

REPORT

Centre for
Mental Health



Mental health and criminal justice

Views from consultations across England & Wales



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Executive Summary

It is estimated that as many as 90% of prisoners have some form of mental health problem, personality disorder, or substance misuse problem. In seeking to determine how the mental health of the prison population can be improved, Centre for Mental Health was commissioned by the Department of Health and the Ministry of Justice to conduct a consultation. The consultation reviewed the experiences of people with personal or professional knowledge of the interfaces between the criminal justice system and mental health services. The consultation was conducted via 17 events held across England and Wales, and also by a small number of one to one interviews and meetings with small groups of stakeholders. Over 200 people took part in the review. The views reported are those of the stakeholders who took part, where there was a general consensus of views. We cannot claim that the ‘findings’ of this consultation are entirely representative of the whole interface between criminal justice and mental health. However, there was a marked consistency in what was reported across all events held in England and Wales.

The events all took place in February 2015, but Centre for Mental Health has conducted other work in and around prisons mainly in the West Midlands and London since then, which do not indicate any significant differences to our original findings.

Key Findings

Commissioning

Few clinical commissioning groups (CCGs) prioritise health care provision for people leaving prison, courts or police custody, or for those in contact with probation services.

There are a number of commissioning organisations responsible for offenders with mental health difficulties, and this can lead to clashes or gaps between them.

Impact of cuts

Cuts in criminal justice services were widely cited in our events as having a negative impact on the care and treatment of vulnerable people,

particularly those in prison: for example by reducing numbers of prison officers available to escort prisoners to appointments. There are of course other factors, such as increased and changing demand in prisons. Whilst reduced staffing was consistently reported by those working in prisons, only a minority of prisons were represented (approximately 20).

Training in mental health awareness

Professionals working in prisons who attended our events reported that mental health awareness courses for prison staff are poorly attended, for a range of reasons. Training for police officers was more positively received. Probation staff who had been trained in mental health also reported that it had been helpful to them, but access to training, especially for those working in the Community Rehabilitation Companies was reported to be limited.

Information sharing

We found that information exchange within and between mental health and criminal justice services has improved markedly, where Liaison & Diversion services are in place. These services were reported as providing sentencers with relevant information which was felt to reduce delays and the need for remand to prison. Where such services were not in place, delays were reported to be common and mental health advice was hard to come by.

Prison mental health care

Primary mental health care remains the weakest element of mental health support within prisons. The complexity and severity of need among prisoners requires a level of resourcing and specialism that is currently lacking in the health care of the prisons represented. Few of the prisons represented reported being able to offer psychological interventions

Transfers to hospital

Transfers to hospital remain a major problem in many prisons, with delays of 3-4 months frequently reported, especially when seeking an ‘out of area’ bed.

Services for people with personality disorder

Services for people with personality disorder and who pose a high risk of harm were highly regarded among the people we met. Some now provide Psychologically Informed Planned Environments (PIPEs) with higher staffing levels and multidisciplinary teams. Other prisons and approved premises are developing Enabling Environments to provide a supportive environment for staff and residents (Standards for Enabling Environments are a development by The Royal College of Psychiatrists, and are not specific to offenders or those with personality disorder).

Resettlement

Leaving prison remains problematic for people with mental health problems, with little continuity of care. ‘Through the gate’ interventions are widely supported but access to these is limited.

Probation

Probation services had been disrupted by Transforming Rehabilitation reforms but in most areas were settling down by early 2015. Dedicated mental health resources were thought to be essential for all probation services.

Mental Health Treatment Requirements

Mental Health Treatment Requirements for people on community services remain rare. The biggest barrier is the lack of mainstream community mental health care available at the point of sentencing.

The interface between mental health & criminal justice in Wales

In Wales, the 2010 Mental Health Measure had improved access to mental health services but it was reported that the lack of an equivalent to the national Liaison & Diversion programme in England meant that people who could be diverted were being missed in police custody. Where Welsh Liaison & Diversion schemes did exist, these were largely focused on adults with severe mental illness rather than the broad range of vulnerabilities and all-age response given by the new services in England.

Key themes

Some consistent themes emerged regardless of the part of pathway that was being discussed. Our participants felt there was a need for:

- Robust screening and assessment processes for a range of vulnerabilities in all justice settings;
- Wider availability of support and care for people’s vulnerabilities regardless of setting;
- Providing pragmatic and practical support (e.g. with housing and debt) at critical periods (e.g. on release from prison);
- Adopting a psychological and trauma focused approach across all justice services and providing training in these for all who work in them;
- Increasing access in both the community and custodial settings to psychological interventions that are adapted to reflect complex and multiple need;
- Increasing the use of mentors and peers, and the voice of service users in the planning and provision of services.

Achieving such changes and reforms is difficult to achieve at any time and especially during such a straitened fiscal time. But it is likely to bring about better value for money both short-term and over people’s lifetimes. Joint working, joint budgets and creative thinking are called for. And it is vital that CCGs and local authorities engage in meeting the health and care needs of some of their most vulnerable citizens.

The following ideas for changes and improvements emerged from the consultation findings:

1. Commissioning

Clinical commissioning groups (CCGs) need to take the lead role in commissioning health services for people leaving custodial settings in their local areas. This would be facilitated through closer working between CCGs and their local probation providers. The role of CCGs in supporting probation and offenders in the community (on community sentences and

following release from prison) could be written into the next NHS Mandate. New guidance from NHS England could set out clear expectations for CCGs. One expectation would be CCGs enabling local community mental health services to give sufficient priority to the provision of Mental Health Treatment Requirements, through variation in local contracts where necessary. There is a need for some national oversight to ensure a consistent and equitable approach is taken and this is a role that could be filled by NHS England. The Welsh Assembly should provide similar guidance and oversight to Welsh health boards.

2. Training and workforce development

There should be a joint commitment across Ministry of Justice, Home Office, Department of Health, NHS England and the Welsh Assembly that all professionals in criminal justice should receive mandatory mental health awareness training (and periodic updates) that helps to achieve a psychologically informed approach to managing offenders.

3. An operating model for prison mental health care

It would be helpful for NHS England and the Welsh Assembly to develop a national framework for prison mental health care, similar to the English Liaison & Diversion services. The consultation exercise suggested that the following elements would be helpful:

- A.** Based on a stepped-care model, offering primary as well as secondary care and a range of NICE approved psychological therapies. Guidance published by the Royal College of Psychiatrists and forthcoming NICE guidelines may provide a starting point for this framework.
- B.** This should include designing evidence-based pathways and programmes for a range of vulnerabilities including mental health problems, ADHD, learning disabilities, personality disorder, acquired brain injury, dementia and autistic spectrum disorders. The framework should also address the needs of young people in transition, older prisoners, women, people from different ethnic and cultural communities and foreign nationals.

- C.** The aim should be to ensure parity of esteem for people in prison with mental health problems and related vulnerabilities. Parity in this context means both equivalence to the care offered outside the criminal justice system and equality with physical health care.

- D.** The vehicles for monitoring quality should reflect the Framework and be informed by service user measures of quality.

- E.** Guidance should be produced by NHS England and the Welsh Assembly on the prison mental health role in resettlement, 'through the gate' support, and on how Clinical Commissioning Groups (CCGs) should work with probation providers. This should be monitored by the appropriate regulatory bodies.

- F.** NHS England, the Welsh Assembly and Ministry of Justice should work together to make mental health reports for Parole Boards a commissioned activity.

4. Transfer to secure mental health care

NHS England, the Welsh Assembly and the Ministry of Justice should take urgent steps to speed up transfers from prison to secure care, particularly where these occur outside local areas.

- A.** A rationalised process of assessment should be included in this reform, where a single competent gateway assessment takes place rather than multiple assessments, regardless of where a bed is being sought. A time limit for the assessment to be conducted should be set at the point of request.
- B.** If an assessment indicates a need for transfer, this should happen within a set time limit (14 days).
- C.** NHS England and the Welsh Assembly should oversee and monitor the timely transfer under the Mental Health Act.

5. All prisons as Enabling Environments

The Ministry of Justice, Department of Health, NHS England and the Welsh Assembly should jointly work towards all prisons achieving

the Royal College of Psychiatrists' Enabling Environments standards. This could include a far greater role for service user involvement including peer mentoring type interventions to support prisoners with vulnerabilities. It should include training of mentors and research into the impact of these Enabling Environments.

6. Release from prison as a 'time of crisis'

Release from prison should be treated as a time of 'crisis' for people with marked vulnerabilities, and covered by the Crisis Care Concordat in England and an equivalent policy directive in Wales. Targeted 'through the gate' support for people with poor mental health and related vulnerabilities should be the joint responsibility of NHS England (to the point of release), CCGs, and the National Probation Service and Community Rehabilitation Centres. This should include a pre-release engagement and time-limited support post-release that includes the provision of health and care support (including psychological interventions adapted for people with complex need) and help with basic needs and advocacy. Mentoring and peer mentoring should form part of the response to supporting people leaving prison. Similar support should be provided for people in Approved Premises.

7. Mental health support for probation providers

CCGs should commission effective mental health support for probation providers in their work with people with mental health problems on community sentences. At the very least consultation surgeries could be provided, but timely access for probation clients to a therapy service may require a variation in contract for local mental health providers.

8. Court reports

Court psychiatric reports should always be provided by psychiatrists who work with offenders, understand the needs of the courts and who work locally and can make connections with local services. Her Majesty's Court Service, NHS England and Welsh Assembly should work together to achieve new contracting arrangements or templates for them, that ensure consistency and quality of psychiatric reports to courts.

Chapter 1: Introduction

Centre for Mental Health was commissioned by the Department of Health and Ministry of Justice to support a review of the interfaces between the criminal justice system and mental health services. The review was a broad one covering all parts of the pathway beyond the development of new services such as Liaison & Diversion in courts and police custody.

The review had been prompted after ministerial concerns were voiced over the state of prison mental health care in September 2014, which saw a reported increase in suicides by prisoners.

Centre for Mental Health was asked to run consultation events for people with experience of the criminal justice system and its interface with mental health services across England and Wales during February 2015, and to provide an independent report on the findings.

Scale of the issue

It is almost two decades since the most robust study of psychiatric morbidity in prisons was conducted across England and Wales (Singleton *et al.*, 1998), and almost a decade since some smaller-scale robust studies were conducted (Harding *et al.*, 2007 and Stewart, 2008). All of these told us that prisoners suffer significantly greater psychiatric morbidity than the general population (see table 1) and that even within prisons there is variation; for example, that male remand and female prisoners have greater levels of need (see table 2). Recent analysis of data on a longitudinal survey of newly sentenced prisoners (1435 people sentenced in 2005-2006; Stewart, 2008) found that 16% of the sample reported symptoms indicative of psychosis. This was considerably higher in female prisoners, 25% of whom reported symptoms indicative of psychosis (males = 15%). Male prisoners with psychotic symptoms were 10% more likely to reoffend within a year after release than other male prisoners in the sample. There were no differences in reconviction rates between women with and without symptoms (Light *et al.*, 2013).

However, we have less information about other

parts of the criminal justice system. A single study of the probation service found that around 40% of people on probation have a current mental health problem (Centre for Mental Health, 2012a). A survey of those on community orders (between October 2009-December 2010) found that 35% of offenders had a formal mental health diagnosis and 29% reported having a current mental health problem. For female offenders the proportion reporting a current problem was much higher (46%) (Cattell *et al.*, 2013). Data on police contact with people with mental health problems suggest that between 15-40% of police contacts are with people with mental health problems and related vulnerabilities (Home Office, 2014 and ICMHP, 2013).

Personality disorder features prominently in the prison population and is likely to be highly prevalent in both probation caseloads and police contacts. Prisoners seldom have a single problem or vulnerability and typically will have multiple and complex needs. Histories of trauma, unhelpful use of substances, poor relationships, poor life skills, learning difficulties and learning disabilities, acquired brain injury, poor education and work histories are all common among prisoners, and make the provision of care and support all the more challenging.

Table 1: Mental illness among prisoners and the general population

	Prisoners (%) ¹	General population (%) ²
Psychosis	8	0.5
Personality disorder	66	5.3
Depression or anxiety	45	13.8
Drug dependency	45	5.2
Alcohol dependency	30	11.5

¹ Singleton *et al.*, (1998)

² Singleton *et al.*, (2001)

Table 2: Mental illness among sentenced and remanded prisoners

	Sentences		Remand	
	Male (%)	Female (%)	Male (%)	Female (%)
Psychosis	6	13	9	13
Personality disorder	64	50	78	50
Depression or anxiety	40	63	59	76
Drug dependency	34	36	43	52
Alcohol dependency	30	19	30	20
Suicide attempt in last year	7	16	15	27
Self-harm (not suicide attempt)	7	10	5	9

Singleton *et. al.* (1998)

Chapter 2: Methodology

The events

A total of 17 events were held across England and Wales.

The timetable for the consultations was limited and the events were organised over a three week period. Existing Centre for Mental Health, Ministry of Justice, Department of Health, Welsh Assembly and NHS England contacts were used to establish the events and invite lists. Additionally local area NHS England commissioners were contacted and invitations were sent via the Royal College of Psychiatrists' Quality Network for Prison Mental Health Services (the College had conducted a recent national consultation into prison mental health standards).

- London (x4 covering London and South East)
- Birmingham (x2)
- Cambridge
- Dorset
- Huntingdon
- Leeds
- Newcastle
- Nottingham
- Stafford
- Swansea (x2)
- Warrington
- Wrexham

In addition, 19 key stakeholders (who were unable to attend the events but still keen to participate) were involved in one-to-one interviews and small groups. Just over 200 people contributed to the consultation overall. The events, small groups and interviews were facilitated by a single interviewer and all consultations took place in February 2015.

All events, groups and interviews were recorded (in excess of 60 hours) and mind-mapped for ease of analysis. The mind-mapping took place initially as a form of note-taking during the consultations, and were further developed by repeated listening to the recordings as part of the analysis. The interviewer conducting the data collection also conducted the analysis.

The questions set out in the topics section (page 11) were used to provide an initial coding framework for analysis and the data were explored to find evidence about each item and for additional themes that emerged during the discussions. These questions were developed initially following a brief literature review, particularly of certain areas of current policy, and then developed in consultation with those steering the review, and representatives from Ministry of Justice, Department of Health and NHS England in particular.

All those taking part were assured confidentiality. In places, quotes have been altered to maintain confidentiality.

Limitations

The evidence for this report was largely collected at 17 events, and is therefore representative of the views of those who attended. It may not apply more widely, as if other events had been held elsewhere our findings might have differed.

However, there was a sufficient consistency of experience reported across all events, and overlap with other Centre for Mental Health review work (see Durcan *et al.*, 2014, Durcan 2014a & 2014b), for us to conclude that the findings are likely to be reflective of the 'state of play' across both England and Wales.

Since concluding the last of the events, Centre for Mental Health has had the opportunity to review at least some of the issues and findings raised in the consultations through other programmes of work, particularly those relating to Liaison & Diversion, prisons and resettlement. This work has been conducted in South Wales, London and the East and West Midlands.

Who took part?

A very broad range of stakeholders contributed to the consultation events and interviews:

- Former prisoners and mental health service users;
- Prison governors;
- Police and Crime Commissioners;
- Police;
- Sentencers and Court services;
- National Probation Service;
- Community Rehabilitation Companies;
- Carers;
- Inspection bodies;
- Voluntary sector and special interest groups;
- Local health commissioners;
- Specialist & offender health commissioners;
- Public health services;
- Mental health teams in prisons (primary mental health care, inreach and other teams – e.g. psychological therapy services);
- Forensic mental health;
- Prison health care;
- Community offender health services;
- Professional organisations;
- Local authority representatives;
- Mentors, including peers.

Topics and themes explored in the consultation

The consultation covered a broad range of issues and although Centre for Mental Health's brief did not include Street Triage and Liaison & Diversion from Courts and Custody, participants at all events wanted to include these in their discussions to describe a 'whole pathway' approach. At all events there was an emphasis on intervening as early as possible and at "critical time points", such as meeting the police at a time of crisis, on arrest or when in court, but also on release from prison.

The following topics/areas were covered in the consultation events:

- Street Triage;
- Liaison & Diversion;
- Prison mental health care;
- Enhanced regimes, e.g.:
 - o Personality disorder –PIPEs
 - o 24 hour health care
 - o Specialist mental health care
 - o Therapeutic Communities
- Transitions;
- Transfers to & from hospital;
- Leaving prison and continuity of support;
- 'Through the gate' interventions;
- Working with probation;
- Alternatives to custody & courts;
- Reports for parole boards and courts;
- Mental Health Treatment Requirements.

For each of the topics we discussed:

- What is the current experience?
 - o Strengths
 - o Weaknesses
 - o Gaps
 - o Good practice examples
- What needs to be in place?
- What is the experience for different groups, e.g.:
 - o Women
 - o Veterans
 - o Young adults
 - o Older prisoners
 - o People from BME communities
 - o Foreign Nationals
 - o People with particular diagnoses or challenges (e.g. autism spectrum disorders, hearing problems, learning disabilities, acquired brain injury, attention deficit hyperactivity disorder).

The events took between two and four hours.

Chapter 3: Overview of the system

From our conversations with participants and other recent review and research work, a picture has emerged of what an ‘end to end’ system for providing services for people with mental health problems in the criminal justice system could look like (with some commentary on the current state of services).

Stage of pathway	Service	Definition
Early Intervention	Street Triage	An intervention involving mental health practitioners working directly with police, either via joint patrols, or via radio and phone from police control centres or via dedicated phone service. Though primarily aimed at reducing the use of section 136 of the Mental Health Act, it has been reported to Centre for Mental Health that it can also prevent other arrests.
	Liaison & Diversion	Liaison & Diversion services are those that work in courts, police custody and in youth offending teams to ‘divert’ people with mental health problems and related vulnerabilities. These services date back to the late 1980s and are found across the United Kingdom. However, NHS England radically reformed these services in a programme of development to create for the first time a standardised model that covers multiple vulnerabilities, all ages and (since April 2015) 50% of the English population. People with drug and alcohol problems may also be supported by Liaison & Diversion teams or by a dedicated specialist service.
	Practical support	Liaison & Diversion services may also have community support/link workers as part of their service. This is in recognition that people in contact with the justice system often have complex and multiple needs. These workers will provide some time-limited support to help offenders engage with a range of services (e.g. health and housing). There are other good practice models such as that provided by Community Advice & Support Services (CASS) in magistrates courts in Devon and Cornwall (see Durcan, 2014b).
	Adapted psychological treatment	Largely unavailable but would form part of the Increasing Access to Psychological Therapy (IAPT) offer in all localities. Essentially, easy access to the provision of evidence-based interventions that are adapted to reflect the complex needs of the user.

Stage of pathway	Service	Definition
Alternatives to custody and community	Mental Health Treatment Requirements	The least used of the 3 treatment requirements available as part of a community order. On the whole, where available, these are provided by a mainstream community mental health service. This is described more later.
	Probation caseloads	The availability of psychological and other mental health interventions directly to people under probation with either the National Probation Service (NPS) or a Community Rehabilitation Company (CRC). Probation services have found it difficult to engage mental health services in providing this support (often due to high entry thresholds) except via a specific contract. A key offer would be adapted, evidence-based psychological interventions.
	Probation consultation	Several probation services have contracted mental health services to run consultation surgeries where probation officers seek advice on the management of cases.
Custody	Mental health inreach	Mental health inreach teams were originally intended to provide an equivalent service to a community mental health team, i.e. they have a secondary or specialist role to work with those who have severe mental health problems, including those with severe and enduring poor mental health. This is largely still true, though some have merged with primary mental health care. The notion of mission ‘creep’ or ‘stretch’ is discussed later.
	Primary mental health care	Primary health care services comprise the same elements as in the community, with general practitioners (GPs), nurses, dentists and so on. The mental health care element, for those with mild to moderate mental health problems, is provided by GPs (for medication) and largely otherwise by nurses who in many prisons have general nursing responsibilities, as well as a mental health qualification. The complex and multiple nature of need in prisoners provides major challenges for this type of provision, and primary mental health care services have been seen as the weakest element of the pathway.
	Adapted psychological treatment	A limited number of prisons have access to clinical psychologists or nurse therapists who can offer adapted evidence-based psychological interventions, for different levels of need (including the equivalent of IAPT-style services for people with complex and multiple needs).

Stage of pathway	Service	Definition
	<p>Special regimes:</p> <ul style="list-style-type: none"> • PIPEs • Enabling Environments • Therapeutic Communities • 24 hour health care 	<p>Psychologically Informed Planned Environments (PIPEs) are described later but consist of a small number of units provided within prisons (and some other settings) for those likely to have a severe personality disorder who pose a high risk of serious repeat offending. Likewise, services that have achieved the Enabling Environments Quality Mark (Royal College of Psychiatrists) and Therapeutic Communities (in prisons) are limited in number and described later.</p> <p>Some prisons have wings that provide a type of inpatient bed and at least some limited health care provision at night and at weekends as well as during the working week. Prisons without these can refer prisoners to one within their region.</p>
<p>Release from Custody - resettlement</p>	<p>Through the gate Follow-up</p>	<p>There are a variety of ‘through the gate’ initiatives and most prisons have access to at least some limited post-release support. This should increase with the introduction of CRCs who have a post-release responsibility for any person released after a sentence for a mild or moderate risk offence. ‘Through the gate’ initiatives often involve some engagement prior to release, may involve being met at the point of release and offering some time-limited support post-release. Peer mentoring can form part of the offer. A very small number have specifically targeted people with mental health problems and learning disabilities. NHS England has piloted such an initiative for people with drug and alcohol problems in the North West of England. In addition there are a variety of post-release support initiatives. These can include quite intensive community support such as was provided by Elmore Community Services in Oxford but also include volunteer mentors such as those provided by Sova.</p> <p>‘Engager’, a ‘through the gate’ and post-release intervention for prisoners with common mental health problems is described later.</p>

Chapter 4: Consultation findings - commissioning

The role of clinical commissioning groups

All of our participants at the 14 consultation events in England saw clinical commissioning groups (CCGs) as having a crucial role in supporting continuity of care, diversion and early intervention with people in contact with the criminal justice system. Commissioning in England (when compared to Wales) is complex and there has been much reform in recent years. This may have resulted in some confusion over commissioning responsibilities.

Commissioners from CCGs attended some of the consultation events and several of them were funding initiatives for diverting former offenders. For example, several were joint funders of pilot Street Triage schemes, and were persuaded by the benefits of investing in 'diversion'. However, by and large, the perception of most participants at the consultation events was that CCGs do not see it as their role or as a priority to invest in services for people leaving prison, police custody or the courts or for those involved with probation.

"...CCGs have lots of competing demands on their resources..."
(CCG participant)

Similar statements to the above were made by a range of stakeholders across several events.

At around half of the events, participants reported that local CCG commissioners considered 'offenders' to be the domain of NHS England. NHS England is responsible for commissioning services provided in police custody, courts and prisons, and it was the perception of our participants that some CCGs do not realise they are responsible for resident offenders once people have left these settings.

"...I don't think they get that an ex-offender in the community is their business....if they hear "offender" they think it's NHS England's job..."
(Prison health participant)

A particular area of concern at events attended by probation, CRCs, court officials and sentencers was that of the Mental Health

Treatment Requirement (MHTR). This will be discussed in more detail later.

"...this is a very difficult area for CCGs to see [what] they need to do...as far they are concerned they commission community mental health teams to provide community care so the MHTR is covered...it is hard to engage them long enough to see [that] some sort of priority needs to be given for MHTRs to work..."
(Probation participant)

"...it's hard to demonstrate the saving to health, though doubtless there is one....so they see the courts benefitting and think they should fund them.....it's the same to a degree with Street Triage..."
(Manager of community criminal justice mental health service)

"...The sad thing is they are going to spend money on these people in any case, on Section 136, at A&E....but it's difficult to persuade CCGs to invest in earlier intervention and not just in crisis ... surely it would save money..."
(Police participant)

Other local commissioning bodies

"...the people I work with have lots of problems and issues....they're complex... it's not just the NHS but also councils....they all have to see they have a part to play..."
(Prison inreach service manager)

"...the single biggest problem is housing, nearly all of them are homeless or on the verge of it... there is a massive role for housing departments and councils here..."
(Voluntary sector participant working with people released from prison)

A more mixed view was given by our participants of the part played by local authorities, but it was recognised that councils had experienced significant cuts in funding and that this would continue to be the case for the rest of this decade "at least".

"...it begs the case for joint budgets..."
(Local authority participant)

“...all local commissioners should sit down and prioritise the top 100–150 people with complex needs and commit to jointly fund services for these people...”

(NHS England participant; Police participant – nearly identical quotes at different events)

The role that Police and Crime Commissioners play was generally commended and in most areas there was reported investment from PCCs or at the very least an interest in investing.

“...it’s funny...they are the new kids on the block...but they seem to have ‘got it’ straight away...”

(Liaison & Diversion participant)

Commissioning clashes

“...we are meant to be working together but NOMS commissioning doesn’t seem to take any or enough account of health...”

(Senior mental health prison clinician)

Such “clashes of commissioning” were reported at all events where prison mental health professionals were represented, which was the majority of events. However, representatives of criminal justice services (albeit with less consistency) also reported that health commissioning did not take into account the needs of the criminal justice services that health services were being commissioned in.

Several examples were given. One was the ‘re-rolling’ of a prison by NOMS to serve a different population:

“...the needs of [the new population] are very different to those of [the prison’s current population]... and we are expected to make the changes to our team in a matter of weeks...there appeared to be no understanding of what was involved for us...”

(Inreach participant)

Likewise, criminal justice practitioners and representatives who spoke about NHS commissioning complained of a lack of consultation and acknowledgement.

“...we have lots of people on our caseloads with some sort of mental health problem....we can’t get them into mental health services...health commissioners need to find a way to provide a service to us...”

(Probation Manager)

Different strands of commissioning within NHS England

At one event it was pointed out that it would be desirable to commission pathways for individuals, and particularly those who require entry to secure mental health care. Participants stated that funds need to follow the person. This was difficult when an individual moved to services funded by different commissioners, e.g. NHS England to a CCG; but it was also the case within NHS England if a patient moved between services funded by different commissioning strands (e.g offender health funding and secure care); the funds failed to follow the patient.

“...you hit these barriers every time you move between services...”

(Probation participant)

“...It would be great if the funding followed the person or funded the pathway...”

(NHS England participant)

“...we can say “no they don’t need secure care” and state that they need some other form of care...but we can’t make that happen because we don’t fund it...”

(NHS England participant)

The impact of procurement

All prison mental health services represented at events had recently experienced (within the last 18 months) or were currently undergoing procurement exercises, where NHS England was putting out to tender the current prison health contracts. These were universally reported as “incredibly disruptive”.

The tender process was reported as taking 12-18 months, during which it was commonly reported that there would be staff losses.

“...I know good staff are always going to move on, but if there is any uncertainty, they are not going to hang on....I lost three really experienced people...”

(Inreach manager participant)

“...procurement has a negative impact during the process and after....even if you win the contract...”

(Inreach participant)

Chapter 5: Consultation findings - prisons

The context of prison mental health care

At all events there was significant discussion about the context in which prison (and other) mental health care was provided. The following are commonly cited issues which both health and justice representatives report as having an impact on the ability to work effectively with people with mental health problems, learning disabilities or other vulnerabilities.

“...we have too many people in prison....it’s hard to organise anything that’s not chaotic....it’s hard to do mental health care....it’s hard to do anything...”

(Senior prison service participant)

Though falling out of the remit of the consultation, two events had lengthy discussions about sentencing policy and the need to drastically reduce the prison population in order to work effectively.

However, at all events, significant cuts to criminal justice services were cited as negatively impacting on the care and treatment of vulnerable people. From all the prisons represented at the events, participants reported that there had been “*drastic cuts*” to prison officer numbers.

“...there are very few staff on the wings now...”

(Inreach participant)

“...all the most experienced guys in our prison have taken redundancy and left...there are fewer staff and they are much less experienced...”

(Prison health care)

“...there is a lot less time spent out of cells...”

(Former prisoner)

“...I can’t see that being locked up in a small space most of the day is good for your wellbeing...”

(Former prisoner)

“...in the past I could go and have a chat with my personal officer....that had all gone out the window this last time (most recent spell in custody)...there are not enough staff and they have no time...”

(Former prisoner)

In Centre for Mental Health’s experience, non-attendance rates for mental health appointments in prisons have always been high, and participants at these events reported that rates have become even higher. A non-attendance rate of 30–50% was reported at our events. Escorting by prison staff was seen as a major issue. Staff shortages were reported as the main reason for this, as these affected the ability of staff to escort prisoners.

The design of some prisons more naturally allows for wing-based health consultations (i.e. rooms that are both safe and allow for confidential exchanges, which reduces the reliance on staff escorts) whilst others are not.

Prisons and other criminal justice services should “*see poor mental health and supporting mental wellbeing as part of their mainstream business...and not just the responsibility of a visiting service...*” (senior prison-based clinician).

Mental health awareness

Mental health awareness training for prison-based staff was reported as poorly attended at all events where mental health practitioners working in prisons were represented (most events). According to our participants, planned training was often cancelled due to undersubscription, and it was prison wing-based staff who were deemed to most need training and be least likely to attend. Views across our participants were split as to why this was, but cuts and shortages were frequently cited.

“...staff just can’t be released to attend training...”

(Senior prison service participant)

“...to be honest I am not sure what good awareness training would be at the moment... there are so few staff and much less prisoner-officer interaction than in the past...”

(Senior prison-based clinician)

But not all participants entirely agreed that this was the reason.

“...mental health is not prioritised... our prison regularly goes into lock-down to allow release of staff for training... but mental health awareness training is never on the list...”

(Inreach participant)

“...it’s down to the governor.....if they are interested then things tend to be better...”

(NHS England participant)

Some mental health practitioners reported engaging in what one participant labelled *“smart awareness training”*. As one participant working in a prison in the South East reported, this involved the mental health team visiting a particular wing and spending much of a shift there, spending time with officers and offering more ad hoc awareness training.

Awareness training for police was reported more positively; in all force areas we visited, police were engaged in training.

“...a significant factor is it’s mandatory... but officers recognise they meet people with vulnerabilities every day...”

(Police participant)

Street Triage schemes and Liaison & Diversion services were seen as having a significant impact on police awareness.

The picture for probation was a mixed one. In some areas, many if not most officers had undergone some form of awareness training, and in particular the Knowledge and Understanding Framework (KUF) awareness training on personality disorder. This was seen as valuable and very useful. A participant who had delivered training on the KUF to staff in a probation hostel reported how positively it had been received: *“it was like a [road to] Damascus moment for these staff”*. They recognised what was being described and found it useful to have an explanation of why some of their clients reacted and behaved as they did. Some probation officers attending events had also received broader awareness training, but this was reported at only two events.

“...the bulk of people my team work with have some form of mental health problem or personality disorder...without training we are working in the dark...”

(Probation participant)

About a third of the probation services represented (both NPS and CRC) had direct access to mental health practitioners either currently or in the recent past, and (like the police) reported positively on the impact of their work, claiming greater awareness as a result of being able to directly consult practitioners. Most of these contracts, if still current, were due to end by April 2015 with uncertainty as to what would follow.

New Psychoactive Substances

The use of synthetic forms of cannabis (so-called ‘legal highs’) and other drugs was reported as an issue for both custodial and community settings, but most of the discussion at the events concerned the impact on prisons. At one event in the North of England, prison health care staff stated that two inmates had experienced seizures that day and that ‘legal highs’ were suspected. In other Centre for Mental Health work in the Midlands (a project that works with 7 prisons), it is apparent that this continues to be an issue.

Several health practitioners in prisons described the use of legal highs as a *“crisis”* and that their use was seen as having risen significantly in the 6-12 months prior to the consultation. At the time of the events there were no reliable means of detecting and testing for their use. Knowledge of the drug use came occasionally by discovery of the drugs themselves, but mainly from self-reporting.

The perceived impact of such drugs were seizures and increased rates of psychosis -

“...it’s frightening how rapidly people can become psychotic...”

(Inreach participant)

“...they are making people very unwell...I’d much prefer people took skunk...”

(Prison health care participant)

In two prisons, represented at two separate events, it was reported that new substances (so-called ‘legal highs’) had been tested on vulnerable inmates first by other inmates before they would risk taking a substance themselves.

Information flows and exchange

Silo working and poor information exchange have long been a complaint of all agencies working in criminal justice and in particular in the prison estate. However, in recent years there have been significant improvements. It was reported that the transfer of health information between prisons was seen as a much less difficult issue since the introduction of the TPP SystemOne electronic information system, which provides transfer of health information between prisons.

Where there were NHS England National Liaison & Diversion pilots in place (covering areas representing 22% of the English population at the time, extended since April 1st 2015 to 50% (NHS England 2015)), the exchange of information, particularly concerning health between prisons and courts, had reportedly improved. Practitioners in the new pilots in England have made an effort to develop (previously non-existent) links between themselves, inreach and health care services in the local prisons that primarily serve the courts they work with. But for most of England and Wales, as represented at these events, the information exchange between courts and custody was deemed to be poor.

Obtaining information from community mental health services was often difficult for criminal justice staff. One court-based probation officer stated:

“...it can take days and sometimes longer just to find out who I need to speak to...”
(Probation participant)

The availability of mental health practitioners, such as via a court Liaison & Diversion service, made an “*enormous difference*” to accessing health information:

“...X has access to the Trust’s information system, plus she knows who to phone...it’s unusual for her not to get the information on the same day...”
(Probation participant)

Prison primary care

“...the prison mental health care at [a women’s prison] was excellent ...but for only people at the apex...there is very little for people below this level, many of whom have marked need...”
(Senior prison-based clinician)

“...where is that person that states that ‘we have this proportion of people with this problem’ and ‘this proportion of people with that problem’ and then setting up a service to meet that [sic]... instead we have prison inreach, where most [of] the people don’t meet the entry criteria...what is the use in that?...”
(Senior prison-based clinician)

Prison primary mental health care has long been identified (Durcan, 2008) as the weaker element of prison mental health services. Prisons provide challenges for primary care that are unique, not least those which come from the population it serves. Prisoners are almost exclusively drawn from the most deprived communities, and have significantly higher morbidity for poor physical and mental health. This is coupled with a ‘default’ towards a complexity and multiplicity of need. A history of trauma is common, as is some level of unhelpful use of substances. Many prisoners have some level of learning difficulty and a significant proportion will have a learning disability (Prison Reform Trust, 2015 estimate between 20-30% have a learning disability or borderline learning disability). Histories of poor relationships are common, and many prisoners are poorly skilled in activities of daily living; are poorly educated; have limited work experience; and suffer debt, homelessness and unstable housing when outside prison.

It is the concurrence of so many problems that provides the challenge for prison primary care and probably requires a level of resourcing and specialism that none of the prisons represented at the events had available to them.

“...the level and breadth of need is astounding...”
(Senior prison service participant)

The consistent view across all events was that primary mental health care remains weak and with very limited provision.

“...there is some great work done, but we can’t do much with most of the people who need something from us...”
(Prison health care participant)

There were also a number of commonly reported gaps in services for people with specific diagnoses (see Table 3).

Prescription practices for prisoners with mental health problems varied hugely by prison. Several examples were given of medications being available in one prison but not in other prisons, causing distress to prisoners.

Some prison mental health services had to some extent merged secondary care with primary, and this more readily gave access to a broader range of clinical skills and better clinical supervision arrangements.

There was widespread support for the development of a stepped-care model of provision and most prison mental health services were attempting to develop such a model of provision, or at least desired to.

“...mental health promotion should be a big part of what we provide in prisons...getting in there before there is a problem or helping it get recognised early...not just waiting for things to happen...”

(NHS England participant)

There was also discussion at several events on the use of prison segregation departments for *“...housing people with the sort of vulnerabilities we are talking about...”* Participants saw this as unacceptable.

Table 3: Prevalence rates of mental health disorders/learning disabilities in prisons

Diagnosis/ vulnerability	Prevalence in the adult prison population
Learning disability (LD)	7% of the prison population is estimated to have a marked disability and 25% to have a borderline disability. ¹
Acquired brain injury (ABI)	The largest UK study found that 47% of adult prisoners report a traumatic brain injury and 30% had experienced 5 or more. ²
Autistic spectrum disorder (ASD)	A recent UK study indicated a prevalence rate of 4%, significantly higher than in the general population. Some international studies have found the prevalence to be even higher in prison populations. ³
Attention deficit hyperactivity disorder (ADHD)	Prevalence ranges from 24 -45% across several studies of prison populations. ⁴
Personality disorder (PD)	64% of male prisoners are estimated to have personality disorder, but remand prison population prevalence is 78%. 50% of female prisoners have a personality disorder. ⁵

¹ Talbot, (2008)

² Pitman *et al.*, (2013)

³ King & Murphy, (2014)

⁴ Eyestone & Howell, (1994), Rosler *et al.*, (2004)

⁵ Singleton *et al.*, (1998).

Psychological interventions

The availability of psychological interventions (either via prison primary mental health care or prison secondary mental health care) appears to be a relatively rare commodity if these 17 events were representative. A few of the prisons had either clinical psychologists or nurses with significant training in delivering psychological interventions, and were able to make a significant psychological intervention offer. However most were not so resourced and could not.

An important part of psychological practice is the development of psychological formulations. These go somewhat further than a diagnosis, and are rather a narrative that looks at a wider context in defining an individual's issues and also therefore in designing interventions. As a result of both contexts and the outcomes of intervention, such formulations are subject to change and as such are a 'movable feast'. Our participants saw this as a particularly useful way of approaching and supporting people with multiple and complex needs. Such formulations are quite widely used in mental health care.

The perception of our participants was that a very large number of prisoners could and should benefit from psychological interventions.

"...you have to adapt the approaches...because these are not like community populations..."
(Prison-based clinician)

"...there are loads of prisoners with mild to moderate mental health problems...who may or may not get some medication but that's about it..."
(Prison health care participant)

Examples were given of successfully supporting people with marked personality disorder and of reducing behaviours that had led previously to frequent punishments.

Living with trauma was seen as a significant issue and prison-based participants reported very high numbers of prisoners who had suffered from past trauma.

"...I've worked with several veterans...but also load of guys who have undergone abuse in the past...quite a few have Post Traumatic Stress Disorder...and then there are loads of other ways that trauma can manifest itself..."
(Prison-based clinician)

"...I think we should adopt a trauma informed focus to intervention with offenders....so many have had significant history of trauma in their lives..."
(Prison-based voluntary sector participant)

Providing interventions for victims in prisons is recognised as challenging, particularly for those with shorter spells in prison, but very important and in *"desperate need of development"* (voluntary sector participant).

A variety of psychological approaches were reported as being used both inside and outside prisons with offenders, several of which have research supporting their efficacy for people with complex problems and personality disorder. Most are derived from Cognitive Behavioural Therapy and those mentioned included in particular Social Problem Solving Therapy, Mentalisation Based Treatment and Dialectical Behaviour Therapy.

Adopting a psychologically informed approach

A psychologically informed approach to working with offenders can be seen as one which seeks to understand the motivations and thinking of the person, and where such knowledge informs how staff members react and respond both through day-to-day communication and through specific therapy. Developing such an understanding can allow workers to be proactive.

Psychological informedness is often used specifically when discussing people with personality disorder and specific environments such as the Enabling Environment concept (developed by the Royal College of Psychiatrists and described by Johnson & Haig, 2012) and Psychologically Informed Planned Environments (developed by Department of Health, NOMS and NHS England), both of which are described in this report. However, a psychologically informed approach also involves using formulations to understand the individual. Formulations can be described as having the following characteristics:

- A summary of the service user’s core problems;
- A suggestion of how the service user’s difficulties may relate to one another, by drawing on psychological theories and principles;
- The aim to explain, on the basis of psychological theory, the development and maintenance of the service user’s difficulties, at this time and in these situations;
- Indication of a plan of intervention which is based on the psychological processes and principles already identified;
- Being open to revision and re-formulation.

(Johnstone & Allen 2006, cited in British Psychological Society (BPS) 2011, p. 6)

Formulations are an attempt to understand an individual in their context, and to do so using ‘plausible account’ (Butler, 1998 cited in BPS, 2011) in the form of a shared narrative rather than a categorical diagnosis. The formulation provides a hypothesis to be tested and its narrative changes as the individual does.

A psychologically informed approach has a wider application than just to those diagnosed with personality disorder, which is in any case highly prevalent in offender populations. Aspects of a psychological approach, such as formulations, lend themselves particularly well to working with people with complex and multiple needs.

Prison mental health care - Inreach

There has never been a blueprint or operating model for prison mental health inreach services, and many current services began as largely mono-discipline services, consisting of nurses sometimes with some psychiatry sessions. These services have on the whole grown and many are now more multidisciplinary than they were in the past. Some have incorporated prison primary care services. However, there remains huge variability of provision and this was evident from the prison-based secondary care practitioners and managers who attended events.

Our participants were keen for some equivalent template for prison mental health care to that

which is available for Liaison & Diversion, i.e. NHS England’s Operating Model. Two other projects that may support the development of more standardised prison mental health care were cited in the events. These were:

- The development of Prison Mental Health Care Standards by the Royal College of Psychiatrists’ Quality Network for Prison Mental Health Services (Royal College of Psychiatrists, 2015);
- The National Institute for Health and Care Excellence (2012) project developing guidance for offender mental health care.

Stakeholders involved in both of these developments contributed to the review, and

those involved in the ongoing NICE project were keen to be involved in what emerges from this review.

Some prison mental health services were able to deliver a range of interventions including adapted psychological interventions, while others could only make a more modest offer. On the whole the availability of psychological interventions was reported to be low.

All participants reported that the prison mental health inreach had undergone mission “creep” or “stretch” over the years. This was reportedly due to pressure from the prisons for teams to take on cases, but also due to recognition of the role mental health teams could play in supporting people with complex and multiple needs.

In all the prisons represented, the demand for mental health inreach was far greater than the resource available, and this was reportedly due both to the weakness in primary mental health care and the high levels of psychiatric morbidity in the prison population.

“...we are only ever going to be small teams... we can't take it all on...we need to share what we know with prison staff...”

(Inreach participant)

At several of the events participants expressed support for developing more of a mental health consultancy approach:

“...we do a bit of it already....I think some interventions could be delivered by prison staff....but they need skilling up...consultancy would spread our resource more widely...”

(Senior prison-based clinician)

It was also recognised that the cuts to staffing in prisons make such interventions “challenging”.

Transfers to psychiatric care

The reasons for delays in transferring prisoners to hospital were reviewed by Centre for Mental Health (2011) and the issues reported during this consultation differ somewhat to those the Centre previously reported. However, lengthy delays in transfer are still being reported and were so at all our events. Previously each unit that a prison mental health team referred their ‘patient’ to would conduct an assessment; this

sometimes resulted in multiple assessments and delays. This is currently not the case for most inter-region referrals and a single referral is sufficient. However, if there is no bed within the region and a referral to an out-of-region resource is required, this results in further assessments and delays. Regional Gateways are currently reported to be the problem. Any form of specialised bed (e.g. for someone with learning disabilities or someone who is deaf) is reported to result in delay. Waits of three and four months were reported across events, and one wait of nearly 12 months.

Difficulties in transferring to secure mental health care were not necessarily related to shortages in beds; indeed in one region it was reported that they had closed some beds as occupancy had been quite low.

A psychiatrist at one of the English events stated that a patient of his was floridly psychotic, in need of intensive treatment, and not suitable for treatment in prison. However, it took several weeks to transfer him to hospital, by which time his condition had significantly deteriorated.

Prison-based psychiatrists reported that there was an issue of clinicians from the ‘receiving’ unit ‘not trusting assessments’ even from very qualified prison-based clinicians (this was also the case in 2011). This was far less of an issue for local and internal NHS trust referrals (i.e. where the same mental health provider is in the prison and receiving unit).

The default for referral is now to low-secure facilities, unless the level of risk determines otherwise. Centre for Mental Health previously found that the default had been to medium-secure facilities (2011). It also appeared to be the default to refer to a unit in the prisoner’s area of origin. This was felt to make sense if the prisoner was to be released from this unit or transferred from this unit to a local prison. However, several incidences were reported where prisoners had been transferred to low secure or psychiatric intensive care units (PICUs) some considerable distance away from the prison only to be transferred back when recovered. This made liaison with the receiving unit difficult. All clinicians reporting this stated that it made more sense to refer to a local unit (if the prisoner was likely to be transferred back

to the referring prison), which they could work with and be involved in the treatment of their 'patient'.

"...it makes no sense....when we have a unit in this trust within a mile of here....it would be easier to ensure continuity of care and to work with the team at our local unit...we can't attend case reviews if they are placed miles away..."
(Senior prison-based clinician)

"...PICUs are funded by CCGs....we have had a PICU from the area of the prisoner's origin saying we should refer the prisoner to our local one. The local one refused saying 'they are nothing to do with us'...and whilst we were trying to resolve this we had to admit the patient to a medium-secure [facility] as that's where we had a bed and we had big concerns about him..."
(Senior prison-based clinician)

At one event it was reported from a medium-secure unit that over the past year it had become difficult to transfer patients back to the referring prison. This appeared to be related to a policy of trying to place prisoners in prisons closer to their area of origin. The prison of origin informed the medium secure unit that the prisoner was no longer 'theirs' and the new prison refused to accept the return transfer. The unit reporting this found the process of returning the 'patient' to prison lengthy and difficult as it was far from clear as to which prison now had 'ownership'.

PIPEs and the personality disorder pathway

Services for prisoners with severe personality disorder and/or who continue to pose a serious risk of repeated sexual or violent offending were highly regarded. One type of approach is the Psychologically Informed Planned Environment (PIPE). These are units where all of the staff have been trained in providing a psychologically informed approach, where the whole unit experience is designed to support those with complex needs with an effective transition through a pathway of services. Crucially, criminal justice staff received training in working with people with personality disorder and working in a psychologically informed way. At several events, staff who had undergone this

training reported positively on it, and saw the training as having a much wider application.

"...all prison work should be psychologically informed..."
(Voluntary sector participant)

PIPEs differed from other prison regimes in other ways, most significantly in staffing levels. PIPEs have a higher staff to resident ratio and more of a multidisciplinary team.

"...I don't think all prisons need to become PIPEs but it would be great if we could all aspire to achieve status as Enabling Environments"
(Participant with recent experience of reviewing several prisons including PIPEs)

Enabling Environments are not specific to prisons or even health; rather, they are settings that strive to achieve a set of standards that have been developed by the Royal College of Psychiatrists (2013). These Enabling Environment standards are:

1. The nature and quality of relationships are of primary importance.
2. There are expectations of behaviour, and processes to maintain and review them.
3. It is recognised that people communicate in different ways.
4. There are opportunities to be spontaneous and try new things.
5. Everyone shares responsibility for the environment.
6. Support is available for everyone.
7. Engagement and purposeful activity is actively encouraged.
8. Power and authority are open to discussion.
9. Leadership takes responsibility for the environment being enabling.
10. External relationships are sought and valued.

Therapeutic Communities were also talked about positively, but there was very limited expertise on these at the events. There are a range of other services within the Personality Disorder Pathway and not all were discussed at our events. One of the small groups was held with mentors supporting people released into the community as part of the pathway. This group also stressed the benefits of knowledge of personality disorder and of taking a psychologically informed approach.

The issue in applying lessons from the PIPEs and Enabling Environments was in ‘scaling up’ in a climate where resources were very limited.

Mental health prisons and wings (MHPs)

Mental health prisons do not currently exist but have been mooted at times and exist in other jurisdictions. Unless changes were made to the Mental Health Act, MHPs would be for voluntary prisoners / patients (a prison is not a place of safety under the Act). These units would most likely be for those with severe illness, would be expected to have a higher staff ratio and a fuller compliment of psychiatric disciplines. One proponent of MHPs suggested to Centre for Mental Health prior to the review that MHPs would concentrate psychiatric resources.

At all of the events, the notion of MHPs was discussed and two participants voiced some support for some form of MHP. Both were clinicians and saw a role in such units in intervening early to prevent the necessity of transfer to external secure mental health care, but also for observation and detailed assessment. However, the majority of participants saw little role for MHPs.

“...it misses the point...the vast majority of prisoners have issues with their mental wellbeing...”

(Senior prison-based clinician)

“If a prisoner is willing to accept treatment, then there isn’t an issue...we can treat them on the wings...”

(Inreach participant)

“...a small number of people have such severe illness that requires they be transferred to a secure unit [NHS commissioned secure hospital]...but actually we are pretty good at caring for people with severe and enduring mental illness...”

(Senior prison-based clinician)

“...I think the people we... and the prisons... struggle to cope with are people with complex needs...with personality disorder....it’s a huge number and most would fall well below the threshold for a secure unit and even a community mental health team... they are [in] the realm of primary care...”

(Senior prison-based clinician)

Rather than special units, most clinicians saw the value of investment in and development of programmes to support people with vulnerabilities for which they felt they offered little at present (see diagnoses/vulnerabilities listed earlier).

Clinicians felt screening for the previously listed vulnerabilities needed to be improved; indeed, it was reported that only very limited screening took place in any of the prisons represented at the events. Participants at our events saw the value of supporting not just prisoners with these disorders but also prison staff who worked with them:

“...guys... especially those with ADHD are just seen as discipline problems....they get punished and nothing changes...I think we could make a real difference...”

(Prison-based clinician participant)

24-hour prison-based health care

The majority of clinicians stated that they valued 24-hour health care provision, but few had it in the prisons they worked in.

“...if you can get someone in quickly then they are really useful for a bit of intensive work and really good for observation...”

(Inreach participant)

Most prison mental health care staff reported difficulty in accessing these beds and this was especially difficult if the 24-hour facility was located in another prison.

“...I don’t think I have ever managed to get anyone in...we need more of these...”

(Prison health care participant)

Some prison health care staff reported that such units remained under the control of the prison governor and in some prisons they housed people that did not warrant, in their view, a bed. It was reported that in most cases such usage was for people who were not coping with ordinary prison regimes but who did not have a ‘health’ related problem.

“...it was worse in the past....all sorts of folks would get placed in the health care unit...but it still goes on...I think they (24 hour units) have a real role to play and if you could get someone in quickly then they can avert a crisis...”

(Prison health care participant)

Leaving prison

Our participants saw leaving prison as a critical transition point and a hugely problematic area. It was noted at one event that the first few days and weeks after release pose many challenges for those released and are a time of heightened risk, not least of self-harm and suicide. A recent systematic review of the research of suicide in the post-release period found that suicides were 6.76 times more likely than in the general population (Jones and Maynard, 2013). Ensuring continuity of care was deemed “*incredibly difficult*”, and people leaving prison who by and large have multiple and complex needs often left prison with no or very limited support.

Many prisoners had, in effect, no fixed abode on leaving prison and so at best might be living at a hostel on release. It was a common experience to not know where they would be living until the day of release. Obviously this data was collected prior to Community Rehabilitation Companies (CRCs) being fully 'up and running' and new pathway work and 'through the gate' contracts being awarded, so this may already have improved. However, Centre for Mental Health's work on a resettlement and post-release employment project in the West Midlands suggests it may still be problematic. It has been reported that a small number of people released under the supervision of CRCs and referred to the project had no accommodation found prior to release, and no 'through the gate' support other than that offered by the project's employment specialists (not a part of their role or the project's 'offer'). These may of course be isolated, atypical incidents.

At all events in both England and Wales there was a perception that community mental health services had reportedly raised their entry thresholds in the past 12-18 months.

“...most of the people we work with in here would not meet the criteria for secondary care. (In the community)...it has always been difficult to pass some on to a community mental health team, but it is much more difficult now...”
(Inreach participant)

“...we struggle to get people who have severe and enduring mental health problems into community teams...but the community has even

less to offer if you have a learning disability or ASD [autistic spectrum disorder] ...”
(Inreach participant)

With regards to learning disabilities it was acknowledged there was limited provision in prisons, and that prison mental health care often took people with learning disabilities onto their caseloads. Several prison mental health teams had recruited staff with learning disability qualifications. The leaving experience for these people was described as “*dismal*” by one participant, and this view was generally shared.

“...there is nowhere in our area I can refer prisoners with learning disability to...”
(Prison health care participant)

“...I have had some quite profoundly disabled young men... but these days they do not meet the criteria for [community] LD services...”
(Senior prison-based clinician)

The impact of the Winterbourne View Hospital abuse and subsequent inquiry was discussed at most events and it was felt by participants that the response to Winterbourne View had been a further reduction in resources for people with learning disabilities and particularly beds:

“...there is a danger of the baby being thrown out with the bath water...”
(NHS England participant)

For most categories of prison mental health care patient, ensuring continuity of care in the community on release was described as difficult. It was previously reported that where prison-based services had been able to offer adapted psychological interventions there was often no community service willing to offer a similar adapted approach.

“...most IAPT teams wouldn't touch our folk...”
(Prison-based clinician)

“...it would be great if the period after release could be deemed a 'crisis'....because it often is...and if the Crisis Care Concordat [HM Government, 2014] covered that...”
(Senior prison-based clinician)

“...an awful lot of the people who leave here have nowhere to go to and we don't know where they will be released to, but it will be a hostel somewhere... this makes it impossible for us to

connect that person....even with primary care.... the best we can do is send them out with a letter detailing their needs and treatment, they give this to their GP when they find one..."

(Prison health care participants)

This has also been the experience of another Centre for Mental Health project (which gave evidence to this review). Centre for Mental Health and partners Enable, Sova, University of Nottingham and the South Staffordshire and Shropshire Healthcare NHS Foundation Trust are working on a resettlement project testing out an employment intervention with people with mental health problems being released from seven West Midlands prisons. The vast majority of these prisoners had no release address until close to the day of release, making it difficult to deliver the intervention. Only a minority are being supported by community mental health teams and although virtually all are under probation supervision after their release, the support they receive is reported as minimal at best.

The complexity and multiplicity of need was also highlighted at our events.

"...the first couple of weeks after release are the most difficult...and the first couple of days are a nightmare...I've had everything done for me in prison...then suddenly you're on your own... and there is the stress of getting to your first probation appointment, Job Centre Plus..."

(Former prisoner)

"...being met at the gate and provided with a bit of support might have stopped me going back to prison..."

(Former prisoner)

"...you have to meet someone's basic survival needs first, accommodation, access to funds and so on...then you can worry about treatment..."

(Voluntary sector participant)

There was very widespread support for 'through the gate' type interventions that provide vulnerable prisoners with support and advocacy for a critical period after release. However, access to such schemes was very limited. Surprisingly in one case, the mental health team in a prison which had a high profile scheme had experienced very limited contact with the scheme and had very vague knowledge of it.

At the time of the review, whilst Community Rehabilitation Companies (CRCs) were in existence and indeed represented at most events, their services were not developed. CRCs are committed to providing 'through the gate' support and will be providing support and supervision for a greater number of people post-release than probation services had previously. However, most of our participants felt that people with poor mental health, a learning disability or another related vulnerability required a targeted, enhanced version of whatever the general 'offer' would be. The psychological 'informedness' (a key feature of what is offered to the small number of offenders in the personality disorder programme), was seen by many participants as the "model" to follow, as this resulted in a more tailored approach to the individual.

"...with the change in probation...we now have the CRC coming in here...and they do the 'through the gate' stuff, they work with prisoners up to 3 months prior to release...but they work with everyone and there is nothing specific for people with mental health problems..."

(Prison-based probation participant)

"...I think it's important to have someone working with them who understands mental health, who can give them the time because they have small caseloads....even if only for a couple of weeks after release..."

(Prison service resettlement participant)

Several groups of prisoners provided greater resettlement challenges, for example:

- Women – (largely due to the typically long distance between prison and area of origin, and therefore a lack of knowledge of local services in that area);
- Men and women returning to Wales (this was a problem where there was not well-established communication with the English prison);
- Foreign National prisoners.

On leaving prison it was the practice of all prison mental health services to send information to a prisoner's GP, and any service they had referred the person being released to. However, the release address for many prisoners was

unknown at release, so prison mental health services would provide guidance on how to register to the prisoner upon their release, with a letter on any treatment received and ongoing health needs.

One prison mental health inreach team reported following up on all released former cases, usually a month after release. This was via any service the prisoner had been referred to, their GP or sometimes the former prisoner themselves. This was felt by participants to be an example of good practice as (at the very least) it provided some data on the challenges of the post-release experience.

Liaison & Diversion services as part of the National Pilot Programme employ community support workers. In London these are called Community Link Workers (CLWs – managed by Together for Mental Wellbeing). The CLWs have a role beyond the Liaison & Diversion remit, in that they offer time-limited support after court or police custody. CLWs work with people with complex needs and particularly in supporting their engagement into a range of services, for example mental health services or housing. The consistent view across our events was that a similar offer, such as an outreach-style service, ought to be available on release, or that a community-based service should provide an equivalent response. People with mental health problems, learning disabilities, personality disorder and related vulnerabilities were felt to need enhanced support, i.e. something beyond *“the standard offer on release”*. The commissioning of such a service would most likely primarily be the responsibility of CCGs. There were some examples of this for people leaving prison. One inreach service had an outreach worker who provided some time-limited practical support, and support around service engagement (London), whilst another had access to a ‘through the gate’ service for people with mental health problems (Nottingham).

Reports for parole boards

All the prison-based mental health practitioners we met (particularly psychiatrists) had some experience of producing reports for prison parole boards. And all reported the same

challenges. The participants expressed that this was an important and valuable activity, but:

“...I don’t think the board has any idea of the level of resource it takes to complete a report...I am a very small resource and completing a report effectively withdraws access to a psychiatrist in the prison...”

(Senior prison-based clinician)

“...they are not included in the contracts we have here...so there is no time allocation for them...”

(Inreach participant)

“...I actually do want to do the best for my patients and I do want to report to the parole board...but I think there is an education job to be done with them about what to expect and how to ask for reports...”

(Senior prison-based clinician)

Our participants all agreed on the following:

- Parole board members required mental health awareness training.
- Parole board reports ought to be a contracted activity with time allowances for completion.
- More notice of requests was required.

A limitation of our events was that parole boards were not represented.

Foreign national prisoners

The latter group were particularly difficult as if they were to be ‘removed’ following release, communication with future service provision was *“near impossible”*. However, many foreign national prisoners were not removed from the UK at the end of their sentence.

“...it’s a real concern....it’s heartbreaking...they have little or no entitlement on release.”

(NHS England participant)

Mental health providers at an Immigration Removal Centre (IRC) reported very high levels of severe mental illness and that they had transferred a much greater number to secure mental health care than would be expected from a busy local prison.

“...we were quite shocked by the level of need...it’s our most demanding service...”

(Senior prison-based clinician)

Some prison health care services talked about the struggle to providing meaningful support to people who did not speak English.

Lessons from Engager: towards developing principles for the resettlement of people with vulnerabilities

Engager is a programme of research and practice development focused on people leaving prison with common mental health problems. It is led by the University of Plymouth and Manchester University in partnership with a number of organisations including Centre for Mental Health¹. The following lessons for successful resettlement have emerged from the exercise:

- Liaise with key services before release to find out when key appointments are.
- Release day is a vital time for building trust and engagement: Meet the released person at the gate, accompany them to their release day appointments (this is particularly important for supporting drink/drug abstinence on release day and thus engagement with other key services).
- Informal communication such as texting is important to maintain contact and engagement.
- Assertive contact in the community even in the face of setbacks (e.g. substance misuse).
- Use of inevitable setbacks to gain trust and develop coping skills and a 'shared understanding' of barriers and challenges, and how they might be overcome.

Developing a 'shared understanding' between the released person and the practitioner

- Work together with the released person to understand the thoughts and feelings that are related to behaviours they consider problematic (e.g. offending or drinking).
- Use day to day crises to understand what happens in recurring problems in the community and to support a shared understanding.
- Use this understanding to develop personal goals.
- Develop a written record of this shared understanding that can be shared with other key agencies.

Working on goals and developing a 'shared action plan'

- Match personal goals to available resources (the released person themselves/the practitioner/other services & practitioners/family/friends/peers).
- Liaise and advocate to get other people to work around the person's goals.
- Use a written 'shared action plan' to communicate to other practitioners how their work supports the person's goals.

Working on relationships

- Support good communication between participants and involved practitioners.
- Model good relationships and communication.
- Train in social and communication skills.

¹ The other partners involved with the Engager research programme are Exeter University, University College London, City University - London, King's College, University of South Wales, St George's - University of London, Leeds Community Healthcare, Avon & Wiltshire Mental Health Partnership NHS Trust, Devon Partnership NHS Trust.

Chapter 6: Consultation findings - probation and rehabilitation

Probation

Most events had attendance from probation, both NPS and CRCs, and it was agreed that the impact of the reform process under Transforming Rehabilitation had been very disruptive but was now settling. Both new branches of probation were launched or being established at the time of the events. There was still a lack of clarity over what would be the CRCs' priorities and how these would be reflected in the contracts they agreed with other organisations. At the time of the events, organisations currently contracting with probation, such as a mental health service providing sessions for probation officers and a 'through the gate' intervention for people with mental health problems and learning disabilities, were due to have their contracts finish on March 31st 2015. If these contracts were to be "picked-up" then this would not be until after May 1st when CRCs were due to announce such arrangements.

Centre for Mental Health met with two service users in the community in Wales and their support workers as part of this review. These service users each had learning disabilities and mental illness. They had histories of serious offending but were not currently under any probation supervision. They were not supported by either mental health or learning disability services. The only support they received was from a voluntary sector support service that engaged both of them in prison before release. Both were reported to have responded well to the support and were very appreciative of it. The project they were receiving support from was due to end on March 31st and their support withdrawn thereafter. The prognosis for both was felt to be poor. It has since been confirmed that this service did come to an end.

In some cases the NPS had agreed to continue with any element of an existing contract for people posing high harm and on their caseload.

Most probation officers, both CRC and NPS working in the community, expressed a feeling that they were "...neglected..." in criminal justice and mental health policy.

"...don't get me wrong...it's great what's been done in prisons but we have the bulk of offenders...most of the people I work with have poor mental health and I have nowhere to go with them..."

(Probation participant)

"...we always focus on the tiny group of offenders in prison and forget that most live in the community..."

(Probation participant)

"...the Liaison & Diversion folk are great, but they kind of stop at the court door and can't help us..."

(Probation participant)

Some, but not all, of the probation services represented at the events had previous experience of having some dedicated mental health resource. This took two forms and some services had experienced both:

- Direct and dedicated sessions for people on a probation caseload (in one case this included a form of IAPT service with adapted psychological interventions);
- Probation consultancy surgeries (where mental health practitioners provided advice and consultancy to probation officers about any case they were concerned with).

The added value of having such access to a mental health practitioner was easier access to information on their clients, and a simpler route into mainstream mental health care.

CCGs would need to commission such provision:

"It's shocking how few CCGs realise that they have a responsibility at all for probation, and until...they do and put in place any of your [the review's] recommendations, [they] are going to be firing into an empty space...rather than one structured to receive your recommendations..."

(Senior probation participant)

Research on deaths whilst on probation supervision (Howard League for Penal Reform, 2012) reveals that there is a higher mortality rate within the probation caseload population when compared to the general population,

and that a significant proportion of these are due to suicide (13%). This includes those on community sentences as well as those on license. The suicide rate for men under probation supervision is around 70 per 100,000 (calculated from Howard League, 2012) compared to 9.8 per 100,000 males in the general UK population (World Health Organisation, 2014) and for women is 30 per 100,000 under probation supervision compared to 2.6 per 100,000 in the UK general population (same sources).

Reports for courts

The English and Welsh experiences are somewhat different and the Welsh experience is described later. At events in England, those representing courts who were in receipt of services from the first wave of NHS England Liaison & Diversion pilots reported positively.

“...in the past I might have had to wait weeks... but the diversion people can now get me what I need to know the same day...”

(Sentencer)

The National Liaison & Diversion pilots were perceived as having:

- reduced the need for psychiatric court report requests;
- increased access to timely reports for sentencers and probation;
- provided the type of reporting that met the courts’ needs:
 - o they were short and to the point;
 - o they made grounded recommendations;
- increased timely access to health care information.

However, where a fuller report was required, this was perceived to be just as difficult to obtain as in areas where a national pilot service was not in place. Reports reportedly took 8 to 12 weeks to be produced, and even longer in some cases.

“...then what I get is 40-50 pages of very technical language....it doesn’t tell me what I need to know...”

(Sentencer)

Participants at about half of the events reported that in their experience, reports were often provided by psychiatrists who were not sufficiently knowledgeable.

“...they don’t understand courts and - even worse - they don’t understand local services... they make all sorts of recommendations that just can’t be delivered on...and they’re expensive...”

(Forensic psychiatrist)

Participants from courts and mental health care agreed that the psychiatrist completing the reports should ideally be:

- one who works with offenders;
- one who understands the needs of courts;
- one who works locally and understands services.

At two events, examples were given of where local agreements between courts and health commissioners had been achieved, resulting in timely provision of court reports that were delivered by a psychiatrist meeting the three above qualifications.

Those participants working in and around courts both in England and Wales stated that HM Courts & Tribunal Service and the NHS needed to work together to achieve standardised practice in court reporting, better means of contracting the provision of court reports, and standards for the timely provision of reports.

Mental Health Treatment Requirements (MHTRs)

The experience across all events, where there was expertise to comment, was that these were still extremely rare. But where there were court-based Liaison & Diversion services in place, they tended to have been easier to facilitate.

“...we have facilitated over 30 in the last year...”
(Liaison & Diversion participant)

However, MHTRs fall out of the remit of Liaison & Diversion under the current NHS England operating model and need to be provided for by local commissioners (CCGs) and mainstream community mental health providers.

“...we can still organise them, but we have a minimum wait of about 3 months now.....the same as for anyone being referred locally (non-urgent) to a community mental health team...a magistrate can’t wait that long...”

(Liaison & Diversion participant)

Sentencers were perceived as having knowledge gaps around the MHTR by most participants, but sentencers attending the events understood the requirement:

“...I’d love to use them...but it would mean a psychiatrist being willing to come into my court...”

(Sentencer)

Several of the psychiatrists we met were concerned about the potential workload MHTRs could bring and were sceptical of the “lighter touch” clinical responsibility approaches proposed by other participants and as described below in the Milton Keynes pilot scheme. MHTRs currently require a psychiatrist or consultant psychologist to clinically manage this care. ‘Lighter touch’ approaches to this

propose less active engagement in care than clinical management would normally entail. There were some alternative means proposed for achieving what an MHTR was designed to achieve, but which might be less exacting in terms of clinical responsibility. The Rehabilitation Activity Requirement (RAR) was one such vehicle, proposed at two events and discussed at several others. The RAR has been available since February 2015 and comes under the Offender Rehabilitation Act, 2014. CRCs (and the NPS) using the RAR have considerable discretion as to what they can require by way of rehabilitation activity, indeed they are intended to encourage innovation. A RAR would have a maximum time period for any requirement stipulated. Not all participants felt these were an alternative to MHTRs or an appropriate vehicle for delivering mental health care, not least because MHTRs require the consent of the person to whom they are being applied. The RAR, albeit a flexible vehicle, involves more compunction and stipulation concerning the ‘activity’ (in this case, treatment). The guidelines around MHTRs stress the importance

Milton Keynes Mental Health Treatment Requirement pilot

In Mental Keynes, Probation, the Court, Public Health England and NHS England established a joint pilot project to test out a means of delivering MHTRs. The organisation P3 had been providing diversion link workers in the local magistrates’ court for several years, and these link workers formed a critical part of the new MHTR pilot provision.

An additional element was the provision of psychological interventions by psychology assistants provided by St Andrews Healthcare. These psychology assistants were supervised by a consultant psychologist, who offered the ‘lighter touch’ clinical responsibility approach proposed by some event participants. The Consultant Psychologist had a more remote relationship with the project and its clients, which was by and large only through clinical supervision sessions with the psychology assistants.

The programme offered psycho-social support with P3 initially engaging the clients in court (often at a first appearance), and providing practical support thereafter with psychology assistants providing talking-based therapies. The MHTR pilot had the confidence of local magistrates and had significantly increased its uptake. The use of MHTRs in Milton Keynes in its first six months was more than double that for the whole Thames Valley area in the previous twelve months.

Some commissioners, commenting on the approach, pointed out that it did not appear to be an expensive one, but several added the proviso that such pilots were an “add on” or “additional” service and therefore hard to support and fund in the current financial climate. However, the pilot did provide useful lessons on how the MHTR can operate and the partnership relations required to achieve it. It also demonstrated the savings that such an approach can achieve (e.g. reductions in offending, less resort to custody), as well as benefits to those to whom it is applied.

of consent and that they are not court-enforced treatment. However, most participants at the time including those from CRCs and NPS did not feel they had sufficient knowledge or experience of the RAR, as it had only recently been introduced.

The main barrier to MHTRs described at these events was the availability of mainstream community mental health care to courts.

While some participants questioned whether community mental health services had sufficient knowledge and expertise in the area, most felt that under current commissioning arrangements, community services were just not able to give courts sufficient priority over other referral sources. In order for this to happen, there would need to be a variation in contract with their local CCG allowing for a more timely response.

Chapter 7: Consultation findings - further issues

Young adults

The review focused on adults, but across several events there were participants who worked with children and young people. These and other participants had an interest in the transition from criminal justice services for children and young people to those for adults. It was agreed across events that the transitions both in criminal justice and mental health services were difficult, with child/young people-focused services in both fields perceived as being able to provide greater support.

It was also recognised that some young people in prison have a second transition when moving from an establishment for 18-21 years olds to the main prison estate. Preparation for either transition was felt to be poor, with claims that those moving from services for under-18s to those for over-18s, in particular, faced a “cliff edge”.

At two events the notion of maturity, and how little this was accounted for in criminal justice and mental health services, was discussed in some detail. There was a consensus at these events that young people up to the age of 25 years old, particularly males, act and think differently to adults past this age.

Family support and services

At several of our events the families of prisoners (in particular) were discussed in two contexts:

- Their role in supporting resettlement and rehabilitation;
- Their need for support in their own right.

Maintaining contact with families was described as difficult for some Welsh prisoners (especially those in English prisons some distance away), for most women’s families and for any prisoner located a distance away from their family. But such contact was crucial in achieving both of the bulleted items above. Prison visitor centres play a crucial role in supporting families but are site-based rather than outreach services, so this is inevitably limited. Health services tended to have limited interaction with visitor centres and, as small teams, had no outreach capacity.

On release from prison, families were described as having a critical role, but just as people released from prison struggled to get support, so too did their families and carers.

Women

The discussions around the needs of women were very similar to the general discussions we had and similar themes arose, but with the exception of context and emphasis. It was acknowledged in our events that both the number and proportion of women in prison had reduced over the last decade, and that consequently the female prison estate has reduced. This has the consequence that women are on average located in a prison further away from home than male prisoners. Many women will have been carers prior to incarceration and that ‘caring’ relationship and the children themselves are impacted upon by both imprisonment and difficulties in maintaining contact. Levels of mental distress were perceived as higher in the female estate and this is far from new information (see Durcan, 2008 for summary of evidence).

Two women’s prisons represented reported a perceived greater sympathy from prison staff to the needs of women compared to staff in male prisons. However, both also reported very limited mental health service availability and very limited talking or psychological therapy offers. The proportion of women prisoners who have reported experiencing abuse is higher than that reported by male prisoners. Participants saw a need for introducing a trauma focused approach to working with prisoners and for women prisoners in particular, and psychological interventions geared towards managing trauma. The availability of such services was reported as minimal.

As for any other prisoner, the leaving prison experience of women was reported as generally poor and at one event a strong argument was put forward for ‘through the gate’ support, specifically tailored to the needs of women which lasts for “...a period of months...”.

A trauma informed approach

Clinicians and therapists based in prisons who attended the events also emphasised the need for a trauma focus to intervention in prison, in addition to psychological informedness, as many prisoners had experience of past trauma.

A trauma informed approach has much in common with a psychologically informed approach. It could be argued to be a specific form of psychological informedness, in that in working with an individual it takes account of that person's particular context and understanding of their world, and uses that in intervening with that person. It recognises the lasting impact of psychologically traumatic experiences, but also the possibility of re-traumatisation.

The Substance Abuse & Mental Health Services Administration (SAMHSA, 2015) lists the following characteristics of a trauma informed approach:

- Realises the widespread impact of trauma and understands potential paths for recovery;
- Recognises the signs and symptoms of trauma in clients, families, staff and others involved with the system;
- Responds by fully integrating knowledge about trauma into policies, procedures and practices;
- Seeks to actively resist re-traumatisation.

Experience of significant trauma is common among offenders (Goff *et al.*, 2007 & Social Exclusion Unit, 2002) and when Centre for Mental Health interviewed approximately 100 prisoners as part of a prison mental health needs assessment, many reported histories of psychological trauma (Durcan, 2008).

Mentoring services and peer interventions

Mentoring interventions, both professional (i.e. paid) and volunteer, peer and non-peer, were discussed at events. Mentoring has a number of definitions and takes many forms, as the previous sentence illustrates. The interventions discussed at the events followed Taylor *et al.*'s definition of "a one-to-one, non-judgemental relationship in which an individual gives time to support and encourage another" (Taylor *et al.*, 2013, p.2). Research evidence as to their efficacy is limited but promising for adults (e.g. Jolliffe and Farrington, 2007 and Taylor 2013), but stronger for young people (see Washington State Institute for Public Policy, 2012). Evidence for peer mentoring is very limited (Fletcher and Batty, 2012), but a number of studies have found that mentees feel they benefit from working with someone who has similar experiences to them (Prince's Trust, 2008; Finnegan *et al.*, 2010, Dubois *et al.*, 2011 & Foster and Finnegan, 2014). Peer Mentors also benefit, by gaining new skills, empowerment

and fulfilment (Fletcher and Batty, 2012, p.9).

This research evidence was very similar to the picture given by participants who had knowledge and experience of mentoring. One English mentee reported that he had experienced mental health problems for a considerable period and these had become more severe since his release. He had waited for weeks for a mental health team to offer an assessment and the only support sources he had were his probation officer and his volunteer mentor. Moreover, as stated previously, Centre for Mental Health met with a Welsh 'through the gate' initiative using professional mentors (since closed down) and its service users. Regarding the experience of the English mentee above, the mentoring service was the only community support these two young men with learning disabilities and mental ill-health received. Most of our participants saw mentoring as having a role, not as a stand-alone intervention, but as part of a package and particularly at critical times. There was consensus across events that mentors and peer mentors could have a role in:

- Supporting engagement with other services;
- Advocating on service users' behalf;
- Providing assistance in meeting practical and every day needs;
- Reducing social isolation.

Older people's pathways and access to dementia assessments and support services

The average age of prisoners has risen, in part due to an increase in sentence length but also due to some people entering prison at an older age. Indeed, these have been the group that have increased most within the prison population over the last decade. Around 4% of the prison population is over 60 years and 12% over 50 years (House of Commons Justice Committee, 2013). Those who have been convicted of sexual offences form a significant part of this population, and tend to have lengthy sentences. There is a general consensus that people age more rapidly in prison, and therefore that when considering the needs of the older population, this should include all those aged 50 years and upwards (House of Commons Justice Committee, 2013). Studies have shown high levels of chronic physical illness and conditions in the over-60s group, but also in the 50–59 years age group (House of Commons Justice Committee, 2013). Psychiatric morbidity is also high in both over-60s and over-50s, and particularly so in the 50-59 age group (e.g. see Le Mesurier *et al.*, 2010). Depression is the most common diagnosis. Dementia rates have been estimated at 1-5% across different studies (House of Commons Justice Committee, 2013), but at all our events where prison health and mental health services were represented, concern was expressed that prisoners with such significant cognitive deficits were being missed, and that programmes for screening for dementia and then managing cases was crucial. It was also emphasised that prison staff needed guidance in managing older prisoners and those with dementia.

Our participants agreed that needs of the older prisoner, be that physical, mental and social were markedly different to that of younger prisoners. It was reported that in prisons where

younger adults were merged with the main adult prison population, it was older prisoners who had “...suffered...” most.

“...the younger guys are louder and more aggressive and I think some of the older guys find that hard to cope with....even frightening...”
(Prison service participant)

Outcomes and monitoring

A series of proposals were made across events for greater monitoring to ensure better care for people with mental health and related vulnerabilities. The proposals included:

- The introduction of the Quality Outcome Framework (the outcome-based payments system in community primary care/general practitioner services) to improve prison primary mental health care;
- The further development and strengthening of Health and Justice Indicators of Performance (these have replaced the Prison Health Performance Quality Indicators – which our participants thought were vague and at best limited quality measures);
- Service user / patient measures of quality of care and in particular just how “joined up” their care has been.

Staff development

It was reported at several events that it was currently difficult to recruit general prison health care staff and also in some areas for prison mental health care staff. According to some of our participants prison mental health care offered little in the way of career progression; however, the expansion in England of Liaison & Diversion services has for some participants created greater opportunities to develop such pathways, with a much expanded ‘service’ working in criminal justice settings.

The importance of clinical supervision and systems of staff support was stressed across events, and for any staff working with such a challenging population. Some participants felt that robust supervision being in place should be a measure of quality upon which services ought to be monitored on.

Chapter 8: Consultation findings - Wales

Centre for Mental Health ran three events in Wales, and as with the English events, met a broad range of stakeholders representing all parts of the pathway that an offender might find themselves on. The discussions and findings from these three events were very similar to those of the English events, but the context was different.

Wales had none of the issues associated with the complexity of the English health commissioning system; however, ensuring continuity of care for people leaving prison appeared just as much of a challenge, with many people who may have received a mental health service in prison falling short of entry criteria for community mental health care. The exception to this was for people with a previous history of service use:

“...I suppose what is different here is the Mental Health Measure...people have the right to request an assessment...”

(Voluntary sector participant)

The Mental Health Measure (Welsh Government, 2010) allows former secondary care patients to go back to their mental health team and request a reassessment of their needs, without requiring a GP referral. The Measure also gives a right to more mental health services at the primary care level via GPs, as well as better care planning and involvement in it for secondary care patients and greater access to advocacy for inpatients. Our participants certainly felt that Part 3 of the measure (the right to a re-assessment) was making a difference, but were less clear about other parts of the measure, i.e. Part 1 concerning primary mental health care:

“...I think it varies depending on where you live... but I think the waiting [list] for help is still quite long...perhaps too long for guys leaving here [a prison in South Wales]...”

(Inreach participant)

While the Measure was well received by our participants there was a desire for some English policy initiatives to be introduced in Wales. At these events, just as at previous Welsh consultations for a different exercise (Durcan,

2014), most participants thought Wales would benefit from a Mental Health Crisis Care Concordat.

“...we are starting to do things locally, piloting Street Triage and so on....but a concordat would bring people round the table that we don't have round it at the moment...”

(Police participant)

There was also a desire for the adoption of a programme of Liaison & Diversion services to court and police custody similar to that of NHS England's national programme. Liaison & Diversion services do exist in Wales and, like England, some date back to the late 1980s/early 1990s, but large parts of Wales have no coverage, services that exist work in different ways and most tend to focus only on people with severe and enduring mental health needs. One service represented at the events largely focused on: *“...the more forensic end...”*, i.e. people who have committed serious offences and have a link between their offending and their mental illness.

All women and juveniles (and also some men) from Wales going into custody do so in an English prison. The continuity of care they experienced was variable; communication with some English prisons was perceived as being good and well established, while others were perceived as being difficult to communicate with.

“...we find it very difficult to establish who to speak to....we have had no notice on some releases...”

(Prison health care participant)

Transfers to secure mental health care was perceived as markedly difficult by all our Welsh participants who reported that in both North and South Wales, beds were very difficult to access.

Similarly to England, Welsh participants found it difficult to obtain court reports. It was arguably worse for Welsh prisons as at least in some parts of England requests for these have reduced as a result of the National Liaison & Diversion Programme, where mental health

practitioners often provide same day reports for sentencers and probation. Delays of 12 weeks were reported in Wales, with people often being remanded to custody in the meantime. The reports once produced were often not felt to be useful, or to meet the needs of sentencers requesting them.

Up until recently people being released from prison to Wales had a right to be treated as a priority for re-housing. This right has now been removed. Most Welsh participants were concerned about this and were worried that it would make the release experience even more difficult for Welsh prisoners. However, at the time of the events this was relatively new and the impacts of the two relevant pieces of legislation (the Housing (Wales) Act 2014 and the Social Services and Well-being (Wales) Act 2014) were yet to be determined. The former removes the right to priority housing on release, but gives people leaving prison equal access to enhanced prevention services to assist with finding housing. The latter legislation places a responsibility on local government to meet the care needs of people in prison both pre- and post- release. Some review work conducted by Centre for Mental Health since the change in housing prioritisation suggests that finding accommodation on release in Wales has become more difficult.

“...it’s become a bit of a nightmare really...in the past when our guys were NFA [no fixed abode] on release they had priority...now they don’t and it’s made it very difficult....not just for people with mental health problems but also for the guys with drug and alcohol issues...We’ve had to approve some returns to areas we wouldn’t want them to live in because there has been no choice... ”

(Prison service resettlement representative)

Chapter 9: Discussion

The use of the terms ‘mental health’ and ‘mental health problem’ can mean quite different things to different people and this was obvious across the 17 events, groups and interviews that contributed to this review. These differences can contribute to misunderstandings between professionals and services.

For some of our participants, all the vulnerabilities discussed in this report come under a broad concept of ‘mental health’ or ‘mental health problem’, and they see support and treatment of these prisoners as being the responsibility of prison mental health services. Prison mental health services represented at the events usually understood that they could play a role supporting prisoners with a range of vulnerabilities, but prison inreach teams are small teams working with people with high psychiatric morbidity, and they tend not to have the same range of skills and disciplines as their community counterparts.

Prison inreach teams were introduced to work with people with severe mental illness and while it is acknowledged that there has been some ‘mission creep’ or ‘stretch’, the threshold for entry to an inreach caseload remains high out of necessity.

Prison primary mental health care services arguably have a far greater challenge than their counterparts in the community. Community populations tend not to have the concentrated multiple and complex needs that characterise the prison population. Participants did not believe primary mental health care services in prisons had the skills or resources to meet such challenges effectively.

There are therefore a large number of prisoners who have poor mental health among other multiple and complex needs, but whose needs, when taken individually, fall below the threshold for inreach and therefore fall between the gaps in services. Prison primary care are unlikely to offer an adequate response to these prisoners.

There are a range of problems that our

participants felt were poorly addressed in prisons. Some of these have a high prevalence in the prison population. These are:

- Learning disabilities;
- Acquired brain injury;
- Autistic spectrum disorders;
- Attention deficit hyperactivity disorder;
- Personality disorder;
- Dementia.

Our participants wanted to see better and more routine screening for all of the above; for the results of screening and assessment to have an impact on sentence planning and management; and for specific support to be available for people with such needs in prison. Additionally, participants wanted some form of targeted support that accounted for these vulnerabilities for people leaving prison.

Participants also wanted specific pathways or programmes for older prisoners, and better transitional programmes for young people.

Our events focused on prisons, but were not exclusive to these settings. A far greater number of people come under probation, either under community sentences or on license following release from prison. The mental health and related vulnerability of this population is significant too. Clients of probation services live in the community but our participants reported that often their level of need fell below the threshold for community mental health teams. Mental health services at the primary care level do not for the most part cater for people with complex needs. For example, someone with traits of personality disorder and some substance misuse is unlikely to be accepted by an IAPT service. As with people in prison, offenders in the community appear too often to fall between primary and secondary mental health services, and their complexity of need does not fit into any existing service silos. Some former probation services had contracts that gave a direct service to their clients and/or a consultation service for probation. Some parts of the NPS are reported to have continued these contracts for those offenders who pose a high

risk and their probation officers, but the picture is less clear for CRCs and should be monitored as they develop their offer.

Liaison & Diversion and Street Triage both fell outside the remit of this review but were discussed at all events, where the consensus was that both interventions can play a significant role in intervening early, in supporting the work of courts and in diverting people with vulnerabilities.

Liaison & Diversion services have made a significant difference as evidenced for this review and other recent Centre for Mental Health work. This impact is limited to England and only to those courts that currently have access to such a service. These services have facilitated Mental Health Treatment Requirements, for example, but the timely delivery of the requirement is the remit of community mental health services, some of which have limited experience of working with courts and all of which would struggle to prioritise a person referred by a court over any other referral.

Liaison & Diversion teams meet most of the reporting and information needs of the courts they serve, but our participants told us that a fuller psychiatric report can take very lengthy periods to produce and these are often produced by psychiatrists whom both sentencers and clinicians attending our events felt did not have sufficient expertise or knowledge (particularly of the needs of sentencers and also of local mental health services).

Another opportunity for intervention is at the point when people are released from prison. It was recognised that some releases are hard to plan for, such as remanded prisoners and those on short sentences. But during the events, participants expressed that the leaving prison experience was generally poor and especially so for prisoners with the vulnerabilities we discussed. It was stressed by participants that leaving prison was a critical time and even a crisis time for many people. It was suggested at more than one event that the Crisis Care Concordat should consider released prisoners with vulnerabilities as in crisis and ideally have a proactive response, not least because of the heightened risk of suicide on release.

Our review covered both England and Wales and found a very similar picture across both. The commissioning of health services in Wales is less complex than in England, but ensuring continuity of care on release from prison was seemingly just as difficult. Liaison & Diversion services do exist in Wales, but they are more limited in both scope and coverage. There was a desire among participants for a similar programme of development to that which follows the operating model supported by NHS England. Welsh prisoners had previously had one advantage over English prisoners: prior to April 2015, they were given priority by local authorities in achieving accommodation on release. This has now been removed and recent anecdotal evidence from another Centre for Mental Health review suggests that housing on release has become more difficult for Welsh people released from prisons.

The consultation events took place in February 2015 and much has come to pass since. However, Centre for Mental Health has had the opportunity to review some of the topics covered in a number of areas more recently, and the results suggest that the findings of our consultation remain pertinent.

Key themes

Some consistent themes emerged regardless of the pathway that was being discussed. Our participants felt there was a need for:

- Robust screening and assessment processes for a range of vulnerabilities in all justice settings;
- Wider availability of support and care for people's vulnerabilities regardless of settings;
- Providing pragmatic and practical support (e.g. with housing and debt) at critical periods (e.g. on release from prison);
- Adopting a psychological and trauma focused approach across all justice services and training in these for all who work in them;
- Increasing access in both the community and custodial settings to psychological

interventions that are adapted to reflect complex and multiple needs;

- Increasing the use of mentors and peers and the voice of service users in the planning and provision of services.

There was a desire across events for greater definition of the interface between criminal justice and mental health. There was a strong call for a 'blueprint' for the provision of mental health care and care for related vulnerabilities, similar to that for English Liaison & Diversion services, and covering prisons and other parts of the pathway.

A key policy driver in mental health is the desire to achieve 'parity of esteem', i.e. that mental health be equally valued to physical health. The participants in this review clearly want this applied equally so in prisons and in other settings working with offenders.

Achieving such changes and reforms is difficult at any time and especially during such a straitened fiscal time. But it is likely to bring about better value for money both short-term and over people's lives. Joint working, joint budgets and creative thinking are called for. And it is vital that CCGs and local authorities engage in meeting the health and care needs of some of their most vulnerable citizens.

Conclusion: Addressing the needs identified in the consultation

1. Commissioning

Clinical commissioning groups (CCGs) need to take the lead role in commissioning health services for people leaving custodial settings in their local areas. This would be helped by close working between CCGs and their local probation providers. The role of CCGs in supporting probation and offenders in the community (on community sentences and on release from prison) could be written into the next NHS Mandate. New guidance from NHS England could set out clear expectations for CCGs. One expectation would be that CCGs should enable local community mental health services to give sufficient priority to the provision of Mental Health Treatment Requirements, through variation in local contracts where necessary. There is a need for some national oversight to ensure a consistent and equitable approach is taken, and this is a role that could be filled by NHS England. The Welsh Assembly should provide similar guidance and oversight to Welsh health boards.

2. Training and workforce development

There should be a joint commitment across Ministry of Justice, Home Office, Department of Health, NHS England and the Welsh Assembly that all professionals in criminal justice should receive mental health awareness training (and periodic updates) that helps to achieve a psychologically informed approach to managing offenders. The evidence from this consultation suggests that where awareness training is mandated (e.g. within the police), it works well.

3. An operating model for prison mental health care

It would be helpful for NHS England and the Welsh Assembly to develop a national framework for prison mental health care, similar to the English Liaison & Diversion services. The consultation exercise suggested that the following elements would be helpful:

A. This should be based on a stepped-care model, offering primary as well as secondary care and a range of NICE-approved

psychological therapies. Guidance published by the Royal College of Psychiatrists and forthcoming NICE guidelines may provide a starting point for this framework.

B. This should include designing evidence-based pathways and programmes for a range of vulnerabilities including mental health problems, ADHD, learning disabilities, personality disorder, acquired brain injury, dementia and autistic spectrum disorders. The framework should also address the needs of young people in transition, older prisoners, women, people from different ethnic and cultural communities and foreign nationals.

C. The aim should be to ensure parity of esteem for people in prison with mental health problems and related vulnerabilities. Parity in this context means both equivalence to the care offered outside the criminal justice system and equality with physical health and care needs.

D. The vehicles for monitoring quality (e.g. Health & Justice Indicators of Performance) should reflect the Framework and be informed by service user measures of quality.

E. Guidance should be produced by NHS England and the Welsh Assembly on the prison mental health role in resettlement, 'through the gate' support, and on how Clinical Commissioning Groups (CCGs) should work with probation providers. A framework for supporting probation (NPS and CRCs) for people on license and community sentences should also be developed. This should include specifying CCG, NPS and CRC commissioning responsibilities. This should be monitored by the appropriate regulatory bodies.

F. NHS England, the Welsh Assembly and Ministry of Justice should work together to make mental health reports for Parole Boards a commissioned activity. Reporting arrangements for Parole Boards should be included as part of this process and this will require agreement on commissioning reports agreed with the Parole Board for England and Wales, Ministry of Justice, Department of Health, NHS England and Welsh Assembly.

4. Transfer to secure mental health care

NHS England, the Welsh Assembly and the Ministry of Justice should take urgent steps to speed up transfers from prison to secure care, particularly where these occur outside local areas. It would be helpful if the following were included in future arrangements:

- A.** A rationalised process of assessment should form part of this reform, where a single competent gateway assessment takes place rather than multiple assessments, regardless of where a bed is being sought. A time limit for the assessment to be conducted should be set at the point of request.
- B.** If an assessment indicates a need for transfer, this should happen within a set time limit (14 days).
- C.** NHS England and the Welsh Assembly should oversee and monitor the timely transfer under the Mental Health Act.

5. All prisons as Enabling Environments

The Ministry of Justice, Department of Health, NHS England and the Welsh Assembly should jointly work towards all prisons achieving the Royal College of Psychiatrists' Enabling Environments standards. This could include a far greater role for service user involvement including peer mentoring type interventions to support prisoners with vulnerabilities, and it should include training of mentors and research into its impact.

6. Release from prison as a 'time of crisis'

An idea proposed by one representative and supported when raised at other events was that release from prison should be treated as a time of 'crisis' for people leaving prison with marked vulnerabilities, and covered by the Crisis Care Concordat in England and an equivalent policy directive in Wales. Targeted 'through the gate' support for people with poor mental health and related vulnerabilities should be the joint responsibility of NHS England (to the point of release), CCGs, and the National Probation Service and Community Rehabilitation Centres. This should include pre-release engagement and time-limited support post-release (also for approved premises/supported housing) that includes the provision of health and care

support (including psychological interventions adapted for people with complex needs) and help with basic needs and advocacy. Mentoring and peer mentoring should form part of the response to supporting people leaving prison.

7. Mental health support for probation providers

The consultation revealed a number of examples of good practice in mental health services providing what was perceived to be effective mental health support to probation providers in their work with people on community sentences. This included regular consultation surgeries for probation officers and in some cases a dedicated therapy service for probation clients. Without this, probation providers reported difficulties in receiving such advice (such as provided by consultation surgeries), and difficulties in accessing help for their clients, and receiving both in a timely fashion. Currently people in prison can receive a mental health service, and those in contact with police and courts can be screened, assessed and supported into services. However, beyond the limited number of Mental Health Treatment Requirements, probation providers (and particularly CRCs) have at best limited access to support and yet manage a large group of offenders, many of whom have mental health problems. Many clients on probation also have complex needs. The responsibility for commissioning this is with CCGs, but, like support for people leaving prison, this requires close working with NPS and CRCs and would benefit from new Guidance. At the very least consultation surgeries could be provided, but timely access for probation clients to a therapy service may require a variation in contract for local mental health providers.

8. Court reports

The view from the consultation was that court psychiatric reports should always be provided by psychiatrists who work with offenders; who understand the needs of the courts; and who work locally and can make connections with local services. Her Majesty's Court Service, NHS England and the Welsh Assembly should work together to achieve new contracting arrangements or templates for them, that ensure consistency and quality of psychiatric reports to courts.

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