



London's prison mental health services: A review

The results of SCMH research and analysis, presented and interpreted clearly and concisely to inform and influence policy and practice.

Introduction

Mental health and prison

The prison population has soared in the last decade, from 50,000 in the mid 1990s to just over 75,500 in January 2006 (NOMS, 2006a). Around 70% of sentenced prisoners suffer two or more mental health problems and a significant proportion of those who end up in prison will have previously experienced a psychiatric acute admission to hospital (Prison Reform Trust, 2005). This shows a degree of overlap between the populations in contact with mental health services and with criminal justice services. The Government has acknowledged the need to improve mental health care for prisoners and as a result responsibility for prison health care has been transferred to the NHS (with a target date of April 2006, but with many PCTs assuming this responsibility in April 2005).

The aim for prison health care is to give prisoners "access to the same quality and range of health care services as the general public receives from the National Health Service" (DH & HMPS, 2001).

The Department of Health report *The Future Organisation of Prison Health Care* (DH, 1999a) states that the Prison Service and the NHS need to work together to develop prison mental health care in accordance with national policy on mental health. The report *Changing the Outlook* (DH & HMPS, 2001) was jointly produced by the Prison Service and the Department of Health and set out a vision for the development of prison mental health care. More specifically, it states that the National Service Framework for Mental Health (Department of Health, 1999b) should apply as much to prisoners as it does to the general public.

This has presented a significant challenge. Prisons are overcrowded and lack staff skilled in dealing with mental health problems. There is also a high degree of co-morbidity among prisoners; some have a combination of mental health problems, substance misuse, personality disorder or learning difficulty. Some groups of people suffer disproportionately from mental health problems in prison. These include women and young people.

Aims of the review

This review is a collaboration between the London Development Centre, part of the Care Services Improvement Partnership (CSIP), and the Sainsbury Centre for Mental Health (SCMH). The review sets out to achieve both an overview of mental health provision in London's prisons at a time of significant new investment in prison mental health care, and an understanding of the issues faced by those providing prison mental health services.

Method

The scoping review employed a number of different methods to gather evidence.

- ❖ Policy documents and other literature relevant to prison mental health care were reviewed. The review team also met with researchers and others engaged in reviews in prisons.
- ❖ The review team collected available statistics from sources such as the Home Office, Prison Health and the University of Durham National Service Framework Service Mapping website (www.dur.ac.uk/service.mapping/amh/index.php).
- ❖ The review team visited London's prisons and met with those providing mental health services and those working alongside them, as well as people from a range of agencies involved with offenders. Some 40 stakeholders participated in the review including:
 - inreach leads and workers
 - commissioners
 - non-statutory sector providers
 - health and mental health professionals
 - General Practitioners (GPs)
 - researchers
 - reviewers
 - CSIP representatives
 - prison health representatives
 - an ex-prisoner.

Outline of this paper

This paper is based on both the review of existing information about prison mental health in London and the findings of our scoping review. The paper begins by setting out the scale of the problem faced by the NHS in improving the mental health of prisoners, and then describes current policy and practice in prison mental health care. The paper then describes in detail our findings about the role and function of inreach teams in London's prisons and the issues they face, and presents our findings about the needs of specific groups of prisoners. The paper concludes with a description of the whole system of services for people with mental health problems in prison, and looks at the challenges ahead if it is to be improved.

The mental health needs of London's prisoners

The prison population

The total prison population on 27 January 2006, according to a briefing from the National Offender Management Service (NOMS, 2006a), was 75,661 (71,305 men and 4,356 women). This figure had risen by 994 prisoners since 31 December 2005 (NOMS 2006b), equating to a 1.3% increase. The population figures fluctuated over the course of this review. They peaked at 77,752 at the beginning of November 2005. At times over the review period prisons had very little spare operational capacity (were near to full). The prison population, while fluctuating from time to time, continues to grow.

London's prisons hold about 9% of all those held in custody in England and Wales, and some Londoners are accommodated in establishments outside the capital. At the end of December 2005, London's prisons held 6,551 prisoners. There is a high turnover in this population, with London's prisons managing between eight to ten times their daily populations over the course of a year (London Resettlement Board, 2005). Nationally, it is estimated that at least 135,000 people pass through prison in a single year (Prison Reform Trust, 2005).

Mental health problems among prisoners in the UK

The statistics on prevalence provided by the Office of National Statistics (ONS) study of psychiatric morbidity (mental ill health) among prisoners (Singleton *et al.*, 1998) are much cited. These statistics indicate that approximately 90% of prisoners have either a psychosis, a neurosis, a personality disorder, or a substance misuse problem. Many prisoners have more than one of these; seven out of ten prisoners in the ONS study had more than one problem and those with a psychosis were likely to have three or four other problems. Remand prisoners were also more likely to have multiple problems.

Rates of self harm and attempted suicide in prison are high. Attempted suicide over a 12 month period ranged from 7% (in male sentenced prisoners) to 27% (in female remand prisoners). Self harm during the current spell in prison ranged from 5% (in male remand prisoners) to 10% (in female sentenced prisoners) (Brooker *et al.*, 2002). The greatest risk of suicide or self harm is among newly arrived prisoners in their first seven days in prison (Shaw *et al.*, 2004).

Figure 1: Mental health problems in prisons and the general population

	Prevalence amongst prisoners	Prevalence in general population (adults of working age)
Psychosis	6% – 13%	0.4%
Personality disorder	50% – 78%	3.4% – 5.4%
Neurotic disorder	40% – 76%	17.3%
Drug dependency	34% – 52%	4.2%
Alcohol dependency	19% – 30%	8.1%
	Source: Singleton <i>et al.</i> (1998)	Source: Singleton <i>et al.</i> (2001)

Farrell *et al.* (2002) reported that the incidence of psychosis in their national survey was 20 times greater than in the general population. They also found a strong association between severe dependence on cannabis and psychostimulants and psychosis (see glossary).

Social exclusion

Prisoners are a particularly socially excluded group. Two-thirds were unemployed before coming to prison and 70% will have no employment or placement in training / education on release (Prison Reform Trust, 2005). Approximately 30% were homeless prior to prison (Home Office, 2001) and a similar proportion will be so on release (Niven & Stewart, 2005). In one study 49% of prisoners with mental health problems had no permanent residence on release (Revolving Doors, 2002) and very few prisoners with mental health problems are released into supported housing. Melzer *et al.* (2002) reported that 96% of prisoners with mental health problems were released without supported housing arrangements being made, and this included those who had committed serious offences.

Many prisoners have little in the way of basic level education. The majority – 71% of women and 52% of men – have no qualifications. 65% of prisoners have numeracy skills at or below the level expected of an 11 year old and 48% have reading skills at or below this level (Social Exclusion Unit, 2002; 2004).

Ethnicity

People from Black and minority ethnic (BME) communities appear to be over-represented in English and Welsh prison populations (Rickford & Edgar, 2005). Males from BME communities account for 19% (approximately three times their representation in the population) of those received into prisons nationally, and females from BME communities account for 25%. In London approximately 45% of those discharged from prison were from BME communities (London Resettlement Board, 2005).

Coid *et al.* (2002a) found less mental ill health among African-Caribbean prisoners than among white prisoners, though these findings may be partially explained by a failure to recognise mental illness in African-Caribbean prisoners by health care staff (Coid *et al.*, 2002b; Rickford & Edgar, 2005) and a reluctance to seek help for mental health problems among these prisoners. This reflects the difficult relationship between African-Caribbean communities and mental health services (SCMH, 2002).

The proportion of non-English or Welsh Nationals has changed rapidly over the past decade. Their number increased by an estimated 152% between 1995 and 2005 and they now account for approximately 12% of the overall prison population. The most common reasons for their imprisonment are drugs related offences (Prison Reform Trust, 2005). The mental health needs of this population are not well understood, but some may have experienced considerable trauma prior to their arrival in the UK and many will be very isolated and have no contact with families. Most prisons do not appear to make much use of the translation services that are available. This group accounted for 8 out of 94 suicides in prison in 2003 (Prison Reform Trust, 2004).

Gender

Government policy reflects the need to take account of gender in providing mental health services, including in prisons (e.g. Department of Health, 2003). Current guidance also states that women “are more likely to experience poverty, lone parenthood, poor housing...and have suffered high levels of violence and abuse in child and adulthood” (Department of Health, 2003). Women prisoners are twice as likely as their male counterparts to have received help for a mental/emotional problem in the 12 months prior to imprisonment (Prison Reform Trust, 2000). The proportion of women in prison has increased dramatically over the past ten years (Rickford, 2003).

The social cost of imprisoning women has also been highlighted. Women serve shorter sentences, during which time their children may be taken in to the care of the local authority, and they may lose both their job and their home, increasing the likelihood of re-offending. The *Women's Offending Reduction Programme* (HO, 2004a) has acknowledged this and aims to reduce women's re-offending by ensuring that women receive greater support before, during and after custody. It sets out priorities and actions including:

- ❖ making community interventions and programmes more appropriate and accessible for women
- ❖ meeting mental health needs
- ❖ dealing with substance misuse
- ❖ providing guidance and training on gender issues.

The impact of imprisonment on women, particularly in terms of mental health, has been well documented in the last few years. In a pilot study evaluated by the Safer Custody Group, women prisoners were 18 times more likely to self harm than male prisoners (Rickford, 2003). The Chief Inspector of Prisons' report *Women in Prison* (HMPS, 1997) found all of those interviewed in the sample reported a history of abuse, some experiencing sexual abuse, most experiencing physical abuse and some experiencing both.

The ways in which women's mental health needs are assessed also need to be considered. There is evidence to show that most assessment tools have been developed with the needs of white men in mind and are therefore unsuitable for assessing the needs of women (Ramsay *et al.*, 2001) or people from Black and minority ethnic groups (Department of Health, 2005b).

Best practice guidance for working with women offenders is set out in a new publication, the *Women at Risk* report (Butler & Kossolu, 2006).

Young people in prison

Across England and Wales in December 2005 there were 2,134 prisoners aged 15–17 years and 8,217 aged 18–20 (NOMS, 2006b). Feltham, London's establishment for prisoners in these age bands, held 605 young people.

Young people in prison have an even greater prevalence of poor mental health than adults, with 95% having at least one mental health problem and 80% having more than one (Lader *et al.*, 2000). Few have any qualifications or had worked prior to prison and most experienced traumatic experiences prior to their incarceration. They are 18 times more likely to commit suicide in prison than in the community (Prison Reform Trust, 2005).

The Howard League for Penal Reform reports that at least 8,500 crimes are committed annually by young people already 'failed' by the prison system, and that 70% of young people released from prison will be re-convicted within two years. The Howard League sees the issue of young offenders as being something of a policy blind spot (Howard League for Penal Reform, 2005).

The period of life between 16 and 25 years is a significant one developmentally, with young people developing independence and making the transition to adulthood. Prison is seen as detrimental to this transition, and sentencing often assumes a maturity that young people have not attained (Barrow Cadbury Trust, 2005).

The population of Feltham has been described as one of transient and “volatile and often damaged young people” (Anne Owers, HM Chief Inspector of Prisons, HMPS, 2005). The transience described particularly relates to those over 18 years who are remanded there and for whom the average stay is 11 days. Such short stays pose a challenge for mental health services in prison. Some juvenile prisoners (those under 18 years) are able to spend at least part of their sentence in Feltham and so engagement and even intervention is made more possible. The Inspectorate's report of Feltham was critical of health care provision. The criticisms relating to mental health can be summed up as:

- ❖ All health care provision was dominated by the need to provide care to a small group of seriously mentally ill young people.
- ❖ Seriously mentally ill young people were under observation in the 24hr care facility, largely by agency staff, but otherwise were not engaged.

- ❖ The 24 hour health care unit was in effect “an acute forensic adolescent psychiatric unit”.
- ❖ Health care provision was complex with many different providers.
- ❖ There was no primary health care for minor problems.
- ❖ There was a lack of appropriate inpatient provision outside the prison system.

London's prisons

There are eight prisons in London. Their details are shown below with their populations as at 31 December 2005 (NOMS, 2006b).

Belmarsh (population: 915)

Belmarsh has two roles: it is a category A facility and acts as a local prison for courts in south east London and south west Essex, holding remand prisoners.

Brixton (population: 777)

This is a category B facility serving inner and south London and has both remand and sentenced prisoners.

Feltham (population: 605)

This is a young offender institution (YOI) and remand centre and is a national resource.

Holloway (population: 399)

Holloway is a women's closed prison with both sentenced and remand prisoners. It is also a national resource.

Latchmere House (population: 179)

Latchmere House is London's smallest prison. It serves as a resettlement facility to help prisoners serving longer sentences to return to the community. It includes some life sentence prisoners allocated by the prison service's Lifer Unit.

Pentonville (population: 1,096)

Pentonville is a category B local prison serving local courts with both sentenced and remand prisoners.

Wandsworth (population: 1,413)

Wandsworth is a category B local prison serving local courts with both sentenced and remand prisoners.

Wormwood Scrubs (population: 1,217)

Wormwood Scrubs is a category B local prison serving local courts with both sentenced and remand prisoners.

Prison mental health care provision

Current policy documents

The drive to promote the principle of equivalence of care in the field of mental health in prisons was first set out as government guidance in *Changing the Outlook* (DH & HMPS, 2001). It stated that, “as in all other areas of health care, prisoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS”.

Changing the Outlook outlines ways in which prison mental health care can be improved based on the seven standards set out in the *National Service Framework for Mental Health*, including mental health promotion; primary care and access to services; effective services for people with severe mental illness; caring for those who care for people with mental illness and preventing suicide. According to the document this includes:

- ❖ access to mental health promotion
- ❖ primary care services
- ❖ wing-based services
- ❖ day care
- ❖ inpatient services
- ❖ transfer to NHS facilities and throughcare.

The document recommended the introduction of specialist mental health teams, to work with those prisoners who had ‘severe and enduring mental illness’. It recommended the introduction of a model of mental health provision in prisons that reflected what was being developed in the community.

This policy is central to the broader framework aimed at improving standards within prisons more generally. There is growing evidence that prisons are not effective at reducing offending (HO, 2004b; Social Exclusion Unit, 2002) and that the costs (financial and social) of containing people in prison without resolving issues of access to appropriate health and social care, education, training, housing and employment are too high (Social Exclusion Unit, 2002).

As mental health service providers develop services in prison, they are required to work in a collaborative way with the prison and with other services provided to prisoners (e.g. agencies addressing substance misuse), to ensure that prisoners are offered the most appropriate care.

Considerable work has gone into mapping out the sort of 'path' a prisoner with mental health problems might follow, dependent on the nature of that problem and when it is identified. This mapping is summed up in a recent publication *Offender Mental Health Care Pathway* (DH, 2005a) which is designed to support prisons and their mental health services in ensuring that prisoners get the care they need in a timely fashion.

Mental health services in prisons

Most prisons in England and Wales are now served by a mental health inreach team. These are the realisation of the Government's intention to introduce mental health practitioners to support those prisoners with the most serious mental health problems (DH & HMPS, 2001), providing an equivalent function to community mental health teams (CMHTs). Inreach teams are one of several new 'specialist' teams that have come in the wake of the recent reforms to mental health services. The creation of inreach teams is the most significant mental health development in prisons to date, and is quite unprecedented. But unlike the new teams in the community, such as assertive outreach, crisis resolution and early intervention in psychosis, there has been no implementation guidance nor any 'evidence' (e.g. UK and international research evidence as has been available for assertive outreach and crisis resolution) to guide the teams and those commissioning them.

Primary mental health care

Primary care in London's prisons is variable. Some prisons are served by prison doctors, often locums (e.g. Wormwood Scrubs), and others by a local GP practice (e.g. Brixton and Latchmere House). Pearce *et al.* (2004) identified that while 58% of prison doctors worked with prisoners with mental health problems, most had not received any training in psychiatry.

Continuity of care between the community and prison is also a huge challenge. It is not helped by the fact that approximately 50% of sentenced prisoners are not registered with a GP prior to being sent to prison (Social Exclusion Unit, 2002).

It should be noted that prison nurses provide a significant amount of the primary care service, through nurse led clinics for particular groups (e.g. those with diabetes), through wing-based triage and crisis visits to wings (e.g. following accidents/incidents in which a prisoner has been injured). Nurses also tend to be involved in assessing prisoners in segregation units.

A recent literature review commissioned by SCMHS (Williamson, 2006) took a primary care perspective on improving the health and social outcomes of offenders after their release. It summarised some of the challenges that providers of health care to offenders face:

- ❖ high consultation rates (while in prison)
- ❖ prisoners' (poor) reliability as historians
- ❖ poor prisoner concordance with treatment planning
- ❖ personal health neglect and health damaging behaviours
- ❖ poor clinical information and support systems
- ❖ staff shortages
- ❖ poor planning of services.

This study also states that people with mental health problems suffer particularly after release.

Inpatient facilities

With the exception of Latchmere House, all of London's prisons have 24 hour health care facilities which include inpatient bed units. Some prison nurses may work exclusively in such a unit or have a role split between inpatient and primary care functions.

Most of London's prisons have dedicated units for prisoners with substance misuse problems on detoxification regimes.

General health care beds can be used for any medical problem, but tend to be dominated by prisoners with mental health problems. On the day of SCMHS's visit to Brixton all such beds were occupied by prisoners with mental health problems, many of whom had self-harmed. Most of these prisoners were thought to have moderate mental health problems and to be likely to use the inpatient beds for a maximum of two days before returning to ordinary location – there was therefore a considerable turnover in this unit. However, four patients had severe mental health problems and were awaiting either transfer or assessment for transfer to NHS provision outside the prison. This group was difficult to treat, especially if not cooperative with the prescribed care, as prison inpatient units are not regarded as hospitals under mental health legislation and compulsory treatment under the Mental Health Act (1983) cannot be given.

Day care services

Most prisons have a day care unit, which can be used by prisoners with mental health problems. These were staffed in different ways across London's prisons. All tried to provide a non-threatening therapeutic environment, but participants reported on the challenges of doing this in a prison setting. Occupational therapy staff at Belmarsh compared and contrasted prison health care with day care provision in the community, citing for example the limitations on resources and materials that could be used because of prison security requirements. Participants also reported being concerned that day care units may not be as valued as other prison activities (such as work, training and education) by prison staff, as they were not well understood.

Services for prisoners who self-harm

Safer Custody Group, the Home Office unit dedicated to protecting vulnerable prisoners, takes the lead on developing policy and in supporting prisons to implement policy on self-harm. Prisons have Safer Custody staff who coordinate this activity. Currently a new system of managing such prisoners, Assessment Care in Custody and Teamwork (ACCT), is being rolled out. It involves a system of case management, replacing what was largely a paper-based system of observation/monitoring.

Identifying mental health problems in prisons

Screening procedures in prison receptions have been reported to be ineffective. As a result, prisoners with mental health problems have often not been identified and therefore placed on ordinary location (Parsons *et al.*, 2001) and once on ordinary location it is even less likely that a mental health problem will be identified (Birmingham, 1998). Considerable work is being done to improve screening procedures and a new tool has been piloted across ten prisons and is now adopted for use for all new prison receptions (Birmingham & Mullee, 2005; Carson *et al.*, 2003).

The Mental Health Act and prisons

Prisons, even their health care wings, are not recognised as hospitals under the Mental Health Act 1983. Prison health care wings have been described as operating in "a limbo between the community of the prison and the hospital beds of the NHS..." (Wilson, 2004). Some prisoners with severe

mental health problems will be placed there rather than maintained on normal wings, but staff cannot provide treatment without their consent except in rare circumstances. There is no statutory provision for the treatment of people with mental health problems in prisons and treatment without consent can only be given in emergencies (Earthrowl *et al.*, 2003).

Mental health awareness training

One of the envisaged roles of the inreach teams is increasing the mental health awareness of prison staff.

The organisations Prison Health and CSIP (represented in London by the London Development Centre) are responsible for the roll out of mental health awareness training. This forms part of Assessment Care in Custody and Teamwork (ACCT). Additional training is available for some staff. Skills Based Training on Risk Management (STORM), for example, is being given to ACCT assessors and in some establishments ACCT case managers. Newbold Revell (the Prison Service Training College near Rugby) is currently training a team of trainers for each area, nationally, to deliver the ACCT courses to prison establishment staff, as well as preparing a mental health awareness workbook for prison staff.

Diversion from custody and alternative resources

Schemes which divert people from custody, commonly called court diversion or criminal justice mental health liaison schemes, can and do prevent some people with mental health problems from going into prison, and find them a more appropriate resource within the NHS. It is reported that these schemes have been starved of serious investment in recent years. Some have disappeared altogether. The position in London matches the national picture described by Nacro (2005), with some areas having limited or no schemes and extreme variation in quality where they do exist.

An alternative resource for some people at the point of custody or while in custody is a secure NHS inpatient facility. The development of medium secure forensic units has been uncoordinated, leading to patchy provision and under-provision (Coid *et al.*, 2001). This has resulted in delayed transfer to such facilities. It has been estimated that around 40% of prisoners held on health care wings would be more appropriately accommodated in NHS secure accommodation (HMPS, 2004).

Prison inreach teams

The role of inreach teams

Prison inreach teams are at the centre of the Government's policy for improving prison mental health care. These teams now exist in seven of London's eight prison establishments. We sought to review participants' views and experiences of the role and function of inreach services as well as the resources and staff available to them. We also asked participants to describe the model of care provided by inreach teams.

Most teams had originally aimed to provide:

- ❖ a service reaching out to the wings of the prisons where prisoners reside
- ❖ a focus on prisoners with severe and enduring mental health problems
- ❖ a community mental health team model of care (see DH, 2002b)
- ❖ liaison and support to health care and primary care practitioners in prisons
- ❖ liaison and support to wing-based prison officer staff
- ❖ a role in spreading mental health awareness particularly among prison staff
- ❖ evidence-based interventions (e.g. cognitive behavioural therapy)
- ❖ a multidisciplinary service such as one might find in a community mental health service (i.e. a mix of nursing, psychiatry, psychology, social work and occupational therapy among others).

Interventions

The reality for most teams has been somewhat different. It was the view of most participants, and particularly those engaged in inreach, that the range of interventions offered by the teams was very limited. Several teams said that on the whole their work was restricted to assessment, mental health monitoring and medication management, but with considerable effort going into liaison and seeking information from services external to the prison such as mental health services in the community.

The role of inreach teams was said to be restricted by frequent movement within the prison population. Remand prisoners may be in prison for short periods. Average stays in London's prisons for remand prisoners reported by participants in this review ranged from two to three weeks,

although for some individuals a stay in prison is much shorter. Sentenced prisoners also move frequently from one establishment to another. Overcrowding plays a role in this; we were told of several examples of prisoners who had gone for court appearances and then been moved to another establishment to resolve overcrowding problems.

The focus of inreach teams

All teams had intended to focus on the minority of prisoners with a severe and enduring mental health problem such as those who might be under the enhanced Care Programme Approach (CPA) were they in the community. Some teams had developed eligibility criteria to this end, though most teams did not have clear criteria agreed with other agencies in the prisons (e.g. health care, substance misuse agencies) and all had struggled to maintain the focus on those with severe and enduring mental illness. There were a number of reasons given for this by participants:

- ❖ some workers in other agencies did not agree with inreach working exclusively with people with severe mental health problems
- ❖ there were reported to be limited skills and confidence in existing primary care and prison health care staff in managing people with more moderate and common mental health problems
- ❖ many prisoners with mild and moderate mental health problems have complex needs (e.g. co-morbidity with a substance misuse problems)
- ❖ reported differences in defining severity between inreach and others.

The result has been a large number of referrals being sent to inreach teams. Prison health care was not the only source of referral for inreach teams. Some teams reported large volumes of referrals coming from wing-based prison officer staff, for example.

Some prison health care nurses have mental health training. However, as they operate in a generic nursing role they often have less opportunity to practise their specialist skills and we were told that some become deskilled.

Several participants stated that some referrals to inreach teams resulted from "pressure" from both solicitors and "litigious prisoners" for mental health assessments.

Table 1: The staffing of London's prison inreach teams

	Number of whole-time equivalent (WTE) staff
Belmarsh	
Team manager (H grade)	1
G grade forensic mental health nurses	3
Social worker	1 (0.6 in post at time of review)
Psychiatrists	3.5
The day care centre also had 2.5 WTE OTs (incl. one senior) and an Art Therapist	
Brixton	
C – G grade nurses	3
H-I grade nurses	1
Consultant	0.8
Psychiatric trainee	1
There is also additional psychology input from the forensic psychology service	
Feltham	
G grade nurses	2
F grade	2 (vacant at time of review)
Outreach team	5 (from different backgrounds e.g. police, social work)
Holloway	
Team manager	1
G grade nurses	2
Social worker	1 + 1 part time (vacant post)
Latchmere House	
No dedicated inreach resource	
Pentonville	
Team manager	1
Deputy manager	1
Community Psychiatric Nurse (CPN) / Social worker	4
Medical cover – consultant	0.6
Specialist Registrar	(not occupied at time of review)
Senior House Officer	monthly rotation from Trust
North London Forensic Service	0.8 sessions contracted by prison
Wandsworth	
Band 7 CPN Team leader	1
Locum forensic psychiatrist	0.9
Staff grade	0.6
Specialist Registrar	0.6
Band 7 CPN	3
G grade CPN	1
PA/Office manager	1
Wormwood Scrubs	
Consultant psychiatrists	0.5
Associate specialist	1
Team leader (I grade)	1
G grade nurses	2
Admin worker	1

Models of inreach

As stated, most inreach team participants saw themselves as being in the prison primarily to serve a core group of prisoners: those with severe and enduring mental health problems, and particularly those that would meet the criteria for the enhanced CPA were they in the wider community. However, most had also developed a wider brief and recognised that a prison was 'no ordinary community' and there was a need to respond to other needs, particularly because of gaps or shortcomings in primary mental health care.

Participants from all of the inreach teams in London asserted that it was not possible to operate a community mental health team model in a prison. The main reason was the limited mental health skills of primary care and prison health care staff. Other factors cited by participants were:

- ❖ the special nature of prisons e.g. security restrictions inhibiting the actions of both prisoners and mental health practitioners
- ❖ the limited activities and opportunities available for prisoners, and their limited contact with families or home communities
- ❖ the high levels of co-morbidity (for example co-existing mental health, substance use and physical health problems)
- ❖ the fact that prisons themselves were not regarded by participants as conducive to good mental health.

Several teams felt they were evolving a hybrid model of health care provision, encompassing elements of psychiatric liaison and crisis resolution and, for two teams, assertive outreach. An example of the latter was the Brixton Inreach team, which had rebadged itself the 'Outreach Team', as its role was felt primarily to be reaching out to the wings of the prisons. Other teams also provided this type of service, while some worked on a more traditional outpatient clinic model, seeing prisoners in the prison health care unit.

Some participants pointed out that there was no policy implementation guidance describing the roles, functions and make-up of inreach teams. This is not the case for any of the other new specialist mental health teams that emerged from the *National Service Framework for Mental Health* (DH, 1999b) and the *NHS Plan* (DH, 2000a). The teams had to 'learn on the job' and gain an understanding of the requirements through providing a service. Consequently there was some variation across London in the type of model in place.

There was a view among many participants that the model of inreach needed revisiting. To date, most inreach services had developed their model in isolation from other services. The London Development Centre for Mental Health convened the London Prison Mental Health Forum to create a space in which inreach teams and other stakeholders can review the model. Participants were keen to have the chance to meet other people and in particular emphasised the need for a forum at which NHS and prison staff could meet and discuss issues.

The make-up of inreach teams

The staffing of each of London's seven inreach teams is shown in Table 1.

Only one team in London saw itself as being truly multidisciplinary. This was the team serving Belmarsh, which included four nurses, one social worker and 3.5 whole time equivalent (WTE) psychiatrists. Most teams comprised largely one discipline, nursing, with varying degrees of medical support. As one interviewee said, "in reality we are a nurse-led service...with an inadequate skill mix".

This has inevitably had an impact on the range of interventions the teams can offer and was commented on by several participants. This is not to say that London's prisons do not have a range of health professionals providing some degree of service, but as participants pointed out, disciplines such as occupational therapy or clinical psychology tend to be in different teams or offering different services. 'Working together' between services and teams was limited across most of London's prisons, as discussed later in this paper.

SCMH has recently published a discussion document *Defining a Good Mental Health Service* (Boardman & Parsonage, 2005) which suggests some ideal resource levels based on knowledge of psychiatric morbidity levels. For prisons it assumed that inreach teams would provide a community mental health team equivalent service.

Defining a Good Mental Health Service has been published for the purposes of promoting a discussion on appropriate resource levels and the resource levels it suggests are by no means definitive. Table 2 shows the suggested resource levels for a category B prison with 550 prisoners – a total complement of 11 whole time equivalent (WTE) mental health workers.

Table 2: Recommended staff-mix for an inreach team (category B, 550 prisoners)

Staff group	Recommended whole time equivalent staff
Consultant psychiatrist	0.5
Consultant psychotherapist	0.3
Staff grade doctor	0.5
Clinical psychologist	0.5
Mental health nurse (incl. one trained in learning disability nursing)	3.0
Occupational therapist (OT)	1.0
OT helper	2.0
Technical instructor	1.2
Social worker or probation officer	0.5
Counsellor	0.5
Creative therapist	0.5
Speech and language therapist	0.5

(Boardman & Parsonage, 2005)

SCMH's assumptions have been based on adult male prisoners and may not be appropriate for women and young prisoners, who may for example require a greater resource.

It is difficult to ascertain the actual level of resource that supports prisoners with mental health problems in London's prisons; however the indication given by the participants interviewed for this review is that for all of London's prisons the resource level falls short of those suggested in SCMH's discussion document and therefore there may be a case for reviewing the resource levels of London's prison inreach teams. None of the inreach teams is comprised of the range of disciplines that SCMH suggests and some are far less multidisciplinary than others.

Working relationships with prison staff

Participants from the prison inreach teams described carrying out liaison work on the prison wings and working with prison staff to identify prisoners with mental health problems. Most participants reported positive working relationships with prison staff and recognised that they play a crucial role in not only identifying potential mental health problems but also monitoring behaviour. However, because of high levels of general mental health need and limited skills among prison health care and primary care staff, inreach participants said they faced considerable pressure to take referrals from wing-based staff and others within the prison (e.g. chaplains or teams dealing with substance misuse), even when they fell below what the team saw as its threshold.

Referrals to inreach teams

Most teams accepted referrals from any source, except self-referral. This included referrals from prison staff, chaplaincy, primary care, and substance misuse teams. Teams in several of London's prisons were receiving in excess of 1,000 referrals a year and spent considerable time engaged in assessment. All inreach team participants reported receiving large numbers of what they saw as inappropriate referrals, and this included not just prisoners with mental health problems below what inreach perceived as being its threshold, but also those with behavioural problems. Some participants commented that there was a tendency to medicalise behavioural problems in the prison service.

All the prison inreach teams have developed or adapted referral forms which referrers complete. In most cases these are forwarded to a referral meeting during which the team decides on allocation. There appeared to be a growth in bureaucratic procedures linked to referrals, occasionally involving teams that were located within walking distance referring to each other by letter. While it is clearly important to establish correct records for all aspects of care including referrals, it is arguable that some of the bureaucracy was motivated by concerns over the volume of referrals and a desire to gate-keep and set up barriers.

Eligibility and referral criteria are key to defining the boundaries of the service. However, few teams had been able to develop these in a robust way. Where criteria had been developed it was sometimes without consultation with other services, leading to conflict. In some senses this is similar to the conflict between generic and specialist mental health services in the community, where the former

often feel under pressure and resent the specialist team having selective criteria. Communication with other teams and individuals working in the prison was thought to be crucial in building relationships and information sharing. As one participant stated, “if we’re all pulling in the same direction, there’s less chance of things going wrong”.

Assessment

We were informed that, as with a community mental health team, any person thought to be in need of a mental health service in a prison will undergo a comprehensive assessment process. Overall, assessments aim to take account of mental health history, social factors, risk assessment, previous admissions, health history and behaviour. However, the ability to conduct a thorough assessment may depend on a number of factors. Finding out a person’s history was acknowledged by most participants to be problematic, for example in terms of building up a clear picture of past service or medication use. The use of aliases is common among the prison population, and some may give false names to GPs. In addition, few people will know who their GPs are or will not have had one prior to their imprisonment.

On the whole, inreach teams do not use standardised or validated tools as part of their assessment process, tending to develop their own assessment forms or adapting their local mental health trust’s existing paperwork. The decision not to incorporate more robust tools into their assessment process limited opportunities for measuring outcomes and audit of practice. The teams had given limited thought to demonstrating their impact, measuring outcomes or audit. Given the pressures the teams were working under this is not surprising. It should also be noted that in our experience few community-based mental health teams use standardised or validated instruments as part of their assessment and few attempt to measure outcome as a matter of routine.

Once a prisoner is referred to the inreach team and accepted for assessment, that assessment and the checking of personal histories was reported to be a very time consuming process for prison inreach teams and all stated that a significant amount of team time was devoted to this. We were told that in some cases community GPs were unwilling to share information about a patient with the prison health care staff, but more often than not it was hard to track down a prisoner’s former GP. Participants stated that there needed to be improvements in information systems, data sharing protocols and continuity of care with community primary care services.

Several participants said there needed to be a more ‘joined-up’ approach to assessments and information gathering within prisons. It was observed that agencies working in prisons all tended to work independently of each other, carrying out their own assessments and keeping their own information. In the absence of any information sharing protocols it was thought that agencies were reluctant to share data with each other. Prisoners with mental health problems may be recipients of multiple assessments, with considerable overlap between each assessment.

Care planning

There was variation across the prisons as to which patients received a formal care plan. Prisoners on inreach team caseloads were reported to have care plans based on the care programme approach (CPA). However, there was some variability in this as one team reported having limited time for developing formal care plans as they were under considerable pressure to perform assessments.

Inreach teams reported considerable problems in engaging with community mental health services for prisoners who had been on enhanced CPA prior to coming to prison and even more difficulty in this for prisoners due to leave prison who were deemed to have ongoing mental health needs at the enhanced level.

It has been reported to SCMH both in London and in reviews outside London, that some community mental health teams will ‘discharge’ patients when they are sent to prison, while others seem reluctant to maintain responsibility for care coordination under CPA. There are also practical difficulties in remaining engaged with mental health clients if they are imprisoned at a distance from their home.

Culture clashes

Several participants described difficulties in the relationship between the NHS and the prison service, describing it as an ‘arranged marriage’ of two very different ideologies: that of the prison service being based on security and deprivation of liberty, and that of the NHS being based on healing and promoting wellbeing.

Most inreach staff had struggled at times in working in an environment in which security was prioritised over health, and sometimes felt that the success of clinical interventions was jeopardised. For example, one participant said that there is a 30-35% non-attendance of inreach appointments, with security and prison routine playing a significant

part in this. On occasions prisoners could not be escorted to appointments, for example during staff shortages and 'lock-downs', but also sometimes because of perceived staff unwillingness. Where services are delivered to people on the wings this may be less of an issue, but there may still be times when it is not possible (e.g. when additional security measures are in place). This has an impact on inreach teams' ability to provide an 'equivalent' service to one that might be provided in the community.

The prison environment was described as being intimidating for those with little experience of it. Inreach staff all come from NHS services, with a very different ethos to that of a prison, and find it a challenge working where health care is secondary to security. The tension between security/discipline and 'therapy' was evident from discussions with participants and it had informed their views on the essential characteristics needed to work in a prison inreach team. One team leader told us, "having to provide clinical leadership in an alien environment is very taxing. Your aims are quite different from anyone else's."

Participants from several of London's prisons also discussed what they saw as a "blame culture" in their establishments, which, according to one participant, affected people's confidence in using their own judgement.

While some inreach participants felt they were not understood by the wider prison community, and sometimes even regarded suspiciously, most inreach staff felt that they were at least gradually being accepted within their prison. However, several inreach participants described feeling isolated from the mental health NHS trust that employed them and most participants felt somewhat peripheral to their NHS trust.

Several participants suggested that inreach would benefit from rotational working arrangements with community teams in their provider NHS trust, enabling them to maintain links with their trusts and thus having access to the information, updating, support and training which they sometimes missed out on in the prison. Given the limited interventions they reported currently being able to employ, some participants thought that rotational working would help to overcome the problem of staff becoming deskilled. Such working arrangements were also suggested for prison health care staff.

Across England primary care trusts and prisons have formed strategic partnership boards. The boards comprise different groups focusing on particular aspects of health care provision, such as mental health and substance misuse. However,

participants thought that for partnership working to be effective there also needed to be formal protocols between services at an operational level.

Prison inreach teams try to keep prison staff informed about their clients without compromising the need for confidentiality. Wing-based prison staff do not have access to medical records although they may be given a broad outline of the person's needs. Most were happy with this arrangement. However one participant, representing a prison inreach team, felt that prison staff should be given access to medical notes so they could record information directly in them.

Skills and competencies

Participants had begun to identify both skills and competencies required for working in prisons. Inreach participants stated that training in the following approaches would support their work:

- ❖ cognitive behavioural therapy (CBT)
- ❖ brief solution focused therapy (BSFT)
- ❖ general counselling skills.

BSFT is not really just one approach but rather a group of approaches to therapy that have in common an orientation towards solutions to current problems, rather than pursuing the causes of problems, and interventions are delivered relatively quickly (often in four to six sessions). This form of therapy was thought to be a particularly appropriate intervention given the transient nature of the population the staff worked with, and is used in some prisons.

Participants felt that all groups of staff (discipline, prison health care and inreach) required assessment skills, albeit at different levels. For instance, health care staff were thought to require skills in triage, but also in interventions such as CBT, BSFT and counselling for prisoners with more moderate mental health problems.

Inreach staff said that they would find training to develop a greater understanding of the criminal justice system would also be of value, as most had never previously had any significant contact with criminal justice agencies.

Specialist training is now available for staff working in other recently introduced specialist mental health teams in the community such as assertive outreach, early intervention in psychosis and crisis resolution, where they are introduced to the models of working and skills required for their type of service. Participants thought that such training needed to be developed for inreach workers.

Participants also felt that prison health care nursing was a speciality, or at least nursing in a very special environment, requiring specific skills, particularly an ability to assess rapidly and triage for both physical and mental health problems, to assess for risk and to have a security consciousness. Currently there is no post-basic nurse training that prepares nurses for working in prisons and participants felt this also needed to be developed. It was pointed out that even prisoners with common mental health problems, such as depression or anxiety, tend to have quite complex needs, as the mental health problem, may co-exist with a substance misuse problem and/or learning difficulty and/or personality disorder and often difficult life circumstances prior to coming to prison (e.g. a history of abuse).

Specific training is now available to GPs working in prisons. Though this review does not establish the proportion of prison doctors who have undergone this, it was reported in 2003 that 25 prison doctors nationally had no general practice qualification (Smith, 2003), and more recently, concerns were expressed about the prison doctors being supported in having the opportunity to update and maintain their skills (BMA, 2004).

Education and training for other prison staff

Each prison inreach team described an educational component to their role in terms of providing formal mental health awareness training to prison colleagues, and of being a source of advice and information on mental health issues. The extent to which this happens in reality, given the demands on their service, is questionable. Most inreach teams admitted that they had little time to provide formal mental health awareness training sessions. Participants agreed that prison staff needed (and were in many cases keen) to receive training in mental health awareness. They felt that this should be an ongoing programme of learning and development, covering not only identification, but also 'holding interventions' that can support a prisoner until health care or inreach staff can be involved. It seems particularly crucial that discipline staff on ordinary location are given support in identifying mental health problems, given the reported likelihood of problems being missed at reception.

Specific needs

Treatment without consent

It was reported that prisoners with the most severe mental health problems often receive the 'poorest service'. This was particularly the case for prisoners admitted to a prison health care inpatient bed but who for reasons of their illness would not cooperate with proposed treatment and who were aggressive. These prisoners tended, it was reported, to spend longer times locked in their cells as several officers or health care staff were required to unlock them. As the Mental Health Act has no force in prison, compulsory treatment was usually not an option. We were told of several prisoners who were markedly ill, usually with a psychosis, confined to their cells for lengthy periods and going largely untreated awaiting resolution to a request for transfer to an NHS facility. The issue of transfer is discussed further later.

Participants from three prisons reported that health care staff had resorted to forcible injections, using common law. However, this was not seen as a desirable method of treating someone as it is invasive and necessarily public: people are needed as witnesses and part of the procedure may also be videoed. Thus people will frequently have little or no treatment until a transfer to an NHS facility can be arranged.

Many participants asserted that people presenting with severe mental health problems should be diverted before coming into prison custody to a 'more appropriate' environment, or swiftly transferred if already in prison. Some prisoners were placed in segregation units when they became 'unmanageable'. At the time of writing this report, one of London's prisons (Wandsworth) was due to open a High Dependency Unit, which will comprise 16 gated cells and provide an alternative environment for such vulnerable prisoners.

Women prisoners

In Holloway prison, we were informed that up to 80 of the 450 women in the prison on the day of our visit were self harming. While this claim comes from a participant and is not from a published source, it is similar to rates found in a Safer Custody evaluation (see Rickford, 2003).

One participant who had experienced being a prisoner in Holloway felt that there was too much emphasis on containment and not enough on helping women to cope with emotional distress. From her experience (which predated the

introduction of prison inreach teams), medical staff were quick to prescribe sleeping tablets and antidepressants and lacked the skills to help individuals who were self-harming. In her view, both health care and discipline staff needed specific skills in order to provide appropriate care for women. For example, a woman experiencing mental or emotional distress should be treated as a patient first; staff should have good listening skills and be empathic and they should also be aware of the issues underlying mental health problems, especially with regards to abuse and violence.

Carers

Prisoners often have very limited contact with families and carers and so too do inreach teams. This limits some of the interventions that can be offered and that might be available in a community setting, including therapies that support families. This latter point is important as interventions with families (where they are still in contact) could support the resettlement process even for prisoners with the most serious mental health problems.

Dual diagnosis

Despite the reported high levels of co-morbidity of mental health problems and substance misuse within prisons, participants stated that dual diagnosis was a “big gap” and that service development in this area had been poor, and that substances misuse (e.g. detoxification services) had been historically seen as outside the remit of health care.

In some of London's prisons both inreach and substance misuse teams tended to refer a prisoner onto each other rather than seeking to work jointly with the prisoner when the need for both was identified.

Wormwood Scrubs has designed a care pathway for people with mental health and substance misuse problems. This involves developing agreements across various services about how they will work together and how each will respond in different circumstances, including agreements on joint assessments and regular joint meetings between mental health and substance misuse staff. The emphasis was on prisoners with the most severe mental health problems but there was recognition of the need to consider the ‘pathway’ that prisoners with more moderate mental health problems might follow and to ensure that these people do not ‘fall between two stools’. Given the number of prisoners who suffer with both mental health and substance misuse problems, addressing the needs of

these prisoners should be part of the core business of mental health services in prisons.

Personality disorder

The prevalence of personality disorder is significantly greater within the prison population than it is in the general population. Some 64% of male sentenced prisoners and 50% of female sentenced prisoners have at least one personality disorder (cited in Rickford & Edgar, 2005). Yet only one participant identified a need for training for working with this group, and several participants did not consider that inreach services should work with prisoners with personality disorder.

Learning disability

Singleton *et al.* (1998) estimated that 11% of remand prisoners and 5% of sentenced prisoners had an IQ of 70 or less (indicative of a learning disability). Many more have limited reading skills and poor numeracy.

People with a learning disability may be more vulnerable in prison (e.g. to bullying) and be less able to cope with the stresses of the prison environment than other prisoners.

People with a learning disability are also more likely to have more complex health needs than the general population and this includes a greater prevalence of mental illness (DH, 2000b). It is thus highly likely that inreach teams will come into contact with prisoners with learning disability. However there was little evidence in this review of any specific initiatives or consideration being given to meeting the mental health needs of this group. It may be necessary to consider this group's needs when considering the skills and competencies of an inreach team. The type of intervention appropriate for people with learning disabilities may, for example, be different to that considered appropriate for people with greater cognitive functioning and this needs to be thought through. Additional thought should be given to identifying learning disabilities in routine assessments. This was not evident in the current inreach or health care assessments shared with us. The literature reviewed in the recently published Prison Reform Trust review of male prisoners' mental health needs (Rickford & Edgar, 2005) also suggested that much learning disability is missed due to a lack of routine assessment.

Foreign nationals

One participant discussed the case of a prisoner from Africa whom staff had thought was on hunger strike. After some 'sensitive' exploration by a voluntary sector counsellor, it was established that the prisoner had been traumatised by events that had occurred prior to leaving his country of origin, and that he was not refusing food as a form of protest.

Given the large numbers of foreign nationals in prison and the likelihood that many may not be able to express themselves and their mental health state in English, it is possible that mental health problems are being missed among these prisoners. The lack of translation and interpretation services is likely to exacerbate these difficulties.

Young people

Feltham provides 24-hour health care provision. As this is not always the case among establishments for younger offenders, Feltham will often provide this service for inmates from other establishments. Often these young people will have mental health problems. Most of our participants felt there was very limited secure NHS provision and this was particularly acute for those under 18 years, as there are only three forensic units (with 3 more in development) for adolescents in England and Wales.

Finding appropriate accommodation for young people after release was described as particularly difficult as the support they required was often greater and different to that required by adults, but that there was very little specialist provision.

The 'whole system' of care

Diversion

Participants in the review provided a similar picture to that provided by Nacro in their recent review of court diversion schemes (Nacro, 2005): that provision is patchy, that some parts of London have no cover, and that where cover does exist it is variable in quality. The consensus view was that the more proactive the diversion scheme (e.g. those that visit custody and court holding cells rather than responding to referrals), the more likely they were to divert more people away from prison. Inreach teams all reported having assessed prisoners on remand who in their view should not have come into prison. We were told of the

difficulty in transferring such prisoners to the NHS once they had come into prison.

Nacro's Mental Health Unit provided us with the data for London used in their review. This reveals some 19 active schemes across the capital at the time of its review in 2004, provided by both statutory and non-statutory organisations. Most of these have at most one whole time equivalent (WTE) worker, but usually much less than this, and often only cover one or two half-days per week. Only two schemes (both statutory sector) had what could be called a multidisciplinary team (i.e. at least three disciplines), covering several days of the week.

Reception and screening

Participants each had their own perceptions of the process of reception and screening. It was indicated, for example, that women prisoners tend to get a worse deal on arrival due to the fact that men have to be received into prison at a certain time whereas women do not. Women could therefore arrive at prison as late as 9pm, potentially after a long journey.

Prison receptions are exceedingly busy, with prisoners arriving from courts or other establishments on transfer. Some of London's prisons have to cater for as many as 80 prisoners arriving during a single end of day reception. Inreach teams are not involved in the medical screening of new arrivals to prison. It was reported that receptions are difficult environments in which to perform assessments, with pressure from the establishment to process all new arrivals as soon as possible. Screenings in reception are conducted by prison health care nurses.

Health care staff assigned to reception for medical screening may not have mental health training, be deskilled and have limited experience of mental health assessments. This increases the potential to miss prisoners with mental health problems. Some prisoners may not be amenable to assessments upon arrival into the prison system. This is particularly likely among people with a dual diagnosis (e.g. a combination of substance misuse and mental health problems). Other prisoners may be concerned about sharing the fact they have a history of mental health problems for fear that this knowledge may make them more vulnerable to bullying from other prisoners.

Most prisons use a standardised screening tool, the Don Grubin health screening tool (Carson *et al.*, 2003) to assess the health of prisoners at reception. Participants thought that this tool was not always effective in identifying mental health or substance

misuse problems. Several participants said that identifying mental health problems required some expertise in the assessor as well as an effective assessment instrument, and that nurses engaged in reception screening required further training and support for the task.

Prisoners arrive in the prisons in groups, which are sometimes too large to allow for adequate time for staff to identify prisoners' health needs. Demand at reception can vary considerably from day to day. A consequence of this is that reception will deal with the most obviously distressed and challenging people, while the "quietly mad" will slip through the net. One participant, who had been a prisoner, felt that the reception and screening process was intrusive and insensitive, making it unlikely that prisoners would feel safe to disclose information. More often than not, prisoners have little information with them about their medical history and needs.

Inreach services have not been targeted at reception. It is usually managed by GPs and prison nursing staff, many of whom have neither been trained in mental health nor feel confident in assessing in this area. More effective input at this level may prevent people with mental health problems or who are experiencing distress from being overlooked. There is evidence that the first seven days of entering prison are significant in terms of risk of suicide or self harm (Shaw *et al.*, 2004).

Some of London's prisons have devised special schemes to support prisoners arriving at the prison and to identify their needs. In Holloway the 'First Night in Custody' service is available for all women arriving in prison (regardless of whether they have been there before). They will carry out a 'mini' mental health assessment and also screen for drugs. We were informed that approximately 60% of women will require detoxification and around 70-80% need help with alcohol or drug use. Wormwood Scrubs also has a first night centre for new arrivals. There is space for 40-50 people and they have access to a range of voluntary sector services and a GP. Such schemes are crucial, especially where, for example, people are concerned about the care of children or other family members while they are in prison. Dealing with these practical issues can help to alleviate worries which could otherwise escalate and cause distress.

Primary care services

Improving primary mental health care was considered to be a priority by most participants, including commissioners.

There were different approaches to providing primary care within prisons. For example, one prison had asked a local practice to take on the prison population, but found little enthusiasm for this. Subsequently, they had considered establishing a PMS (Personal Medical Services) practice which would be based in the prison. We were informed that there was some interest in this. However, other options were being considered including contracting out to private health care providers.

Another participant stated that in their establishment "the primary care service is not currently the best aspect of health delivery" (there was only one locum GP in that prison), and in particular that it did not focus on mental health. Again, at the time of this interview, the prison's local PCT had gone out to tender for the primary care service and hoped to have a new and more comprehensive service established by April 2006.

Participants in this review were particularly concerned where there was a reliance on locum doctors; these might be in the prison for quite short periods and therefore their knowledge of the prison and prisoners may be limited. There were some concerns about prison doctors being updated in their skills. This was a matter of particular concern if there was no connection with mainstream primary care.

Significant unmet needs in prisons were reported in terms of common mental health problems including depression, anxiety, emotional distress and adjustment problems. Neurotic disorders such as depression and anxiety are prevalent in both remand and sentenced prisoners, but more so in the former (Singleton *et al.*, 1998). All of these disorders are more prevalent among women.

Prison inreach teams reported seeing clients who would not be eligible for secondary care in the community. However, it should be noted that prisoners with common mental health problems more often than not had complex needs; many had lived quite chaotic lives, had concurrent substance misuse and/or personality disorder, and had experienced impoverishment, abuse and neglect in their lives.

On the whole it was felt that prison health care and primary care practitioners lacked the skills and confidence to work with these levels of complexity and therefore many of these cases were referred to the inreach teams. One participant commented that "GP provision should be as broad as it is in the

community, so they can maintain lower level mental health problems... In the community 90% of people with mental health problems won't be in touch with secondary care." Another said that "[we] see more people with common mental health problems, which primary care could take on themselves with a bit more confidence, so we could focus more on severe mental health problems."

We were told that, on some occasions, referrals to inreach teams were motivated by perceived 'pressure' from solicitors or prisoners requesting a mental health assessment as part of some defence or appeals procedure. Some inreach teams had in turn felt 'pressured' to assess in such cases. Inreach team participants felt that their role should be to assess only when there was a clinical indication for doing so, i.e. when the referrer suspected that the prisoner had a mental health problem.

While many of London's prisons have a range of counselling services, access to psychological therapies at both primary and secondary care levels in prison is limited. In some cases this is because the staff, especially in primary care, have limited skills in this area. In the case of London's inreach teams, there were few psychologists, and other staff trained in psychological interventions often lacked the time to employ these. The provision of more independent counselling was suggested as a way of supporting prisoners who would not traditionally be eligible for secondary care and, crucially, to provide an 'early intervention' service that might prevent escalation of problems. A further advantage of this was thought to be that prisoners would feel safer talking to someone who was 'independent' as opposed to someone who was part of the prison system, who may be perceived as more judgemental. However, some participants had concerns about the use of counselling, pointing out that counselling sessions could bring "issues to the surface" that prisoners (many of whom have experienced abuse and otherwise quite difficult pasts) had not 'dealt with' previously, and might struggle to deal with now, in what was a stressful environment.

Most prisons employ psychologists. However, their role is limited often to providing group programmes and they do not have the capacity to see prisoners individually.

Communication within the prison

A range of health and social care services are provided in prison and to some extent they mirror the services available in the community while reflecting the specific needs of the prison population. They include substance misuse teams, such as CARATs (Counselling, Assessment, Referral, Advice and Throughcare services,

provided in all prisons) detoxification and rehabilitation services, primary care, prison inreach, inpatient wards and a variety of voluntary sector services. Links between these teams varied from place to place, but on the whole, collaborative working and communication between teams was poor. Participants were often unclear about the roles of other services. It was pointed out that different services had been commissioned at different times, had different commissioning bodies and different targets, yet were often working with the same people. One participant described it as a very "human problem" and said that "people get overwhelmed by huge amounts of problems and don't see the benefit of collaborative working".

In Feltham the inreach team (provided by the local mental health trust) and the outreach team (provided by the prison) work hand in hand. The former carry out monitoring, assessment and treatment services. The latter manage risk assessments (i.e. Assessment Care in Custody and Teamwork – ACCT). However, concerns were raised about the efficiency of this arrangement; "our inreach and outreach team massively overlap... and they have different managers and so it's difficult to bring the teams together".

Communication between services could be problematic where there were different lines of management and accountability. In one prison, difficulties were reported between the forensic service and the prison inreach team as a result of them being provided by two separate NHS trusts and having two different service level agreements.

Commissioning

The deadline for the transfer of responsibility for health care from prisons to the NHS is April 2006, although many PCTs have already taken on this role. In some PCTs the transition had been managed by individuals on secondment from other posts or those with responsibility for partnership working. It was not envisaged that these individuals would continue in these roles and we were informed that in one PCT the post of a commissioning manager for prisons was being advertised. In another the aim was that commissioning health care in prisons would not be a specialist role but part and parcel of all commissioners' roles. Participants were concerned about whether PCTs could find commissioners with sufficient knowledge of both mental health and prisons in order to make informed decisions and build effective partnerships between PCTs, trusts and the prison.

Commissioners participating in the review raised questions about the efficiency of the existing inreach services, especially in the light of the

financial pressures many PCTs are facing: “funding is a big issue as a big chunk goes on the mental health contract... [it's a] combination of massive need but also whether services are being run efficiently”.

Commissioners felt that increased spending on specialist mental health care teams meant that other services, such as primary mental health care, suffered. Commissioners we interviewed said they were reluctant or unable to spend any more on mental health. Equally, however, limited understanding of prisons and mental health may mean some commissioners are not sufficiently alerted to the considerable levels of need among prisoners and the need to consider both primary and secondary care services.

Voluntary sector services

There are a range of non-statutory services providing counselling, link working and advice to prisoners, many of which will provide support to prisoners with mental health problems. They include:

- ❖ The Prison Advice and Care Service (PACT), which provides counselling to remand prisoners in Brixton, Holloway and Wormwood Scrubs and link workers for Holloway's 'First Night in Custody' project. PACT also provides support to the families of prisoners.
- ❖ Women in Secure Hospitals (WISH), which provides information and advice, advocacy, befriending and support at Holloway, with an emphasis on self-help and empowerment.
- ❖ Together (formerly MACA), which provides a range of services across London prisons. In Wandsworth two workers provide mental health assessments and interventions including groups for anxiety, depression and anger management and mental health awareness training for staff and prisoners.
- ❖ Counselling in Prison (CIP), which provides counselling services in Holloway.
- ❖ Prisoners Resource Service (PRS), which provides counselling and advice across London's prisons, including Feltham.

The consensus was that there was a huge need for counselling in prisons and that despite the range of counselling providers, more still was required. There was also a desire for more coordination of not only the statutory teams providing services but also of non-statutory agencies, to avoid duplication and to ensure the best use of resources. This desire was expressed by both statutory and non-

statutory sector participants. As stated earlier there was also a concern that counselling needed to be employed with caution, as it might 'open up' issues (such as revelations of previous experiences of abuse) and other services might then be needed to support the prisoner in dealing with these issues.

Links with community services

Mental health services outside prisons were described as being reluctant to take responsibility for people once they were in prison, even when they were previously on the enhanced CPA. Prison inreach teams were not regularly informed about whether a new inmate was previously in the care of a community mental health team and stated that the community teams appeared to 'wash their hands of people' once they had come into prison.

It was also consistently reported that mental health services were reluctant to accept people released from prison, especially those with substance misuse problems or a personality disorder. Prisons accept people from all over the country and it is not practical for inreach teams to develop relationships with all mental health services. Brixton inreach team stated that it put considerable effort into maintaining contact between prisoners and mental health services, and that it would insist that a prisoner's external care coordinator maintained their responsibility. This was more likely to be successful if the care coordinator came from a locally-based NHS trust.

Transfers to NHS facilities

Inreach participants reported difficulties in locating NHS secure beds for prisoners with marked mental health problems, and also in finding acute psychiatric beds where these were deemed appropriate. Participants said that there were not enough appropriate secure beds available. For both secure and acute beds, organising assessments from the providers of these services was often also reported to be quite difficult and time consuming. Some examples were given of providers being slow to respond to inreach team requests. Some NHS trusts had different points of contact for different resources, making it difficult for inreach teams to liaise effectively. Some trusts overcome this by having a single point of referral (e.g. Central and North West London Mental Health NHS Trust has one for everything from generic services to psychiatric intensive care beds).

One psychiatrist, with forensic training and experience of prisons, reported his frustration when referring prisoners for transfer to an NHS inpatient service. Even in relatively straightforward

cases the response was often slow and sometimes resulted in an assessment being conducted by a junior psychiatrist from the trust, not sufficiently experienced to make a judgement. This led to further delays while the junior consulted senior clinicians in the trust, sometimes with a further delay until a resource was available. It was the view of this psychiatrist that he was sufficiently expert to make a good judgement about the need for transfer; “why can't they just take my word for it?”

A further barrier to ensuring continuity of care for prisoners with mental health problems is disputes over catchment areas. If a prisoner has no fixed abode at the time of entering custody, it may be that they are placed according to the area in which their offence took place. Persuading community services to agree to this has often taken considerable time, even without factoring in the need for the agreement of the locality that the prisoner requires a transfer. (A new transfer policy published during the review (DH, 2005c) has clarified the ‘rules’ in these circumstances and should lead to improvements – see below.) The community consultant psychiatrist needs to carry out their own assessment and the Home Office needs to be consulted about the level of security needed for the individual. Then it may be that more than one opinion is sought if their assessment disagrees with that of the prison inreach team's psychiatrist. If a locality does agree to the transfer, commissioners may dispute responsibility. The cost to the PCT of accepting responsibility is significant, and they may not have factored it into the budget (given that it occurs relatively rarely).

Another reason cited for the problems in linking with community services was the difficulty in planning a person's care pathway. For example, if a prisoner has a planned release date, then teams have something to work towards. However, people can be released unexpectedly or transferred to another prison with little warning, which hinders the planning process. Planned release dates can also be problematic because they are non-negotiable; thus teams are not always able to ensure appropriate continuity of care and resolve ‘catchment area disputes.’ Prison inreach teams do try to ensure that prisoners are engaged in the resettlement process at an early stage and will liaise where possible with the relevant community services including CMHTs, social services, housing and so on.

The *Offender Mental Health Care Pathway* (DH, 2005a), published last year, aims to address the issues of pathways through the criminal justice system for people with mental health problems at each stage from before they enter prison to release.

Additionally, the Department of Health and Home Office have recently published revised guidelines on transfers to the NHS from prisons. The guidelines, which are to be reviewed in 2007 and revised again, are designed to address some of the “unacceptable delays in the transfer of acutely mentally ill prisoners to and from hospital under Sections 47 and 48 of the Mental Health Act 1983” (DH, 2005c). The guidelines make clear the responsibility of commissioning PCTs in arranging transfer and tackle circumstances in which the prisoner has no fixed abode, in which case the PCT where the offence took place leading to imprisonment has this responsibility.

Workforce issues

Most of the inreach teams we visited had one or more vacancies at the time of the review, though the general impression was that recruitment was less of a problem than retaining existing staff. Participants from inreach services described the prison environment as stressful to work in, one describing it as ‘claustrophobic’, as much of the work was performed in confined spaces. The various security restrictions could be frustrating, especially to inreach staff, all of whom come from the wider NHS and a very different culture. Most inreach teams had at some point struggled to establish the team, as some recruited staff realised, within months usually, that the prison environment was not for them.

However, where recruitment and retention issues appeared to be most critical was among prison health care staff. These, largely nurses, are directly employed by the prison and provide general health care, health screening at reception, triage on the wings, support to various sessional specialists (e.g. dentists, chiropodists) and primary care along with GPs. Nurses employed in health care are a mix of those qualified in general nursing and in mental health nursing. On the whole they do not have specialist roles and are expected to provide a range of services. From the mental health perspective some participants felt that health care nurses with mental health training could become deskilled without the opportunity and the support to practise their mental health skills. We were told that most health care services in prisons had vacancies and/or staff on long-term sickness absence. This added to the pressure on existing staff, reducing opportunities for developing their specialism and creating reliance on agency nurses.

We were also told of some difficulties in recruiting prison medical officers and that gaps in these were often filled by locums.

Resettlement

Government policy has demonstrated the need for a coordinated approach to reducing re-offending by supporting prisoners from before sentence through to resettlement (HO, 2003; 2004b). To address this, the Government created the National Offender Management Service (NOMS) which brings together prison and probation services in order to ensure that every prisoner has a clear pathway through the criminal justice system.

From a health perspective alone, this was thought to be a challenging task. There was a consensus of opinion that work done in prisons was often undone when a prisoner was released. One participant said, "we clean them up in prison and send them out to what they came in from".

Another participant informed us that: "we are currently working with a young woman and it is the ninth time of working with her. She won't engage with her own [community] team and [they] will offer her a service but only if she stops her threatening behaviour. She only feels safe in prison and is a prolific self harmer."

This extreme example was echoed in the accounts of other participants describing individuals in distress *because* they were being released from prison to the same situation that led them to crime in the first place. One participant, who had been in prison, commented that "going into prison is devastating but leaving prison is even worse". Thus, it is vital that upon leaving prison, people are well supported and linked in to community services (and that there are services available in the community to support them).

It was thought that there is a need for extra resources to support prisoners released from prison and living in hostels, a lot of whom, we were told, have mental health needs: "clients released from prison who are homeless and stay in the hostel... a lot have mental health needs: depression, suicidal thoughts... [there is] no resource from anywhere to support these people... we are responsible for prison health care but have no extra resources to deal with this...".

The London Resettlement Strategy (London Resettlement Board, 2005) details some of the planned interventions to address the shortcomings it acknowledges in current resettlement provision. The plan specifically addresses mental health needs and its recommendations include:

- ❖ Existing prison information systems should have sections on mental health so that this information is shared.
- ❖ Monitoring systems should be put in place to track prisoners' progress.

- ❖ Consideration should be given to transfer to a local prison for all prisoners with severe mental health problems prior to release.
- ❖ Arrangements should be made to ensure all prisoners are registered with a GP on release.
- ❖ A 'shared care card' should be developed, detailing treatment given in prison, to be given to community services.
- ❖ The feasibility of a 'ring back' service for the most vulnerable ex-offenders (in which they can phone the health care staff from the prison for advice and guidance) should be examined.

The Criminal Justice Act 2003 introduced changes to future probation arrangements, including a new type of sentence, Custody Plus, which is intended to aid intervention in the cycle of re-offending. This sentence will mean that part-custodial sentences of less than 12 months will involve a period of statutory supervision by probation services after the period of custody. The London Resettlement Strategy (London Resettlement Board, 2005) details how London's services are planning to respond to this change in provision as well as how greater joint working will be promoted. One of the challenges to be addressed is meeting the resource requirements of such reform; reportedly there is a national shortfall of 700 probation staff and a 'typical' shortfall of 30% across London's boroughs (Doward, 2006).

Conclusions

Providing mental health care in prison that even approaches equivalence with that provided in the community is an enormous challenge. The mental health needs of prisoners are vast, investment in this area has until recently been minimal and security and custodial issues hold precedence over health care. Nevertheless, the introduction of inreach teams has doubtless brought about vast improvements in the mental health care provision available to prisoners. While transfers to the NHS remain difficult, the impression given to the review team is that there have been improvements in this area too. These improvements are in no small way due to the attention given to this issue at the policy level and the championing on the ground level by inreach teams.

What is also apparent is that there is still much to do. Inreach teams have primarily been aimed at those prisoners with severe and enduring mental illness. It is apparent from talking with clinicians,

though, that prisoners with so-called 'common mental health problems' also often have quite complex needs that prove a challenge for prison primary care and health care services to meet. Many prisoners have a history of impoverishment, neglect and abuse, have poor educational attainment and a chaotic lifestyle, are deemed to have some degree of personality disorder, and in addition to any mental health problem may also abuse substances. Working with such complex needs requires considerable skills and the impression given by our participants is that these are lacking. Consequently, all of London's inreach teams have reported receiving a large volume of referrals for clients falling below their threshold of severe and enduring mental illness.

Prison inreach teams, therefore, have struggled to enforce their thresholds. It is reported that while many prisoners are referred to the inreach teams, significant numbers of those experiencing common mental health problems are given little or no treatment or support.

We believe that the current model of primary mental health care for prisons needs to be rethought and that perhaps a more appropriate model might resemble the intermediate model currently being developed in the community in some parts of England. Box 1 defines the population 'intermediate care' serves in a community (non-prison) setting.

It was felt that not only primary care services, but also non-statutory sector services, had a vital role to play in meeting these needs, as the demand for counselling and advice was great. Furthermore, mental health services need to be boosted at reception and screening to ensure that any emotional or mental health problems are identified at an early stage. In addition to mental health expertise, staff need to be trained to deal sensitively with prisoners when asking personal questions and to be aware of underlying issues such as experiences of abuse or violence.

A prison is an inadequate place to support people with severe mental health problems. Those with the most severe mental illnesses, and those who are not cooperative with care, may find themselves in segregation wings or locked in a cell in a health care wing for extended periods, receiving little or no treatment. Transfers to the NHS, while having reportedly improved since the introduction of inreach, do remain a problem, with a reported difficulty in getting secure beds and an apparent reluctance among external NHS providers to accept responsibility for follow-up care. Additionally, mental health services appear to show reluctance to maintain links with people once in prison, in some cases discharging the person.

Given the number of prisoners who suffer with both mental health and substance misuse problems, addressing the needs of these prisoners should be part of the core business of mental health services in prisons. Some of London's prisons have designed or are designing a care pathway for prisoners with substance misuse and mental health problems, but there are still challenges in terms of information sharing and joint working and in skills. Working with people with personality disorder and mental health problems is another area where mental health professionals and prison health care staff feel they lack skills.

Court and custody diversion schemes were not within the scope of the review originally, but it is apparent that they have a significant impact on mental health services within prisons. We were able to include some participants working in non-statutory diversion schemes and collectively with other participants they provided a critique of London's diversion schemes.

Nacro's data for their national review of diversion also indicated significant gaps and resource constraints in parts of the capital. London's patchy provision results in some people entering custody when a mental health inpatient facility or another resource (e.g. home treatment by one of London's crisis resolution teams) would be, in the view of our participants, more appropriate.

Tackling the needs of prisoners is also hampered by difficulties in maintaining continuity of care. Communication between the wider NHS and

Box 1: Intermediate care

"There is a group of people whose problems cannot be managed with confidence in primary care, but who are not appropriate for secondary care services. This group has the following characteristics:

- ❖ They have continuing mental health difficulties despite several treatment options from primary care, but do not have a severe and enduring mental health problem as described in the National Service Framework for Mental Health (DH, 1999b);
- ❖ Their employment or accommodation is frequently at risk;
- ❖ Their physical health, or another long term condition, is frequently worsened by their mental health problem."

(Hague & Cohen, 2005)

health care services in prisons, for both primary and secondary care, is still generally poor. This is a particular challenge for remanded prisoners and those on short sentences, who may pass through prison before effective links can be established. Considerable thought also needs to be given to information systems that can support continuity of care.

Inreach teams were described as being under-resourced, nurse-led, overwhelmed by referrals and offering a limited range of interventions. The prison service's expectation that prison inreach teams will deal with all mental health problems is in opposition to community models of mental health care, where it is expected that the vast majority of mental health problems will be managed within primary care and only people with severe conditions will be referred to secondary care.

Most of our participants felt that working in prison mental health care is a specialist area and that those working in this field need support in developing specialist skills.

The training needs of inreach staff, health care staff, primary care staff and discipline staff need to be addressed. Participants in this exercise thought that a specific inreach training course should be developed, in much the same way as has occurred for crisis resolution, assertive outreach and early intervention in psychosis services. Prison health care nursing was also felt to be a specialist role that required some dedicated training.

Ideas are beginning to emerge about what skills, competencies and training are required to provide health care in a custodial environment, but more work needs to be done. Prisoners with substance misuse and mental health problems, those with a learning difficulty and mental health problems, and those with personality disorder are not felt to be particularly well served.

It was universally agreed that discipline staff should have mental health awareness training and that this should form part of all prison staff induction programmes. However, it is questionable whether it is realistic to expect inreach teams to deliver mental health awareness training single-handedly. Such an expectation assumes that inreach team members have the necessary training skills. Moreover, pressure on inreach team time has proven a barrier to providing this training to date and is likely to remain so.

All of London's prisons have a number of agencies, services and teams working in them. Participants in this review felt that there was a need for greater coordination and cooperation as the different services often worked with the same prisoners.

Mental health practitioners in prisons should consider adding robust validated tools as part of their assessment process. Participants in this review felt that there should be a more joined up approach to assessments. Obviously this will require issues of confidentiality to be thought through and information sharing protocols to be developed.

The London Prison Mental Health Forum, hosted by the London Development Centre for Mental Health (LDC), provides an opportunity for agencies working in the field of prison mental health to network and share information and good practice. Participants were keen to have the chance to meet other people and in particular emphasised the need for a forum at which NHS and prison staff could meet and discuss issues.

LDC, and indeed CSIP nationally, can play a key role in developing the sort of guidelines that have been available with other reforms of mental health services.

Recommendations

The recommendations are divided into those specifically for London and those which we believe have a wider application.

Primary mental health care in prisons

1. A model of primary mental health care for prisons should be developed and piloted, to address the complex needs of prisoners.
2. The model of primary mental health care in prisons needs to ensure continuity of care with primary care services outside prison.
3. Information systems that are shared between community and prison primary care services also need to be developed.
4. There needs to be more clarity about the role of secondary mental health care in prisons.

Competencies and skills for supporting people with mental health problems in prison

5. A review is needed to clarify the competencies and skills required for working with people with mental health problems, including an ethnically diverse population, for the following:
 - ❖ workers in inreach teams
 - ❖ prison primary and health care staff

- ❖ prison officers
- ❖ non-mental health agencies.

Recommendation for London

A project should be initiated to review the competencies and skills required for each of London's prisons.

Skills mix for inreach teams

6. A review of the skills mix of inreach services should be conducted, addressing the needs of each prison and recognising that different prisons may have different needs. Inreach teams require a mix of workers skilled in: social care, psychological and psychosocial interventions, occupation/activity, dual diagnosis, and others.

Recommendations for London

The above review of competencies should also include a review of skill mix and a training needs analysis.

Collaborative working

7. Integrated methods of working need to be developed between inreach and other agencies working with prisoners whilst on remand, serving a sentence and in preparation for resettlement. This includes information sharing, regular meetings, joint case conferences, and joint working where appropriate.
8. Information sharing protocols and templates need to be developed:
 - ❖ between different specialist services (e.g. inreach and substance misuse teams)
 - ❖ between prison wings and health care/inreach
 - ❖ with the mainstream NHS.

These should include consideration of data protection legislation and satisfying the different agencies' confidentiality policies.

Recommendations for London

LDC should support the pilot of collaborative working in one or more of London's prisons including more 'joined-up' assessment processes. LDC's prison forum should be adapted to include a broader range of prison services (e.g. non-statutory sector and substance misuse services).

Good practice guidelines

9. Good practice guidelines should be developed to support those working with people with mental health problems in prisons. Specific areas that these guidelines should include are:
 - ❖ inreach team development / make-up / processes / practices
 - ❖ inreach to special populations
 - women
 - young people
 - Black and minority ethnic communities
 - foreign nationals
 - remand prisoners
 - dual diagnosis
 - personality disorder
 - ❖ primary mental health care (as for inreach above)
 - ❖ complex care and collaborative working
 - ❖ working with mainstream mental health (& wider NHS responsibilities)
 - incorporating new policy on transfers and how this should be interpreted
 - defining NHS responsibilities for follow-up
 - ❖ commissioners (type of service to commission, relationships with other commissioning agencies and providers in criminal justice field, and monitoring arrangements and mechanisms once a service has been commissioned)
 - ❖ measuring outcomes and auditing practice
 - ❖ care coordination
 - defining inreach role
 - defining mainstream NHS role
 - care plans.

Recommendations for London

A pan London prison strategy for dual diagnosis should be agreed. A pan London prison strategy should be developed for working with people with personality disorder. Entry criteria for inreach teams in London need to be clarified.

Diversion

10. Good practice guidance needs to be developed which describes the type of service that supports police, courts and others in their contact with people with mental health problems and that 'diverts' from custody those inappropriately detained by criminal justice agencies.

Recommendations for London

LDC should support mental health and criminal justice agencies across London in addressing the existing patchy and uneven provision for diversion and liaison.

Glossary

Affective psychosis* involves the combination of a major depressive illness or episode with other features of psychosis.

Assertive Outreach Teams are specialist mental health teams who provide intensive support to people with severe mental health problems with whom mental health services have found it difficult to engage. These teams will have smaller caseloads than community mental health teams and often several members of the team will have frequent contact with a person using their service.

Care Programme Approach (CPA) is a system of supporting mental health service users, introduced in England in the 1990s by assigning them a care coordinator, who manages their care and treatment and oversees regular reviews. The care coordinator works with the service user and others, supporting them in developing a care plan. There are two levels of CPA support, standard and enhanced. Enhanced CPA has more stringent care coordination requirements and is designed for clients with more complex needs.

Community Mental Health Team (CMHT) is a secondary care multidisciplinary team (ideally including at least the following disciplines: community mental health nurses, social workers, psychiatrists, occupational therapists, psychologists and support workers) that will support most people with marked mental health problems in the community. CMHTs see people in their homes, at clinics and outpatients, but will ideally also support people on their caseload who are inpatients.

Crisis Resolution Teams are specialist teams that work with people in mental health crises, particularly to prevent admission to an inpatient bed and to provide intensive home treatment for a limited period as an alternative.

Delusional disorders* are a form of psychosis and tend to involve deeply held beliefs that the person is in danger, and/or is being conspired against; these delusions may seem plausible at first but are resistant to reason. Delusional disorder was termed as paranoia in the past.

Neuroses** are a group of common mental health problems that include most types of depression and anxiety.

Personality Disorders** are generally not described as mental illnesses but as a distinct set of problems and there is much debate about validity of such 'diagnoses'. People deemed to suffer from a personality disorder often have problems in relating with others and their behaviour may be deemed at odds from what is regarded as acceptable in our society ('antisocial').

A **Psychosis**** is a severe mental health problem and is quite rare when compared to neurosis. It involves distortions to a person's perception of reality. They may experience hallucinations and have delusional thinking.

Psychiatric Liaison Services are mental health services that link with medical services providing support/advice to health care practitioners and direct interventions to people with mental health problems. They may also assess patients with mental health problems at accident and emergency departments.

Psychostimulants* include drugs such as cocaine, crack cocaine and Amphetamine.

Schizophrenia* is a group of psychotic disorders where the person will experience marked disturbance in their thinking. People with schizophrenia will suffer from two or more of the following:

- ❖ Delusions
- ❖ Hallucinations
- ❖ Incoherent / disorganised speech
- ❖ Disorganised behaviour /extremely excited behaviour or stupor (catatonic behaviour)
- ❖ Negative symptoms such as being very flat or lacking volition.

* Adapted from: http://www.psychnet-uk.com/dsm_iv/

** Adapted from: <http://www.mentalhealth.org.uk>

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