied for in-cell education.

Case study: The other young adult was a remand prisoner being held under GOOD following a fight. He had been in the segregation unit for three and a half weeks. Staff were aware that he had mental health problems, but they had not been briefed by the MHIRT. The prisoner said he had seen the MHIRT once but had not had the level of care he was used to in the community. He had good access to books, could visit the gym twice a week and had in-cell education. He said he got on well with staff.

5.50 For these two young adults the level of input from the MHIRT, not only directly with the prisoners, but also in terms of advice to staff, was insufficient. There had been no briefing of staff and no CPA reviews recognising the segregation staff as primary carers. In-cell education (applied for and not yet delivered after a month in one case) would not provide a sufficient level of distraction for two such troubled young men.

Case study: One man on the MHIRT caseload had been held under GOOD in the segregation unit of a lifer prison for seven months, with short periods of respite in the healthcare centre and on the wing. He had a very limited regime that consisted of some in-cell work. He had declined exercise. The segregation staff were aware that he had problems, and there were references in his record to him being 'miserable' and 'manipulative'. He had not been seen by the MHIRT. The segregation unit staff had not been briefed about his needs or been provided with any strategies for supporting him, though he was being seen regularly by a primary care mental health nurse, which he felt helped him.

Case study: A second man on the MHIRT caseload had been held on GOOD in the segregation unit of a category C prison for six weeks. He did not want the stigma of being a vulnerable prisoner, though he was in debt due to his drug use. The segregation unit staff had referred him to the psychiatrist but the prisoner had refused to be seen. He had since seen the MHIRT twice, though there was no record of this in his history sheet, or of any feedback to the staff who had referred him. His regime consisted of daily in-cell work folding leaflets, a daily shower and access to books from education and the library. He had declined gym and education.

5.51 In the first man's case, despite some support, there was no involvement of staff in a coordinated care plan, and the input of the mental health nurse took place in isolation. The second man did not appear to be cooperating with mental health staff, which limited their effectiveness. However, there were no feedback notes in his segregation record to staff following their referral, or any record of what they should look out for in terms of behaviour that might signal deterioration in his mental state.

5.52 In our opinion, none of these clients in segregation with recognised mental health problems were being sufficiently monitored or supported. With the possible exception of the woman, they illustrate the isolation of MHIRT staff from other disciplines, and the limitations of their input. Segregation units, with the isolation they impose, are high-risk places for those with mental health problems, yet there was no evidence that the MHIRT staff had attempted to advise the segregation staff of their clients' needs, or of how they could help to mitigate the impact of isolation. CPA reviews did not appear to continue in segregation or involve the segregation unit staff, and segregation reviews were rarely attended by MHIRT staff. At the very least, segregation staff should be advised of the importance of distracting activities to occupy such prisoners in their cells, and of the importance of regular supportive communication and a change of scene whenever possible.

Summary and recommendations

5.53 The boundaries between primary and secondary mental health need were not clear cut, and secondary need was in general prioritised, rather than the more predominant primary need. Only 19% out of 84 MHIRTs thought they could meet the needs of prisoners. However, where there was effective primary healthcare, the co-location of the two services could result in a more responsive and flexible service than was possible in the community.

5.54 GPs are responsible for primary care in prisons, but the nine we interviewed lacked specialist training in the care of prisoners or their complex mental health needs. It is known that many male prisoners are distrustful of doctors and fear the label of mental illness. From inspections in general, few GPs appear to have any specific responsibilities for clinical team leadership or direction, and they work largely in isolation. From our interviews, relationships with MHIRTs were good, but GPs said they had little direct contact with psychiatrists or input into multidisciplinary meetings. They described a shortage of talk therapies and therapeutic interventions for primary mental health and substance misuse problems.

5.55 MHIRTs were mainly nurse-led and staffed by RMNs, with variable access to other health professionals from their trusts. Most lacked the support they would have had in the community and some felt professionally isolated. A third of the 84 MHIRTs surveyed preferred to receive referrals from healthcare staff and almost a fifth were reluctant to receive referrals from prison staff who had no mental health awareness training. Few prisons had RMNs in the primary care team who could screen referrals or deliver primary mental healthcare, and links with primary

care teams were not always good. The average number of referrals to MHIRTs was 51 a month, and most were dealt with quickly: the average caseload was 33 clients per practitioner, though numbers were higher in local prisons.

5.56 We interviewed 66 MHIRT clients. Nearly half were suffering from depression or self-harm, with some incidence of schizophrenia and psychosis. Personality disorder and learning disability occasionally featured as a co-morbid condition but not as a single diagnosis, and there were some anxiety disorders and anger management problems. Three-quarters of the clients had received some psychiatric care in the community before prison, but contact with previous providers had been made in only 59% of cases. Half had physical health problems and 70% had substance misuse needs.

5.57 About two-thirds of the clients in our sample had a care plan, though only about a third appeared to know about it. Over half had regular appointments with a mental health professional. Targets were mainly health focused and included few social or custodial elements, although these came high in the lists of things that prisoners believed would help them. Over half (57%) claimed they had been given some choice about their treatment, though less than half had been asked what had worked for them in the past. Most had been given information about their medication, and 72% felt their treatment had helped them.

5.58 Hearing voices was an obvious indicator of distress, but was not always considered treatable by MHIRT staff. Yet research from Safer Custody Group has shown that hearing voices is associated with 20% of self inflicted deaths.

5.59 Only 58% of the 66 MHIRT clients sampled had a key worker or regular contact with families. Prison staff had facilitated contact in emergencies, but involvement of families in care planning was rare. Prisoners' comments confirmed the importance of a holistic approach to mental and emotional wellbeing, identifying the positive impact of activity out of cell, supportive wing staff, and support from other prisoners, even more than contact with healthcare staff and family. Some clients had become at least psychologically dependent on their medication and there were insufficient other therapies to overcome this, where appropriate and necessary.

5.60 Only a quarter of MHIRT leads believed they had sufficient interventions to meet the extent of prisoner need. The most common interventions were cognitive behavioural therapy, medication and counselling. There was some evidence of new therapies, including occupational and art therapy, but their impact was not effectively recorded. Many of the interventions overlapped with those provided by other prison specialists. There was little quality control or evaluation of therapies and a lack of coordinated case management integrating the work of mental health staff with other disciplines.

5.61 Prison officers' awareness of mental health problems had increased. All 66 wing staff interviewed recognised that a proportion of prisoners were mentally unwell, and felt that they managed them quite well, though they lacked confidence that what they were doing was right. Only about a quarter of those interviewed had received mental health training though most wanted it, or wanted more. Over 70% said they would refer to the MHIRT, but there was frustration when difficult to manage prisoners were returned to the wing, and confusion about the distinction between personality disorder and mental illness.

5.62 New practice guidance for the management of segregated prisoners requires healthcare staff to screen prisoners on arrival and to provide input to monthly reviews. The Prison and Probation Ombudsman has highlighted the vulnerability of mental health patients in segregation. Of the five MHIRT clients in our sample who were in segregation, only one, a

woman, was being effectively monitored or supported by the MHIRT, who were not advising and involving segregation staff on their management and care planning.

Recommendations

5.63 There should be sufficient resources in primary care teams to meet the high level of primary mental health need in prisoners, and greater coordination between them and MHIRTs to ensure that referrals are appropriately allocated and managed.

5.64 GPs should receive specific training for delivering primary mental healthcare in prisons, and should take responsibility for the clinical management of primary mental healthcare.

5.65 There should be a greater range of primary mental health services to treat the high level of depression and anxiety, and reduce psychological dependence on substances.

5.66 Primary mental health services should include guided self-help programmes based on cognitive-behavioural models and psychological treatments as specified in NICE guidelines.

5.67 Mental health practitioners in prisons should be trained to understand the specific mental health needs of prisoners and should adopt an ethical approach that respects their wishes and feelings without compromising public protection, and that specifies the limits of medical confidentiality.

5.68 Mental health practitioners in prisons should also have access to psychiatrists trained in the specific competencies required to meet prisoners' psychiatric needs.

5.69 All mental health practitioners should receive regular clinical supervision and opportunities for professional development.

5.70 Interventions should be subject to clinical audit and other NHS reviews, and where appropriate should operate under the supervision of a psychologist.

5.71 All discipline staff should receive mental health awareness training, with at least bi-annual updates. The training should be quality controlled.

5.72 MHIRTs should accept referrals from prison officers and include them in multi-disciplinary care planning and review.

5.73 All interventions with prisoners should be agreed with the individual after options have been discussed and the effects of any medication fully explained.

5.74 Interventions should be planned by a multidisciplinary team and coordinated by a named key worker, to ensure coordination and to avoid duplication or undermining of work carried out elsewhere.

5.75 Care plans should be integrated documents with contributions from all disciplines as appropriate. They should include health, social care, custodial and resettlement needs.

5.76 There should be an auditable trail to evidence that all care plans are regularly reviewed, updated and shared with the prisoner.

5.77 Family involvement in CPA case reviews should be rigorously pursued and all family contact should be documented in the multidisciplinary care plan.

5.78 Staff with expertise in mental health should work in conjunction with segregation unit staff to ensure that prisoners held in segregation are supported and provided with appropriate distracting activities.

5.79 Complaints by prisoners that they are hearing voices should always be taken seriously and every effort made to alleviate this as quickly as possible.

5.80 Interventions for prisoners with personality disorder should be developed in cooperation with forensic psychologists.

6 Diversity of mental health need

6.1 This chapter 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 these needs. We did not specifically look at older prisoners, who are known to experience higher rates of dementia and depression, or at the needs of foreign nationals, as both have already been commented on in previous thematic reviews.[37] [38]However, recent changes may have increased the vulnerability of foreign nationals and this is referred to later.

The experiences of women

6.2 It is well documented that the mental health needs of women prisoners are complex; often linked with histories of abuse; include significant co-morbidity; manifest themselves in high levels of drug misuse; and are compounded by the impact of imprisonment. Women experience high levels of both severe and enduring mental illness and psychological distress, and seek help more readily than men [39].

Substance misuse

6.3 Our findings showed women were slightly more likely than men and much more likely than young adults to present with drug problems on arrival in custody, though much less likely than men to be alcohol dependent (see Table 8). Almost a third (30%) of our reception sample were referred to a doctor because of substance misuse. As stated earlier, more women than men are prescribed methadone on their first night in a low dose that can be adjusted once the results of urine tests are known, and this is commonly maintained on transfer to another prison (see 4.25).

Table 8: The numbers and proportions of men, women and young adults reporting substance misuse needs on reception and referred to the doctor or MHIRT, from reception screens

	Men		Women		Young adults		Total	
	n	%	n	%	N	%	n	%
Requiring alcohol detoxification	21	18	7	9	3	5	31	12
Drug problems on arrival	54	50	39	57	21	42	114	45
Referred to doctor for substance misuse	29	25	24	30	8	14	61	24

Mental health

6.4 We also found higher levels of both previous and current mental health problems among women than in other prisoners, which is consistent with other studies. Over a quarter of our reception sample reported previous psychiatric treatment in the community, with 9% having

[37] HM Inspectorate of Prisons (2004)
[38] HM Inspectorate of Prisons (2006)
[39] HM Inspectorate of Prisons (2005b)

been hospitalised. A quarter also reported a history of self-harm, with one in 10 reporting current thoughts of self-harm. These rates were almost twice as high as the average for all prisoners, yet women were only half as likely to receive a secondary health screen (see Table 9).

Table 9: The numbers and proportions of men, women and young adults reporting mental health (MH) needs on reception, from 252 reception screens, and referrals to services

	Men		Women		Young adults		Total	
	n	%	n	%	n	%	n	%
Previous treatment for MH issues in the community	15	14	17	27	6	12	38	15
Previous hospitalisation for MH reasons	6	6	7	9	0	0	13	5
Previous medication in community	20	22	20	39	6	17	46	18
Psychotropic medication on arrival in custody	16	14	14	18	2	4	32	14
Self-reported history of self-harm	17	16	16	25	7	14	40	16
Current thoughts of self-harm	4	4	6	10	3	6	13	5
Referred to MHIRT	10	10	8	13	2	4	20	8
Received a secondary health screen	61	53	20	25	44	77	125	50

Wellbeing

6.5 In terms of general wellbeing, a raft of measures indicate that more women than men or young adults suffer a level of psychological distress in prison:

- OASys assessments indicate that more women (55%), than men (30%) or young adults (25%) are identified as having problems in the area of wellbeing[40].
- Our own GHQ12 analysis showed that more women (65%) scored above a threshold that indicated clinical need than did either men (52%) or young adults (27%).
- In our survey, more women (46%) than young adults (17%) or men (15%) said that they needed support from healthcare staff for emotional problems.

6.6 These high levels of mental ill health and psychological distress among women are consistent with other prevalence studies, and with research that links psychological distress with previous abuse, both domestic and sexual, which is the background of many women in prison[41]. In particular, women suffer from separation from their children, for whom they are more likely to be the primary carer[42]. They are also likely to be held further from their homes, which makes contact with families and community-based services even more difficult. This was confirmed from our examination of MHIRT clients' clinical records where there was less continuity of care between prison and the community for women (43%) than for men (63%) or young adults (80%).

[40] O-DEAT data
[41] The Corston Report (2007)
[42] HM Inspectorate of Prisons (2005b)

6.7 In terms of resettlement, the OASys data on criminogenic needs[43] indicate that those with needs in the area of emotional wellbeing have greater needs in all other areas associated with reoffending (see 7.15). When these data are analysed to identify the leading criminogenic needs for those with and without emotional needs by prison type, relationships emerge as the dominant need for women with emotional problems; but this is not the case for men. This underlines the importance of specific interventions to address relationship skills for women with emotional wellbeing needs if they are to be successfully resettled.

Table 10: The leading criminogenic needs for those with and without emotional wellbeing needs

Functional type	With emotional wellbeing needs	Without emotional wellbeing needs
Local prisons	Thinking and Behaviour	ETE*
Training prisons	ETE and Thinking and Behaviour	ETE
YOIs	ETE	ETE
Women's prisons	Relationships	ETE
High security prisons	Thinking and Behaviour	Lifestyles and associates
Open prisons	ETE	ETE

*ETE: education, training and employment

Mental health services

6.8 Our examination of clinical records revealed no significant differences in the delivery of services between men, women and young adults in terms of whether they had care plans; how well care was integrated with other disciplines; the appropriateness of treatment; or their involvement in their treatment as patients. Exceptions to this were that a higher percentage of women MHIRT clients (80%) received medication than men (82%) or young adults (29%), and more women than men or young adults said they had a care coordinator in prison.

6.9 In terms of available interventions, MHIRT leads reported a greater range of interventions for women, which included treatments for personality disorder, and dual diagnosis. There was also a greater range of non-statutory organisations providing counselling for bereavement and survivors of abuse. However, MHIRT leads in women's prisons commented that they needed more interventions for survivors of abuse and self-harm.

6.10 The high number of women MHIRT clients on medication gave us some cause for concern, especially as some said they wanted to reduce their medication as they had been on it for years and felt it was no longer working, and they would prefer to talk about their difficulties (see paragraph 5.32). A study carried out in 2001 identified that more women in prison were on medication than in the community[44]. It has been suggested elsewhere that medication has been used to contain rather than address women's problems in prison:

[43] See Appendix III
[44] O'Brien et al (2001)

'There is anecdotal evidence that this increase in medication is not a result of careful exploration of the mental health needs of women in prison but rather a response by under-trained staff who resort to medication to contain a "problem". Some of these medications are addictive and have unpleasant side effects, and would normally be prescribed outside prison only after careful professional judgement, and with proper supervision.[45]'

6.11 The Care Services Improvement Partnership (CSIP) has been particularly critical of the lack of high quality primary care in mental health services available for women in prison.[46] They point out that primary care is the place where women first seek help, and given that much of their need is expressed in depression and anxiety associated with previous trauma and separation from children and family; it is here that services for women need to be concentrated. It is also here that the lack of services can result in medication becoming a default treatment that creates its own problems. Our recommendation that there should be an enhanced mental health service within primary care teams, with a named key worker coordinating a range of counselling and other supportive interventions, is therefore particularly relevant for women.

The experience of black and minority ethnic prisoners

6.12 It has been established that people from black and minority ethnic (BME) communities are more often diagnosed as schizophrenic, held by the police for mental health assessment, sent to hospital for treatment by the courts, compulsorily detained under the Mental Health Act and given high doses of medication.[47] The most recent monitoring information from the 2006 national census (see 3.6) has revealed that black patients are less often referred to psychiatric hospitals by GPs and community health teams and more often referred by the criminal justice system. The experiences of black people and other ethnic minorities of mental health services in prison is less well documented, not least because prisoners' ethnicity is not reliably recorded in clinical records[48].

6.13 We aimed to interview and survey equal numbers of BME and white prisoners, but in the event there were not enough BME prisoners on the MHIRT caseload to make this possible, though this was achieved for the reception sample where 47% were from a BME group[49].

6.14 In our survey of MHIRT leads, BME clients accounted for 18% of referrals and the same proportion in caseloads, which was lower than the 26% BME proportion of the prison population as a whole. The referral rate of foreign national prisoners was also lower than their proportion in the prison population, though this was not the case for young adults, where both BME and foreign national prisoners were over-represented in referral statistics. Foreign national MHIRT caseloads were higher than their proportion in the population in both YOIs and dispersal prisons.

Substance misuse

6.15 In reception screens, the biggest difference in recorded need was in terms of substance misuse, where BME prisoners reported less use of alcohol and heroin than white prisoners, and relatively more use of crack cocaine and cannabis. Higher levels of cannabis use may have contributed to fewer BME prisoners undertaking or completing detoxification, or being

[45] Prison Reform Trust (2003)
[46] CSIP (2006)
[47] Fernando (2003)
[48] HM Inspectorate of Prisons (2005a)
[49] 53% white, 23% black, 10% Asian, 11% mixed, 3% other.

referred to a doctor. Lower levels of referral may also reflect the higher proportion of foreign nationals in the BME sample, who are known to have lower levels of drug use than British nationals. Ten per cent were referred to substance misuse services compared to 23% of white prisoners, and 15% of BME prisoners were referred to the doctor from reception, compared to 33% of white prisoners. Our specialist drugs inspectors point out that CARATs is often perceived by prisoners as a 'white service' since it is orientated to the predominant drug in the prison, usually heroin, which is mainly a white prisoners' drug. There were no differences in the proportions reporting that they were asked about substance misuse in reception, or that a full history was taken once substance misuse was disclosed, or that drugs workers had been involved in their care.

Mental health

6.16 In terms of mental health, there were no statistically significant differences between BME and white prisoners' GHQ12 scores or their perceived need for support with emotional problems on first arrival. BME prisoners were not statistically more or less likely to claim they were asked about self-harm or emotional wellbeing in reception, though there was a trend for more white prisoners to be placed on an ACCT monitoring form. In fact a greater proportion of BME (67%) than white prisoners (58%) felt that their healthcare needs had been met on their first night in prison, and that their medication had helped them (73% as opposed to 65%). However, our own examination of clinical records found that the issues identified in reception screens had been adequately followed up for fewer BME prisoners (49%) than white prisoners (68%).

6.17 In the reception survey, BME prisoners themselves reported poorer outcomes in the following areas:

Table 11: Reported outcomes for BME and white prisoners, from the reception survey (n=252)

	BME %	White %
Have a care plan	5	14
Have a key worker	14	21
Knew how long the medication would take to work	18	60
Knew the side effects of their medication	36	50

6.18 The main area of difference between BME and white clients, for those interviewed, appeared to be in relation to previous contact with mental health services in the community. Table 12 below indicates that on a range of measures from reception screens in clinical records BME clients were less engaged with mental health services before their arrival in prison, less likely to be on medication, and reported fewer thoughts of self-harm.

Table 12: Engagement with services for BME and white prisoners, from reception screens in clinical records (n=237)

	BME %	White %
Outside treatment for mental health issues	10	25*
Previous hospitalisation for mental health reasons	4	9
Medication in the community for mental health	22	30

On medication when entered custody	11	25*
History of self-harm	12	24*
Current thoughts of self-harm	5	7
Referred to the MHIRT	3	16*

*statistically significant, p=<.05

6.19 These figures appear to support other studies which show a lower take-up of mental health services in the community by those from BME communities. As that is a key trigger for further referral in prison reception screening, any gaps in accessing community services are likely to lead also to gaps in accessing provision in prison. We have suggested in an earlier chapter that a more focused screen for psychological distress should be used: and indeed, when we applied the GHQ12 screen ourselves, we found no difference in the scores and therefore the potential need of white and BME prisoners (see paragraph 6.16).

6.20 Recording of ethnicity on client records is required as part of the NHS minimum dataset, but in only 30% of the MHIRT clients' records we sampled was ethnicity recorded. Only 52 out of 84 (69%) MHIRT leads in the national survey claimed they were aware of the ethnic mix of their client caseload, and only 13 (31%) were aware of the ethnic mix of the inpatient ward. Our interviews with GPs indicated that most judged ethnicity from visible appearance, and were not aware of any ethnic monitoring or the implications of ethnicity for their practice.

6.21 When asked whether they felt equipped to meet the needs of different ethnic groups, 75% of MHIRT leads claimed that they did. However, only one team described specific services for different ethnic groups. Some claimed they sought support from the local PCT, other specialists in the community or BME community groups. However, others were more candid in admitting to a lack of cultural and ethnic mix within their teams, and that more training was needed to help them understand different cultural beliefs about mental illness. One MHIRT lead suggested that there was reluctance on the part of some BME prisoners to speak out about their problems.

6.22 These findings suggest a complex picture. There appears to be a different pattern of drug use and possibly of mental health need for BME prisoners, and a general lack of appreciation of these differences by healthcare staff. BME prisoners, possibly already distrustful of 'white services', would not be reassured by contact with apparently racially unaware staff, who might be perceived as equipped to treat only white prisoners' mental health problems. In terms of racial awareness, there was little evidence of effective monitoring or reflective practice by healthcare staff, informed by an appreciation that clinical practice may impact differently on different racial groups.

6.23 Eight of the 14 foreign nationals who completed our GHQ12 questionnaire (57%) scored above a threshold of need on the GHQ12, compared to 49% of British nationals. This is higher than we found in our recent foreign nationals thematic report. Recent figures also suggest that the incidence of self-inflicted deaths among foreign nationals has increased. This may well reflect the added vulnerability and uncertainty of their immigration status, given the delays and increasingly restrictive approach of the immigration authorities. At Bullwood Hall, where the population is exclusively foreign nationals, the MHIRT lead reported that it had been expected that the need for mental health input would decrease once it ceased to be a women's prison. In fact they had received prisoners with severe mental illness requiring 24-hour health cover which they were no longer able to provide, and there was evidently a need for emotional support that they were finding hard to meet because of language and cultural barriers. Given

their limited resources, they were confined to providing medical interventions, though they hoped to have self-help booklets translated.

Summary and recommendations

6.24 From our reception sample, women had higher levels of drug use than men or young adults, though lower levels of alcohol dependency. Almost a third of the 80 women prisoners were referred to the doctor for substance misuse problems on arrival. Women also had higher levels of both previous and current mental health problems, including self-harm, yet were less likely than other prisoners to receive a secondary health screen. Two-thirds of women exhibited signs of psychological distress, higher than men or young adults. This was exacerbated by separation from children and distance from home. For women with emotional problems, unlike men, the most important need was for interventions to support relationship skills.

6.25 This profile confirms the importance of good quality primary mental healthcare for women. We did not find significant differences in the delivery of services between women, men and young adults, but there were high levels of medication. Some clinical notes and interviews confirmed at least a psychological dependency on medication, arguably exacerbated by the absence of alternative treatments, and other studies suggest a higher level of medication for primary mental healthcare needs. There did, however, appear to be a somewhat wider range of interventions available for women than for male prisoners.

6.26 The aggregated experiences of BME clients in prison are largely unknown because of a lack of monitoring and evaluation. Our findings suggest a lower level of engagement with and referral to MHIRT services in prison for adult BME and foreign national prisoners. BME prisoners in general reported higher levels of satisfaction with immediate healthcare needs than white prisoners, though fewer understood their medication. However, our examination of reception screens showed that issues identified in reception were adequately followed up for fewer BME than white prisoners.

6.27 On reception, the 121 BME prisoners in our sample presented with a different pattern of substance misuse from white prisoners. Fewer were referred to the doctor or underwent detoxification. This may have been because services were not appropriate to their need or were not sufficiently culturally aware.

6.28 There was no difference in levels of reported psychological distress between the BME and white prisoners in our sample on entry to prison, or in the extent to which they felt they needed support from healthcare staff, but fewer were referred either to the GP or to the MHIRT. This may well reflect, and stem from the same causes as, the well-documented under-use of mental health services in the community by people from BME groups, and argues for a more effective reception screening tool, and more culturally sensitive mental health services. Ethnicity was not reliably recorded on clinical records and awareness of different racial need among primary and secondary mental health teams was low. Only one MHIRT had specific services for different ethnic groups, and many said they needed more training.

6.29 Our research and the statistics on self-inflicted deaths suggest that foreign nationals may be becoming increasingly emotionally and mentally vulnerable. In practice, healthcare staff were finding considerable needs which they were unable to meet.

Recommendations

6.30 There should be a wider range of mental health interventions available in women's prisons to meet their high levels of primary and secondary mental health need. Particular emphasis should be placed on emotional management and relationship skills.

6.31 There should be a high level of coordinated work between substance misuse teams and MHIRTs in women's prisons.

6.32 Clinical audits should monitor the prescribing patterns for psychotropic medication, including by ethnicity and gender.

6.33 The ethnicity of patients should be recorded on all clinical records and the uptake and outcomes of mental health services in prison by ethnicity should be audited.

6.34 The outcomes for BME mental health patients in prisons should be included in future Department of Health 'Count me in' mental health ethnicity audits.

6.35 The provision of both primary and secondary mental health services should be assessed for their impact on different ethnic groups and nationalities to inform the development of more culturally sensitive services.

7: Missing links

7.1 This chapter 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 misuers; forensic psychologists; and those providing resettlement services.

Self-harm risk and mental health

7.2 There is a strong link between mental health difficulties and self-harming behaviour. Fourteen per cent of our MHIRT client sample were on an open assessment, care in custody and teamwork (ACCT) monitoring form, for those at risk of suicide or self-harm, at the time of our fieldwork. The ACCT procedures require the case manager, who is normally a wing senior officer, to involve relevant disciplines in the case management of individual prisoners. Two-thirds (68%) of MHIRT leads in our survey said they willingly cooperated with ACCT case reviews for existing clients, or those with a suspected mental health problem, but they stressed that it was not appropriate for them to be involved where there was no mental health diagnosis. However, we found evidence that care was not always jointly planned. We agree that self-harm should not be inappropriately medicalised, but if there was a functioning primary mental healthcare team, this would be an appropriate context to deploy a primary care RMN.

Case study: A woman who was a prolific self-harmer had recently transferred by means of a governor to governor agreed transfer. Her clinical record indicated that she had had a good care plan in place with the MHIRT in the sending establishment. Both the sending and receiving healthcare departments were puzzled as to why she had been moved and concerned for her welfare. They had not been consulted about the impact of a move on her mental state, or been included in the decision to move her, despite their crucial role in her care.

7.3 There is evidence from the Care of at Risk Prisoners Project evaluation[50], carried out for the Prison Service on the impact of its new ACCT procedures, that the care of prisoners with mental health problems improves when both healthcare and residential staff are involved. The quality of care planning improved when mental health nurses attended case reviews of prisoners with mental health problems on residential wings who were placed on ACCTs. There were more social and custodial elements in healthcare's care programme approach (CPA), and more health-focused interventions in the ACCT. Similarly, when self-harm on inpatient wards was managed by nurses alone, the care plan often overlooked social and custodial elements and delivered a reduced package of care. Given that the National Study of Prison Suicides[51] identified that 17% of prisoner suicides took place in healthcare centres and 9% within a week of discharge, this was a concern.

Good practice: At Manchester prison, the MHIRT ran a self-harm group as part of a day care programme.

[50] See footnote 8.
[51] Shaw et al (2003)

MHIRTs and residential staff

7.4 DH practice guidance[52] recommends that wing staff should be involved in CPA if the prisoner is held on residential wings. Half of all MHIRT leads claimed that they shared information with wing staff on a need to know basis with the patient's consent, where this concerned risk to self or others. But this fell short of interdisciplinary case management in which information is shared routinely between those responsible for providing care and ongoing support.

7.5 An examination of 55 MHIRT clients' wing history sheets showed that only 25% contained any comment from healthcare staff, and in 29% of these cases the comments related to a period when the prisoner was an inpatient. An example of a rare but useful entry was: 'will visit GP on Monday for medication. Inform RMN if change in mood or tearful'. One file informed staff of the prisoner's likely drowsiness due to her medication, and the need for staff to encourage her to attend the prison shop and then gradually restart her normal routine. In two cases, MHIRT staff had informed wing staff of particularly vulnerable times for their patients so that extra support could be provided. One entry asked staff to monitor the prisoner's behaviour, particularly whether he was washing constantly, and mentioned concerns about his hearing voices.

7.6 However, in general, MHIRT staff under-estimated the extent to which wing staff were able to contribute to case management. Only 12% of MHIRT leads reported genuinely cooperative working and CPA reviews rarely included residential staff. Only just over half described any procedure for briefing wing staff when an inpatient was discharged back to the wing. Half claimed to have wing-based treatment rooms that could be used for multi-disciplinary case reviews, but only six described having wing-based mental health liaison officers. One officer said:

'We are left in the dark. We don't know what condition they have or whether they are taking their meds. If the nurse doesn't turn up we assume this is because they are no longer taking medication. We don't know whether to chase this up. Some demand medication when they are not written up for it.'

7.7 The capacity for shared working was evident from some of the entries made by wing staff in MHIRT clients' wing history sheets. One record described the prisoner's depression and the signs to watch out for. Another noted that the prisoner was on anti-depressant medication and added 'does not seem to be good at coping, but with friendly motivation from staff does well'. Another record contained entries indicating that staff were providing back-up to the MHIRT by following the prisoner up after they had spent time with him, and had contacted healthcare staff when he had refused medication. Another stated 'Cat D review. Has done exceedingly well with targets. Will speak to in-reach ref medication'.

7.8 But such entries were not common. Despite the guidance in PSI 25/2002 about the importance of sharing information with other agencies, there remained a widespread belief among both healthcare and non-healthcare staff that clinical information should not be shared. About half (53%) of the 66 wing staff interviewed for this review who had referred individual prisoners had received some feedback, but this was limited and staff seemed to accept that this was unavoidable. One officer said:

[52] www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4102231

'Prisoners on the wing have mental health issues but we are not informed as this information is usually classed "Medical in Confidence".'

Case study: A young prisoner with learning disability, speech problems and anger control difficulties was under the care of the MHIRT and receiving weekly counselling. In the meantime, wing staff were trying to arrange an inter-prison phone call between this young man and his father. The young man believed that his father had been convicted of armed robbery, but it came to light that he was a sex offender and subject to the restrictions of PSO 4950. It became apparent that the father was not actually interested in receiving a phone call from his son. All this was communicated to the young man without the impact of this being understood by the wing staff. Deterioration in his behaviour was noted in the wing record, but not shared with his mental health counsellor, who would have been in a position to help the young man deal with his situation more appropriately.

Case study: A woman prisoner was refusing food because of her fear that it was contaminated, and she was underweight and pale. Staff viewed her as stubborn, though her clinical record indicated that there was a family history of psychosis, and her paranoia was believed to be symptomatic of paranoid schizophrenia, though she would not cooperate with assessment. She also required a wheat-free diet, which healthcare staff had requested from the kitchen. A wheat-free diet was being delivered to the wing every day as she refused to go to the communal dining hall to eat. Her refusal to eat the food delivered each day was not known to either the primary care team or the MHIRT, but was being managed as a disciplinary matter. This was a clear failure of coordinated case management.

7.9 In contrast to the multidisciplinary ACCT procedures, arrangements for including non-healthcare staff in CPA were under-developed. There is no reason why the CPA framework could not be used as the vehicle for shared casework management of prisoners with a mental health problem, with wing staff overseeing the social and custodial elements of the plan and mental health specialists overseeing the healthcare elements, with contributions from other disciplines as appropriate. This would build residential staff's confidence in their ability to understand and provide practical support to prisoners with mental health problems. It would also help relatively new mental health staff to better understand the context in which they work and the contribution to effective case management that prison staff could make as primary carers.

Good practice: At Full Sutton, the MHIRT involved education, probation, the personal officer, the community mental health team and the primary care team in the care plan for prisoners with a mental health problem. Information was shared with wing staff with the patient's consent. The MHIRT provided a brief overview of the prisoner's needs and alerted staff to what to look out for in terms of changes in behaviour or routine. The MHIRT lead reported that 'wing staff have been involved in the care and management of their prisoners and this has reduced the stigma of mental health. A difficult group have appeared to become less volatile and this in turn has reduced the time staff have had to spend dealing with individuals with complex needs'.

Substance misuse and mental health

7.10 In our survey of MHIRT leads, 62% claimed to have some link with substance misuse teams either in the prison or in the community. Eight prisons (11%) claimed they had a dual diagnosis nurse in their team, with one prison seconding a dual diagnosis nurse to the CARAT team. Only four prisons (5%) said that referrals passed both ways between MHIRTs and CARAT

teams, though one of these stated that CARATs did not attend CPA meetings although they were invited. Overall, less than half the MHIRT leads were confident that they liaised adequately with substance misuse staff, though an additional 39% stated they were 'sometimes' successful.

Case study: In fieldwork we came across a referral by a CARAT staff member to the MHIRT of a woman prisoner who had been sectioned as a teenager and who was reporting current symptoms. This referral had been quickly returned with a note explaining that referrals were only accepted from the primary healthcare team. She remained untreated.

7.11 All 14 of the CARATs records of those with substance misuse problems who were also MHIRT clients mentioned their mental health needs, but only six showed evidence of joint working.

Case study: At Gartree, where life sentence planning was well established, CARAT care plans were included in life sentence plans and clinical records – although we saw no examples of care plans relating to mental health work included in CARAT files.

7.12 Our routine inspections reveal gaps in joint working between mental health and substance misuse services. We generally find that where there are protocols between the MHIRT and CARATs they cover issues of referral rather than any models of joint working, and often they are generic to all health areas rather than specific to mental health. Where there are substance misuse practitioners with mental health experience, this has usually come about by accident rather than design. There continues to be a lack of coordination between substance misuse and mental health services.

MHIRTs and forensic specialists

7.13 There was no evidence of shared work between forensic psychologists or probation staff and MHIRT staff. As psychologists in prison do not work within a medical model, there is no tradition of shared working with healthcare staff, though some psychology departments have built good links with their forensic clinical colleagues in local secure units with whom they liaise directly, particularly in relation to the sectioning of individual prisoners. Such arrangements pre-date the commissioning of mental health services in prisons, and the resulting situation can create a confused mix of clinical responsibility which acts against prisoners' interests.

7.14 Individual sentence planning, particularly for sexual and violent offenders, involves in-depth analysis of personality and emotional makeup to identify the links between these and the offending. Psychologists in prison have therefore been working with mental health for many years without the benefit of direct input from mental health practitioners. The commissioning of a mental health service to prisons did not appear to consider how this service would dovetail with what was already provided, which was a major oversight. We came across an example where a visiting specialist registrar had made referrals of his patients to prison psychologists and been rebuffed, and several examples where psychologists had sought information about their clients from mental health staff and had been similarly rebuffed.

Resettlement and mental health

7.15 Mental health is part of the third resettlement pathway in the Reducing Reoffending National Action Plan (2005). Healthcare staff therefore have a responsibility not only to treat individual need but also to share relevant information with resettlement teams or substance misuse staff in prison and with community mental health teams outside. Data from OASys assessments[53] show that a substantial number of prisoners have emotional wellbeing needs (see 6.5), and that those assessed as having problems with emotional wellbeing are also assessed as having more needs in other areas associated with reoffending. Not only are they more needy, but their risk of reconviction is higher compared to those without such needs across all types of prison. The integration of healthcare needs into resettlement plans is therefore vital, not only to meet individual need but also to reduce the risk of reoffending. The data in Table 12 were supplied by O-DEAT[54].

Table 12: The proportions of those with and without emotional wellbeing needs assessed as having other criminogenic needs, as determined by OASys assessments

Criminogenic needs	With emotional wellbeing needs	Without emotional wellbeing needs
Education, training and employment	74%	54%
Thinking and behaviour	72%	42%
Lifestyles and associates	71%	50%
Accommodation	64%	39%
Relationships	63%	36%
Drugs	48%	30%
Attitudes	45%	27%
Alcohol	44%	25%
Finance	39%	25%

7.16 For those patients with primary care needs, contact with resettlement teams in prison was rare, and contact with primary care teams in the area to which they were to be released was also minimal. Sometimes prisoners were released with a letter for their GP, and occasionally contact was made directly with the GP before release.

7.17 Better links for those with diagnosed secondary mental health problems, and subject to the care programme approach, might be expected. However, for MHIRT clients the links also varied in quality, with only 10 out of 84 establishments in our national survey reporting that resettlement or probation staff attended CPA reviews, and few resettlement teams reporting any input from mental healthcare staff into resettlement plans.

[53] See Appendix III.
[54] See Appendix III.

Good practice: In Birmingham prison, the MHIRT included a probation officer and a social worker, seconded from social services, who continued working with prisoners and their families in the local area for up to a month following the prisoner's release. Communication between the community mental health team and the resettlement team was good.

7.18 The following case studies illustrate the importance of collaborative working between resettlement staff and MHIRT staff.

Case study: A woman prisoner, noted in the clinical record as having a low IQ, stated that she would be returning to live with her grandmother on release and described the relationship as 'ok' with weekly phone calls. However, this was not supported by PIN phone monitoring which recorded the longest call as lasting 14 seconds. Plans were therefore made for hostel accommodation. Despite good sharing of information between resettlement and healthcare staff, the prisoner herself was unaware of the plans.

Case study: A woman prisoner was due to be referred to her local community health team on release, and this formed part of her parole application. However, this process could not be concluded until the client had a fixed address, and there had been no communication about the importance of accommodation between the MHIRT and the woman's probation officer. The woman was already upset at having been refused release on temporary licence, and was becoming anxious that she would also lose her parole.

7.19 Contact with CMHTs had only been recorded in the clinical records of 16 (52%) of the 31 MHIRT clients in our sample due to be released within the next three months, despite 24 out of 28 interviewed (86%) saying they needed support on release. Twenty (71%) also reported needing help in registering with an external GP, but only four (20%) thought this had been arranged. In order to check the extent to which this information had been shared with resettlement staff we checked the prisoners' resettlement records. Not all the prisoners had them. Some were serving sentences of less than 12 months, so resettlement planning was not carried out, and a few had no record yet completed. Eleven of the 18 records available (61%) noted a mental health need, though this information could have come from the prisoner him or herself. Only six (33%) provided any evidence of direct information sharing in the form of plans for ongoing mental healthcare in the community.

Case study: An adult male prisoner on the MHIRT caseload was diagnosed with schizophrenia, but had refused to engage with the mental health team. Clinical records showed there were no plans in place for his release. No contact with the resettlement team had been made as he was serving a sentence of less than 12 months.

7.20 Of the group of MHIRT clients in our sample about to be released, 11 (39%) also said they would need help with drugs or alcohol in the community, but only seven (64%) of these prisoners thought arrangements had been made, and evidence of such arrangements was found in only two clinical records. In fact, the CARATs records of all of those clients who were within three months of release contained release plans which involved contact with drug intervention programme (DIP) teams and GPs, and/or programmes in the community, but these did not appear to have been shared with healthcare staff. Resettlement staff we interviewed reported good working relationships and information sharing with CARATs staff, but told us that links with healthcare staff were weaker.

7.21 There was considerable variation between the 84 MHIRTs surveyed in the extent to which they liaised with CMHTs in other parts of the country. The presence of copies of letters in clinical

records indicated that very little information exchange was taking place electronically, a consequence of the lack of IT and clinical information systems in prison healthcare centres. Most were clear that they would refer to local teams, but not all prisoners were released locally. Clients could also be released suddenly if they were bailed, or if they were granted early release. Only 20% of MHIRT leads reported that they had an agreed referral protocol in the event of an unplanned release, and these applied only to local releases.

7.22 Within the group of 28 MHIRT clients about to be released, only 38% said they had been involved in their release plans. We rated patient involvement as evidenced in 31 clinical records as less than satisfactory, which was particularly poor since if staff do not share information, the prisoner him or herself is the only means whereby information is passed between disciplines.

Case study: An MHIRT client admitted during interview that he was 'obsessed with drugs' but he was unaware of any plans for drug support or continued mental health support on release. Both his clinical and CARATs records confirmed that plans had in fact been made in both these areas, but it appeared that they had not been shared with the prisoner. His resettlement record included the drugs support plan, but there was no record of any mental health support.

7.23 We did not come across any clients in our fieldwork who were on the caseload solely because of their learning disability; though in two cases learning disability was suspected as a co-morbid condition. As learning disability is a psychiatric and nursing specialism, we expected more referral to specialist services by MHIRTs who had such links through their parent trusts. However, this appeared to be a further gap in service.

Summary and recommendations

7.24 Fourteen per cent of the MHIRT clients in our sample were being managed on assessment, care in custody and teamwork (ACCT) procedures, as prisoners at risk of suicide or self-harm. Only two-thirds of 84 MHIRTs said that they contributed to reviews of such prisoners. The evidence suggested that at-risk prisoners were managed more comprehensively when mental healthcare staff and residential staff planned their care together, to include both healthcare and custodial care. There was also scope for the involvement of primary healthcare professionals in this area of work in general.

7.25 The involvement of residential staff in the management of prisoners subject to the care programme approach (CPA) was limited, in spite of guidance from the Department of Health. Only a minority of MHIRT clients' wing records contained any comment from healthcare staff, CPA reviews rarely involved residential staff, and only 12% of MHIRT leads reported genuinely cooperative working. Where joint working did happen, the results were very positive; by contrast, when it was not, prisoner care could suffer. There remained a widespread but erroneous belief among both healthcare and residential staff that clinical information could not be shared.

7.26 Just under two-thirds of MHIRT leads claimed they had a degree of cooperative working with substance misuse teams, either in prison or the community, but only 11% had a specialist dual diagnosis service. Only a third of the records of the 14 MHIRT clients who were CARAT (drug treatment) clients showed any evidence of information received from healthcare, and any protocols concerned referrals between teams rather than joint working.

7.27 There was no evidence of shared working between MHIRTs and forensic specialists, such as psychologists and probation staff in the prison. Prison psychologists have been working with mental health issues for many years, but commissioning had not considered how this would dovetail with the new mental health arrangements, which was a serious omission. This could result in confusion about where responsibility for clinical care lay, to the detriment of prisoner care.

7.28 Mental health is part of the third resettlement pathway, in the national reducing reoffending action plan. Risk assessments show a correlation between emotional wellbeing and criminogenic needs. However, from general inspection, those with primary mental health needs had rare communication with resettlement teams prior to release, and referral to GPs in the community was variable. Links were also variable for the 31 clients in our sample who were approaching release. Only half recorded contact with community mental health teams within three months of the date of release, clients were not routinely involved and kept informed about resettlement planning, and information about ongoing mental healthcare on release was not routinely shared with other disciplines with resettlement responsibilities.

7.29 There were no patients on MHIRT caseloads because of their learning disability alone, and no evidence of any engagement with learning disability services for those with a suspected learning disability, as well as mental health problems.

Recommendations

7.30 An enhanced primary care team should provide RMN input to multi-disciplinary self-harm assessments and reviews.

7.31 There should be a formal documented procedure for briefing wing staff when an inpatient is discharged back to a residential wing.

7.32 All establishments should have an inter-agency information-sharing protocol, which satisfies legal requirements and clearly sets out procedures for both disclosing and receiving information as set out in PSI 25/2002.

7.33 There should be specialist dual diagnosis services for prisoners who experience both mental health and substance-related problems.

7.34 The arrangements for the commissioning of mental health services should take into account, and include where appropriate, existing input from forensic psychiatrists, psychologists and probation staff, and specify how new services will complement existing services.

7.35 MHIRT clients should all be referred to mental health services in the community, either by means of a GP letter or by direct contact with community mental health teams in the area to which they are released. Such actions should be reliably communicated to resettlement staff and included in individual resettlement plans.

7.36 Prisoners' mental health needs should be part of any resettlement planning, and as a minimum this should ensure that a letter to the community GP is provided in all cases.

7.37 Where prisoners are identified with learning disability, this information should be shared with the disability liaison officer, and the prisoner referred for assessment to a specialist learning disability service.

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Appendix II: Methodology

Research papers and publications written within the last 15 years were reviewed and a number of external organisations were approached for relevant information.

As there were 102 MHIRTs working in prisons across the country at the time of the review, it was impossible to visit all of them with the resources available. Fourteen prisons were selected for the fieldwork. This included four young offender institutions, four women's prisons, and six adult male prisons (two local and four training prisons).

The thematic was split into Phase 1 and Phase 2. Phase 1[55] covered local prisons to focus on initial reception into prison, and Phase 2 covered training prisons to focus on continuity of care. Establishments were further split into functional type, i.e. women's, young adults, and adult male, and the need for a geographical spread across strategic health authorities (SHAs) incorporated into the selection procedure.

As the aim was to cover both severe and enduring mental illness and more general levels of psychological distress we sampled both clients of the MHIRT, the 'MHIRT client sample' and a general sample of new receptions at each of the fieldwork sites, the 'reception sample'.

For the reception sample:

- 237 new receptions completed a survey specifically designed for the thematic with 220 respondents also completing the GHQ12[56], a formal measure of psychological wellbeing. This represented response rates of 91% and 85% respectively.
- 252 reception screens were analysed, including the screens of those who refused to complete the survey.
- 24 CARATs records were also analysed in Phase 2. This represented all those who had/were receiving care from the CARAT team and whose records had arrived at their current establishment.

For the MHIRT client sample:

- 66 semi-structured interviews were conducted with MHIRT clients. There were seven refusals.
- Documentary analysis of 73 clinical records was conducted, including the records belonging to those who refused to be interviewed.
- Wing history sheets (total 55) were analysed at all bar the first two fieldwork sites.
- 14 CARATs records were also analysed in Phase 2. Again, this represented all those who had/were receiving care from the CARATs team and whose records had arrived at their current establishment.

Additionally, any MHIRT clients due to be released within the next three months were approached regarding release plans – the interview is reproduced in Appendix 5. Specifically:

- Semi-structured interviews with 28 clients were conducted. There were five refusals.
- Release plans from 31 clinical records were analysed. Two records were inaccessible at the time of fieldwork.

[55] As part of Phase 1 we also conducted field work at one juvenile establishment. However, it was decided that to adequately cover the discrete mental healthcare needs of young people was beyond the scope of the current project. Therefore, data collected at this establishment have been excluded from analyses and no further juvenile establishments were visited as part of this thematic.

[56] General Health Questionnaire 12

- In Phase 2, release plans from 18 resettlement files were also analysed. In seven cases prisoners did not have a file.

A variety of other methods were used to collect data from fieldwork sites. This included interviews with 66 wing staff, nine GPs, seven resettlement teams, and nine reception staff; analysis of use of force forms; and a check on the segregation unit.

Additionally, 114 prisons were sent a survey for the MHIRT lead to self-complete covering different aspects of their service. This is reproduced in Appendix 6. Information about referrals and the teams' caseload was also collected. 84 prisons returned this information, representing a 74% response rate.

Please note that missing data have been excluded from all analyses. The size of the sample should be borne in mind in terms of the generalisability of the findings.

Appendix III: O-DEAT data

This appendix explains what OASys data are, the methodology used to analyse OASys data for this report and lists some limitations of the data.

What is OASys?

OASys is the national risk/needs assessment system for adult prisoners in England and Wales. It was developed in three pilot studies between 1999 and 2001, and has since been rolled out in electronic form across both the prison and probation services with full connectivity between all prison establishments and probation areas. It has become an integral part of the management of offenders, identifying offenders' risks and needs and linking these risks and needs to individualised sentence plans and risk management plans.

Methodology

Assessments completed in the financial year 2005/06 were included in the analysis. Assessments were only included in the analysis only if they met minimum data completion standards. The following validity filters were applied:

- Each of the scored sections (1 to 12) within the core OASys assessment must have had at least four-fifths of their scored items completed ensuring that each criminogenic need was assessed properly.
- In the risk of harm sections, the screening must have been completed, the decision whether to complete a full risk analysis should have been consistent with the information provided, and the four ratings of risk of harm in the community must have been recorded in those cases in which a full analysis was required.
- In the initial sentence plan, a criminogenic need must have been recorded within the 'objectives and plans' section.

After the data completeness was checked, duplicate assessments were removed. This ensures that prisoners can appear only once during a continuous period of supervision by the prison and probation services.

Data limitations

Findings from analysis of 2005/2006 OASys data are limited by sample size, representativeness and assessment style.

Small sample sizes limit the generalisability of findings. It should be noted that many of the profiles are based on small samples and should therefore be interpreted with a great deal of caution.

Assessments completed for select groups of prisoners will not be representative of the population from which they are drawn. OASys is now in general use but it is not required to be used with all prisoners. The relevant NPS national standards require that, at the post-sentence stage, a full assessment should be completed in the community for all those cases designated at offender management Tier 2 and above, with the exception of those Tier 2 cases in which there is a stand-alone unpaid work requirement (National Probation Directorate, 2005). With regard to HMPS assessments, Prison Service Order 2205 specifies that OASys should be completed for all young adult prisoners and all those adult prisoners sentenced to at least 12 months in custody (HM Prison Service, 2005).The use of OASys data is currently subject to the proviso that the findings should not be read as representative of the entire offending population and care should be taken in generalising the results. For example, if OASys is

targeted at higher-risk offenders or offenders with certain offence types or sentence lengths, then the resulting risk/needs profiles will reflect only the risks and needs of these offenders.

Assessment style affects the extent to which an assessment is a true reflection of the prisoner. Thus, if assessments do not properly consider variations between individuals, then the results cannot be relied upon. Another concern is that common definitions may not be applied: different assessors may score some offending-related items systematically higher or lower, or make different judgements on the boundaries between ‘low’, ‘medium’ and ‘high’ risk of harm.

Appendix IV: Reception survey

Section One: About You

Q1 Name

Q2 What is your age?

Under 18 ☐
18 ☐
19 ☐
20 ☐
21 ☐
22 - 29 ☐
30 - 39 ☐
40 - 49 ☐
50 - 59 ☐
60 - 69 ☐
70 and over ☐

Q3 What is your ethnic origin?

White-British ☐
White-Irish ☐
White-Other ☐
Black or Black British - Caribbean ☐
Black or Black British - African ☐
Black or Black British - Other ☐
Asian or Asian British - Indian ☐
Asian or Asian British - Pakistani ☐
Asian or Asian British - Bangladeshi ☐
Asian or Asian British - Other ☐
Mixed Race – White and Black Caribbean ☐
Mixed Race – White and Black African ☐
Mixed Race – White and Asian ☐
Mixed Race – Other ☐
Chinese ☐
Other ethnic group ☐

Please specify_____

Q4 Are you sentenced?

Yes ☐
No – awaiting trial ☐
No – awaiting sentence ☐
No – awaiting deportation ☐

Q5 How long have you been in THIS prison

Less than a week ☐
One to two weeks ☐
Two to three weeks ☐
Three to four weeks ☐
More than a month ☐

Q6 How long have you been in prison on this sentence? (Including time spent in other prisons)

Less than one month ☐
One to three months ☐
Three to six months ☐
Six months to one year ☐
One to two years ☐
Two to four years ☐
Four years or more ☐

Section Two: Reception

Q7 Were you asked about self harm in reception?

Yes ☐
No ☐

Q8 Were you asked in reception whether you had problems with drugs or alcohol?

Yes ☐
No ☐

Q9 Were you asked in reception whether you had any other medical problems, allergies or medication that they should be aware of?

Yes ☐
No ☐

Q10 Were you asked in reception whether you had any problems with feeling unhappy, confused or unable to cope?

Yes ☐
No ☐

Section Three

Q11 Did you have problems with drugs or alcohol when you first arrived in prison on this sentence?

No ☐
Drugs only ☐
Alcohol only ☐
Both ☐

If you answered no, please go to Section 6.
If you answered yes, please continue.

Q12 On your first night, were your healthcare needs met?

Yes ☐
No ☐

Q13 Was a full history taken of your drug/alcohol use and your contact with outside services?

Yes ☐
No ☐

Q14 When was this done?

No history taken ☐
Within 24 hours of arrival ☐
Two to three days after arrival ☐
Three to five days after arrival ☐
More than five days after arrival ☐

Q15 Has the Drugs Intervention Programme team been involved in your care?

Yes ☐
No ☐

Q16 If you are dependent on drugs or alcohol, what kind of treatment are you receiving?

Detoxification ☐
Maintenance ☐
Slow reduction ☐
Not receiving treatment ☐

Q17 How far into treatment are you?

First day ☐
First week ☐
Second week ☐
Completed ☐
Not receiving treatment ☐

Q18 Do you have a care plan here that sets out your treatment?

Don't know ☐
Yes ☐
No ☐

Q19 How involved were you in the development of your care plan?

Do not have care plan ☐
Very involved ☐
Involved ☐
Neither ☐
Not very involved ☐
Not at all involved ☐

Q20 Do you have any comments you would like to make on your first night or treatment?

Section Four:

Complete only if you are on detox now.

Q21 Are you currently detoxing?

Yes..... ☐
No..... ☐

If you answered no, please go to <u>Section 5.</u>
If you answered yes, please continue.

Q22 If you used alcohol and drugs, are you being detoxed from both of these?

Not applicable..... ☐
Yes..... ☐
No..... ☐

Q23 If you are detoxing from alcohol and drugs, which are you being detoxed from first?

Not applicable..... ☐
Drugs..... ☐
Alcohol..... ☐

Q24 Are you receiving any support?

Yes..... ☐
No..... ☐

Q25 If yes, what and who from?

Q26 If you have been on detox for more than 5 days, have you been given advice about harm minimisation?

Not been on detox for more than 5 days..... ☐
Yes..... ☐
No..... ☐

Q27 Do you have any comments about detox?

Section Five:

Complete only if you have completed detox.

Q28 Have you completed detox during this sentence?

Yes..... ☐
No..... ☐

If you answered no please go to <u>Section 6.</u>
If you answered yes, please continue.

Q29 Where did you complete your detox?

_____
_____
_____

Q30 Was the programme gradual enough for you?

Too fast..... ☐
About right..... ☐
Too slow..... ☐

Q31 If you used alcohol and drugs, were you detoxed from both of these?

Not applicable..... ☐
Yes..... ☐
No..... ☐

Q32 If you were detoxing from alcohol and drugs, which were you detoxed from first?

Not applicable..... ☐
Drugs..... ☐
Alcohol..... ☐

Q33 Did you receive any support?

Yes..... ☐
No..... ☐

Q34 If yes, what and who from?

_____
_____
_____
_____
_____
_____
_____

Q35 Have you been given advice about harm minimisation?

Yes..... ☐
No..... ☐

Q36 Do you have any comments about detox?

_____
_____
_____
_____
_____
_____
_____

Section Six: Well-being

Q37 Have you needed any treatment or care from healthcare due to feeling unhappy, confused or unable to cope?
Yes..... ☐
No..... ☐

If you answered no, you do not need to answer the rest of the questionnaire.
If you answered yes, please continue.

Q38 Were you asked whether you had been receiving help for these problems outside before coming into prison?
Yes..... ☐
No..... ☐

Q39 If receiving care in the community, is your primary worker aware that you are in prison?
Was not receiving care in the community..... ☐
Yes..... ☐
No..... ☐
Don't know..... ☐

Q40 If receiving care in the community, has your primary worker been involved in your care plan?
Was not receiving care in the community..... ☐
Yes..... ☐
No..... ☐
Don't know..... ☐
Do not have a care plan..... ☐

Q41 What treatment, care or support are you currently receiving from Healthcare?

_____

_____

_____

_____

_____

Q42 Have you been given any choice about your treatment or care?
A lot of choice..... ☐
Some choice..... ☐
No choice..... ☐

Q43 Were you involved in any care plan that sets out your treatment?
Do not have a care plan..... ☐
Yes..... ☐
No..... ☐

Q44 If so, do you agree with it?
Do not have a care plan..... ☐
Yes..... ☐
No..... ☐

Q45 Has anyone asked what has worked for you in the past?
Not applicable..... ☐
Yes..... ☐
No..... ☐

Q46 Is there a nurse here who is your primary worker whilst you are in this prison?
Yes..... ☐
No..... ☐

Q47 How often do you see this nurse?
Not applicable..... ☐
Daily..... ☐
Weekly..... ☐
Not very often..... ☐
Never..... ☐

Q48 Are you currently taking any medication?
Yes..... ☐
No **Go to Q54**..... ☐
If yes, please specify _____

_____

Q49 Do you know what your medication is for?
Yes..... ☐
No..... ☐

Q50 How did you find out what your medication was for?

Do not know what medication is for..... ☐
Patient information leaflet..... ☐
Pharmacist..... ☐
Nurse Doctor..... ☐
Other, please specify_____
_____

Q51 Have you been told how long you will need to take your medication for?

Yes..... ☐
No..... ☐

Q52 Have the possible side effects of your medication been explained to you?

Yes..... ☐
No..... ☐

Q53 Has your medication made you feel better?

Yes..... ☐
No..... ☐

Q54 Has this service helped you?

Yes..... ☐
No..... ☐

Q55 Do you have any other comments?

_____
_____
_____
_____
_____
_____

Thank you for completing our survey

Appendix V: Prisoner under care of MHIRT interview

Shading has been used to indicate where an answer needs to be circled.
'Comment' boxes are for any additional relevant information the patient provides.

NAME OF INTERVIEWER: _____

CLIENT'S NAME: _____

PRISON NUMBER: _____

ESTABLISHMENT: _____

Personal Information

Age: _____

Ethnicity: _____

Nationality: _____

Length of time in prison on this sentence: _____

Length of time in this prison: _____

Sentence status: (please circle) _____

Remand / trial / convicted not sentenced / sentenced / licence recall

---

Q1 a) Have you been receiving mental health care in the community before coming into prison?

Yes / No ***(If no, go to Q2)***

If yes, Counsellor / CPN / consultant/psychiatrist appointment / day care

b) Is your care coordinator outside aware of you being in prison? Yes / No

c) Has he or she been involved in your care plan here? Yes / No

If yes, how?

Comments

_____

_____

_____

_____

_____

Q2 Were you identified as having mental health problems on reception?

Yes / No If no, when identified and by whom?

_____

_____

_____

_____

Q3 a) Do you also have a problem with drugs/alcohol?

Drugs / Alcohol / Both / No ***If no, go to Q4***

Comments

b) Was this picked up on reception? **Yes / No**

c) Was a urine test conducted? **Yes / No**

Comments

d) Has the CJIT and/or CARATS team been involved in your care plan?

Yes / No

Comments

e) Are you going through de-toxification, or have you on this sentence?

Currently on de-toxification / Completed detoxification / No ***If no go to i***

Comments

f) If you used alcohol and drugs were you gradually reduced from both of these? **Yes / No**

g) Alcohol then drugs? **Yes / No**

Comments

h) Was your mental state monitored as you de-toxed? How? **Yes / No**

i) **Was your physical health monitored as you de-toxed? How?** **Yes / No**

j) **Are you on maintenance prescribing?** **Yes / No** ***If no go to l***

k) **If so, what drug are you being prescribed?**

l) **Is this working for you?** **Yes / No**

Comments

m) **Have you been given advice about harm minimisation?** **Yes / No**

Comments

Q4 **Were you asked whether you had any other medical conditions, allergies or medication that they should be aware of?** **Yes / No**

Comments

Q5 a) **Do you know if you have a care plan here?**

Have one / Don't have one / Don't know

b) **What treatment, care or support are you receiving/ does your care plan set out? (Give details)**

c) ***If have a care plan,*** **were you involved in drawing it up?** **Yes / No**

Comments

d) ***If have a care plan,*** **do you agree with it and consent to it?** **Yes / No**

Comments

e) Have you been given any choice about your treatment or care? **Yes / No**

Comments

f) Has anyone asked what has worked for you in the past? **Yes / No / N/A**

Comments

g) If you have moved prisons / are a licence recall, has your care plan followed you?

Yes / No **been transferred / licence recall**

Comments

Q6 a) Is there someone in Healthcare who is your care coordinator whilst you are in this prison? **Yes / No**

b) How often do you see this person?

Comments

Q7 a) Are you taking any medication? (other than for de-tox) **Yes / No**

If no go to Q8

b) Do you know what it is? **Yes / No** **Cross reference with current prescription**

c) Do you know what it is for? **Yes / No**

d) How did you find out?

e) Did anyone explain how long they would take to work? **Yes / No**

f) Were the side effects you may experience explained? **Yes / No**

Comments

g) Do you feel better? **Yes / No**

Comments

Q8 a) Approximately how far is this establishment from your home area?

Q8 b) Are you able to maintain contact with your family/partner/friends?

Yes / No / To some extent

Problems?

Q8 c) How often do you receive visits?

Q8 d) How often do you have phone contact?

Q8 e) Do wing staff/Healthcare staff facilitate contact with family/friends? Yes / No

Details: wing staff / Healthcare staff / Other, please specify:

Q8 f) Have family/partner/friends been involved in your care plan/treatment? Yes / No

If yes, how?

Comments:

Q9 Has this service helped you? Yes / No

Comments:

Q10 a) What helps in prison?

Q10 b) What makes things worse? (if anything)

Appendix VI: Client pre-release interview schedule

PRISON: _____

CLIENT'S NAME: _____

NUMBER: _____

ETHNICITY: _____

DATE OF RELEASE: _____

Ask Client:

Q1 **What area will you be released to?**

(How close to prison:)

Q2 **Do you have a designated care co-ordinator?** **Yes / No**

Comments:

_____

_____

_____

Q3 **What plans are there in place to continue your care on release?**

Healthcare

• GP: _____

• Drug/alcohol help: _____

• Mental health: _____

Accommodation

_____

Finance/debt/benefit help

_____

_____

Contact been maintained with family/children/friends? **Yes / No**

• Have they been involved in release plans? **Yes / No** **If yes, how?**

_____

_____

Education/training/employment

Have you completed any programmes, courses, obtained any qualifications during this sentence? (OBPs, work, education)

Q4	**How involved have you been with this?**	**Not at all**				**Very Involved**
		1	**2**	**3**	**4**	**5**

Appendix VII: MHIRT lead national survey

ESTABLISHMENT: _____

PERSONAL INFORMATION

NAME: _____

ROLE: _____

EMPLOYER: _____

LENGTH OF TIME WORKING IN PRISON SERVICE: _____

Q1 **How are your clients identified?**

_____

_____

_____

_____

Q2 **a)** **How often are referrals allocated?**

_____

_____

_____

_____

b) **How are referrals allocated?**

_____

_____

_____

_____

c) **Who can refer to the service?**

_____

_____

_____

_____

Q3 **What are individual caseloads like?**

_____

_____

_____

_____

_____

Q4 a) How long does a prisoner wait for assessment?

• For RMN

• For Psychiatrist

b) How many are on the waiting list?

• For RMN

• For Psychiatrist

Q5 Are you aware of the ethnic mix:

a) Within the active MHIRT caseload? Yes / No

If yes, how is this monitored?

b) Within the Healthcare Centre inpatient ward? Yes / No / No inpatient facility

If yes, how is this monitored?

c) Within the Segregation unit? Yes / No

If yes, how is this monitored?

d) Do you feel equipped to meet the mental health needs of different ethnic groups?

Q6 *If adult prison,* do you have any specific policies relating to older people?

If yes, give details:

Q7 **How long does a prisoner wait for transfer to hospital?**

a) For mental illness

b) For personality disorders

Q8 **Are mental health records kept together with general medical records?** **Yes / No**

If not, how is information shared between the two sets of notes?

Q9 **a)** **Do you have any input into reception screening?** **Yes / No**

b) **What does this involve?**

c) **Is there a written protocol for reception staff passing appropriate information on to Healthcare from the reception screen?** **Yes / No**

d) **Who collects required information from outside GP/Psychiatrist etc?**

e) **What first night arrangements are there in place for those who come in with current/past mental health problems?**

f) **Do you know whether Healthcare inpatients receive induction?**

Yes / No / Don't know / No inpatient Healthcare facility

Comments:

10 a) What interventions does the team offer? (ie. medication/CBT/counselling)

b) Are there sufficient interventions to meet the needs of your population? **Yes / No**

Comments:

c) Do you accept PD prisoners? **Yes / No**

Comments

---

11 a) How do you link your intervention with that for substance misuse?

b) How successful are you at doing this? **Almost never / Sometimes / Very**

---

12 a) Do you continue previous CPAs if there is one in place? **Yes / No**

Comments

b) Do you initiate CPAs in prison if a mental health problem is identified? **Yes / No**

Comments

c) What disciplines do you involve with the CPA?

d) Do you keep electronic or paper copies? **Paper / Electronic**

e) Where are these held?
• Paper –

• Electronic *(within prison or MH Trust main network)* –

f) Are the patients involved in drawing it up? **Yes / No**

Comments

g) Do they get a copy? **Yes / No**

Comments

h) Is their consent obtained for treatment? **Yes / No**

Comments

i) How do you share the CPA information on release? (with home CMHT)

Q13 a) Is medication explained to the patient? **Yes / No**

b) Including possible side effects? **Yes / No**

Comments

Q14 **Do you have a key nurse / primary worker scheme?** **Yes / No**

Comments

Q15 **What specialist services are available to you?**

Q16 a) **What input do you have into the care of the suicidal?**

---

b) **Is this appropriate in your view?** **Yes / No**

Comments

Q17 a) **Who fills in the Segregation algorithm?**

---

b) **How confident are you that those with mental health problems are not missed?**

(Please circle) **Not at all confident** **1 2 3 4 5** **Very confident**

Comments

---

c) What other input do you have with prisoners in the Segregation Unit?

Q18 a) Do you have a policy regarding information sharing with officers? Yes / No
If yes, give details:

b) Do your staff enter comments in clients' wing history sheets? Yes / No
Comments

c) What information do you receive from wing staff?

d) What information would you like from wing staff?

e) Do you have MDT meetings? Yes / No

g) Are there wing based treatment rooms? Yes / No

h) Are there staff working as mental health liaison officers on the wings? Yes / No
If yes, who are they (grade etc.)?

i) **If a client is discharged from Healthcare back on to the wing, how is their care co-ordinated?**

Q19 a) **Do you have any input into primary care?** **Yes / No**

b) **What does this involve?**

c) **How do you link with primary care teams and in-patients?**

Q20 a) **Are family/partners/friends invited to CPA meetings?** **Yes / No**

Comments

b) **Do you help facilitate your clients to contact their family/partners/friends? Please give details**

c) **Are family/partners/friends involved with release plans?** **Yes / No**

Comments

d) How are Healthcare release plans integrated with clients' other resettlement needs?

e) Is there an agreed local protocol for action in the event of an unplanned release?

Yes / No

Please give brief details

Q21 In your opinion, what works well in prisons?

Q22 a) What are the frustrations involved in delivering mental health care in prisons?

b) Do you feel supported within the prison? Not at all / somewhat / completely
Who by?

c) Do you feel you receive ongoing professional support?

Not at all / somewhat / completely

Who from?

d) Do you feel capable of meeting the prisoner mental health needs at this establishment?

Not at all / somewhat / completely

Comments

_____

_____

_____

_____

Q23 Has your team delivered any mental health awareness training? Yes / No

If yes,

a) When:

_____

_____

b) Who to:

_____

_____

c) How often:

Comments

_____

_____

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Thank you for completing our survey.