REPORT

Centre for
Mental Health

The future of prison mental health care in England

A national consultation and review

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Executive summary

Centre for Mental Health has conducted multiple reviews of prison mental health care over the last 15 years. In this time, we have witnessed significant improvements in the provision of mental health services for people in prisons. Despite this, in recent years prison suicides have reached record levels, and so too have recorded self-harm and violence. In some ways, prisons are less safe places now than at the time of previous reviews.

NHS England and NHS Improvement commissioned Centre for Mental Health to conduct a review of mental health care in prisons. This took place over the summer of 2020. We reviewed evidence including more than 100 written submissions and undertook a series of consultation events and interviews.

Mental health and wellbeing in prison are everyone's responsibility. It is not solely the role of health care services to support people's mental health.

There are high levels of multiple and complex needs in the prison population. The entire prison workforce needs to have an understanding of the range of vulnerabilities most prisoners will have and how these might impact on people in prison. This is vital to creating a rehabilitative culture and promoting a positive social environment.

The review concludes that the model of mental health care commissioned by NHS England and NHS Improvement is working well. We found examples of good and innovative practice from the NHS and independent and voluntary and community sector (VCS) providers. But we also found marked variation in provision from prison to prison, and a paucity of psychological therapy offers in some areas and for some categories of prisoners. Screening and assessment processes are not robust and much need is likely to go unidentified.

Pathways in and out of prison are problematic. There are too many avoidable remands and short sentences where a community alternative could have been viable. Those coming into prison on remand and short sentences tend to be those with the highest levels of need. But with short and unpredictable prison stays, and persistent difficulties in communication with services in the community, continuity of care has been difficult to achieve for this group in particular.

Continuity of care for people leaving prison is also problematic. Many prisoners who need support are not receiving it. NHS England and NHS Improvement has commissioned a pilot programme, RECONNECT, targeting the most vulnerable people leaving prison, which is starting to address at least part of this need.

Reforms in the commissioning of healthcare in England offer opportunities for ensuring better continuity of care when people go into prison and when they leave and this can include the meeting of more niche specialist needs. These are Integrated Care Systems (ICSs, which are collaborations between health and social care) and Provider Collaboratives (PCs, which are alliances between local NHS organisations and possibly independent sector providers, to foster closer cooperation between them). These new bodies have the potential for closing gaps in and between mental and physical health care, and in connecting better with social care to address more complex need. To ensure the continuity of care of people who come into and leave prison, it is vital for these new bodies to consider them part of their agenda.

Prisons have made significant adjustments to their regimes during the Covid-19 pandemic to reduce the spread of infections. The cessation of visits and most activities, coupled with long periods of people in prison being confined to their cells, may have some ongoing impact on mental health and wellbeing. While services in the community were able to quickly provide digital alternatives to face-to-face services, with a few exceptions this was not the case in prisons. NHS England and NHS Improvement has invested in 2,000 digital licenses, and Her Majesty's Prison and Probation Service (HMPPS) approved 4G tablets and webcams across prisons. This could have long-term benefits, enabling more support to reach people who need it as an adjunct to face-to-face services.

This review was the first part of a two-stage process. NHS England and NHS Improvement has also commissioned Centre for Mental Health to conduct a mental health needs analysis across the English prison estate which will quantify the levels of service provided, need and (where possible) unmet need. These two exercises combined will inform the future of prison mental health care and any revisions to the national specification for mental health care in prisons.

Recommendations

1. All prisons must work to become trauma-informed environments, and HMPPS should work with its partners to develop a programme of training encompassing the needs of all those working in prison.

    a. There is a compelling case for making significant changes to the basic training that all newly recruited prison officers receive. This should include a significant focus on the vulnerabilities that many prisoners are likely to present with, and on understanding trauma.

    b. Similarly, there is also a compelling case for providing all existing staff with the equivalent knowledge, as a graduated roll-out programme of mandatory training.

    c. All staff in prisons, regardless of agency, should receive at least a basic grounding in common vulnerabilities that present in the prison population. Some of the training in recommendation B could be provided as multi-agency training.

    d. All staff working directly with people in prison should have access to supervision to encourage formal reflective practice.

2. The Government should take steps to minimise the use of short sentences and remands through the following actions:

    a. Rolling out the Community Sentence Treatment Requirement programme to all courts.

    b. Supporting the full implementation of the Independent Review of the Mental Health Act (2018), and the Government's subsequent white paper 'Reforming the Mental Health Act'.

    c. Amending the Bail Act which allows the use of prison as a 'place of safety'. This could be achieved through primary legislation (for example within the forthcoming Mental Health Bill) or through guidance on its implementation to exclude prisons from being used for a person's 'own protection'.

3. The Government should commit to implement recommendation 131 of the Independent Review of the Mental Health Act, to create a new statutory independent role to manage transfers from prisons and immigration removal centres:

    a. This role should have oversight of Section 117 aftercare for people returning to prison from mental health hospitals.

    b. NHS England and NHS Improvement should review compliance with section 117 and provide guidance to providers of prison mental health care to ensure compliance.

4. Integrated Care Systems (ICSs) and Provider Collaboratives (PCs) should be made responsible and accountable for providing continuity of care for people entering or leaving custody from or to their geographical areas.

   a. ICSs will have the range of partners and scale to provide sustainable collaborative care arrangements that people leaving prison require, as envisaged in the RECONNECT programme. This must become a core part of the Community Mental Health Framework as it is implemented over the next three years across England.

   b. Expected legislation to place ICSs on a statutory footing must establish clear responsibility and accountability for the provision of adequate support to people who are leaving prison who have health care needs.

   c. ICSs should develop models whereby specialist services meeting specific needs that cannot be provided at scale within prisons can reach in. This may include perinatal mental health care and support for Deaf prisoners with mental health needs.

5. NHS England and NHS Improvement should initiate a review of the mental health needs and access to care for people from racialised communities in prison. This review should also explore effective approaches in engaging and supporting people from racialised communities.

6. The NHS should develop its digital service capacity in the prison mental health estate. NHS England and NHS Improvement's investment in licenses for all secure settings has already made significant progress in making this a possibility. This programme could test initiatives such as:

   a. Delivering a range of assessments

   b. Extending the reach of psychological interventions

   c. Enabling the delivery of specialist services for people with specific needs.

7. NHS England and NHS Improvement should explore the potential to expand peer support models across the English prison estate. (As a first step, the commissioned Mental Health Needs Analysis will attempt to quantify what is available and where there are gaps in provision.)

Acknowledgements

Introduction

This report details the themes and findings from an independent review of prison mental health care commissioned by NHS England and NHS Improvement. The review was conducted by Centre for Mental Health over the summer of 2020.

Context and history

Centre for Mental Health has conducted several reviews of prison mental health care and particular pathways, regionally and nationally (Durcan and Knowles, 2006; Durcan, 2008; Centre for Mental Health, 2008; and Durcan, 2016). In the 15 years since our earliest review, Centre for Mental Health has witnessed significant improvements and progress in the provision of mental health and wellbeing services. Primary mental health care was rare in prisons in 2008 and now a stepped approach to mental health care forms a key tenet of the current national mental health specification, which is currently due for review. Many prisons are actively involved with the Royal College of Psychiatrists' Quality Network for Prison Mental Health Standards (QNPMHS) and are attempting to apply an aspiring set of practice standards (Georgiou *et al.*, 2018; incorporated into the 2018 version of the national prison mental health specification). However, this consultation has found continuing challenges and areas where people's needs are still not being met. They include:

- Continuity of care for people moving both in and out of prisons

- Offering effective care to remanded and short-term prisoners

- The management and care of most people with a diagnosis of personality disorder

- The particular disadvantages for women in prison

- The unmet level of need for prisoners from racialised communities

- The tendencies for those with comorbidities to fall between gaps in services

- The lack of mental health/vulnerability training and awareness among frontline prison staff

- Transfer from prison to mental health hospital care

- The lack of robust systems to screen and identify mental health need and other vulnerabilities, and to monitor risk to mental health.

The above list is not exhaustive, and all of these challenges (and more) have been known and consistently reported for the last two decades. Some issues have become more prominent and challenging during that time. For example, the prison population has continued to age, and consequently issues such as providing health care for an increasingly frail population and the management of dementia have come more to the fore. In very recent times, prison suicides have reached record levels, and so too have recorded self-harm and violence (including very serious assaults and injuries to prison staff). In some ways, prisons are less safe places now than at the time of previous reviews.

The increased lack of safety is at least in part due to the marked cuts to the prison service (Prison Reform Trust, 2019; Ismail, 2020) as part of the Government's austerity policies which saw staff numbers dramatically reduced and the loss of many experienced staff due to redundancies. In addition, drug use in prison increased with synthetic forms of cannabis and other drugs appearing to flood some prisons and posing huge problems, including the rapid onset of serious physical and mental health conditions. However, synthetic cannabinoids appeared to be less of an issue at the time of this review and reportedly this predated the lockdown.

Prison as punishment versus prison for punishment

A theme present in several of the consultation events was the feeling that mental health and other visiting providers, but also some prison staff and management, clashed with a punitive culture within prisons. The Prison Reform Trust, commenting on this in their written evidence submission, labelled this as 'prison as punishment vs prisons for punishment'. The

latter culture was seen by many as a barrier to rehabilitation. It was perceived as a barrier to understanding mental health and vulnerability and seeing this as a core task of the prison service, rather than something that could be "outsourced to a visiting service". Changing the culture is hugely challenging, and a punitive approach is often reinforced in the news media, social media and in the rhetoric of politicians. Those contributing evidence to this review felt that such a culture change is of critical importance.

The Covid-19 pandemic

The review was commissioned before the pandemic and lockdown, but these inevitably became important considerations for the review as much of the evidence gathering occurred during the summer of 2020. Prisons are always highly restrictive environments, but the level of restriction increased dramatically and largely remains so at the time of writing (December 2020). Visits to people in prison largely ceased, the environmental capacity of the prison estate was expanded to increase single cell occupancy,

time in cell increased and virtually any out-of-cell activity stopped. All of this and more was done with the best of intentions and to stop Covid-19 from spreading in prisons. But it has come at a cost and this was discussed in our consultation events.

Prevalence

The table below emphasises that poor mental health and other vulnerabilities are exceptionally common within the prison population. Most prisoners experience more than one vulnerability. Both the research of Singleton *et al.* (1998) and Bebbington *et al.* (2016) state that 70% of prisoners meet the criteria for two or more diagnoses. With the single possible exception of autism, all of the vulnerabilities listed above have a prevalence rate in prison very much higher than in the general population. Additionally, the experience of trauma and adverse childhood experiences is very common amongst prisoners (Cherie, 2012 and Facer-Irwin *et al.*, 2019). It is therefore reasonable to state that by default, prisoners are vulnerable and have multiple and complex needs.

Diagnosis	Diagnosis/ vulnerability prevalence in the adult prison population
Learning disability	7% of the prison population is estimated to have a marked disability and 25% to have a borderline disability (Talbot, 2008)
Acquired brain injury	60% of adults and 30% young offenders in prison have experienced a traumatic brain injury (Parsonage, 2016)
Autistic spectrum disorder	2% (Underwood *et al.*, 2016 – some studies estimated 4%)
Attention deficit hyperactivity disorder	25.5% (Young *et al.*, 2015)
Personality disorder	66%* (Singleton *et al.*, 1998)
Psychosis	8%* (Singleton *et al.*, 1998)
Depression or anxiety	45% * (Singleton *et al.*, 1998)
Drug dependency	45% * (Singleton *et al.,* 1998)
Alcohol dependency	30% * (Singleton *et al.*, 1998)

Adapted from Durcan (2016)

*Rates and ranges vary by type of prison and between men and women

How the consultation and review was conducted

The aim of the review was to inform future ways of working to promote and improve the mental wellbeing of people coming into prison, and to inform pathways for people with mental health and related vulnerabilities. Such vulnerabilities included: personality disorders, drug misuse (especially in the context of 'dual diagnosis'), learning disability, autistic spectrum disorders, and acquired brain injuries. The review was concerned with arrival in prison, what happened within prison, and leaving prison.

The review was not restricted to the role of its commissioner, NHS England and NHS Improvement, and the mental health care providers it commissioned. It recognised that mental wellbeing and support for vulnerability was everyone's responsibility. Indeed, given the profiles of people in prison, arguably the default is one of multiple and complex need. In light of this, the lead responsibility is therefore with the host, i.e. HMPPS, with mental health care and VCS organisations providing expertise and adding value.

The data

We collected data in four ways:

- There were 12 consultation events where evidence was provided and discussed by anything from 5-20 people

- There were several one-to-one and small group interviews (with regional commissioners, leads from key organisations, people with lived experience and those preferring not to present evidence in a group forum)

- There was a call for written submissions of evidence, published on Centre for Mental Health's website and shared widely to reach as many people and organisations as possible

- We reviewed literature on the topics in the published call for evidence.

Scope

It would be impossible to do every piece of evidence submitted justice in a single report. Indeed, our intention was not to detail every issue we received evidence about. Rather, this report aims to pick up the common themes that emerge and to make recommendations that improve practice and outcomes across a range of areas.

We have also largely limited the evidence we present to that which we have most confidence in. This confidence is given in some cases by robust research to demonstrate a case, or by being a consistent finding emerging throughout the evidence we have seen.

We received over 100 written submissions, and because some of these provided links to other relevant documents and reports, the actual reading list was well over this number.

The call for evidence asked for contributions on a wide range of topics and acknowledged that this list was not exhaustive. The topics that featured in the call were:

Older prisoners

Young adult prisoners

Remand and unsentenced

Short sentenced

Female prisoners

Prisoners from racialised communities

Gypsy, Roma and Traveller prisoners

Different categories of prison

Prison 'hospital' care

Transfer and remission (to/from mental health care)

Release, continuity of care and 'through the gate'

Personality disorder

Comorbid conditions (mental and physical)

Related vulnerabilities

Primary mental health care

Psychological interventions

Self-harm and suicide

Trauma (prisoner and staff)

Veterans

Longer-term impact of Coronavirus

Our original plan had been to run a number of live face-to-face consultation events across the region. The Covid-19 lockdowns meant we had to change the consultation methodology to remote digital events. We used the Microsoft Teams platform and, in some respect, this was advantageous and allowed a much broader coverage and the inclusion of many more voices. Those who found it most challenging to take part were staff working in prisons during an event, who often had limited access to any digital platform and limited equipment to do so. This access (or lack thereof) to digital is itself a finding and is discussed later. Some staff and managers were able to participate from prisons. The 12 virtual events each lasted around two hours.

The consultation events received well over 100 applications and around 70 people took part. These, combined with interviews, amounted to over 30 hours of recorded evidence.

The submissions included documents specifically written for the consultation, as well as published and unpublished reports written for other purposes. Several people submitting evidence had conducted surveys and other research specifically for the consultation. At least one of these included a survey of people currently incarcerated in an English prison sharing their views on provision and what they would like to see. We are especially grateful to them for their invaluable assistance and support for this process.

The contributions to our consultation came from people with lived experience, health care providers, NHS commissioners, prison management and staff, Safer Custody, those with responsibility for the Offender Personality Disorder programme, HMPPS, Ministry of Justice, Inspectorate Bodies, academics, a wide range of VCS providers, and policy and reform organisations.

All regions of the country were covered and prison establishments from every region were represented. Although this was an English review, relevant evidence from Wales and Welsh organisations was also submitted.

Our focus

The aim of the review was not to 'celebrate' the problems, but to look for evidence-based positive practice and new ways of working. However, we do believe we have been given a good picture of the 'state of play', and this is important as it provides us with a baseline that is crucial to the case for change and reform.

Note on examples of services

Several examples of different services are given in this report. We have not evaluated these and are not endorsing them; rather, they are provided as examples of the types and range of services across the estate.

Use of prison

Many of the issues reported here have their roots in or are exacerbated and complicated by the fact that England (and the UK as a whole) puts significantly more of its population in prison than most of its non-former Soviet Union/Warsaw Pact neighbours in western, central and northern Europe (Warmsley, 2018). The overwhelming consensus from the consultation is that far too many people receive a custodial sentence, and short sentences are of particular concern.

Short sentences and remands

Across most of the events and in some written submissions, there were accounts of the challenges of trying to provide mental health care in prisons that have remand and short sentence populations. This is because there is significant 'churn' in such populations and unpredictable lengths of stay, particularly with remanded prisoners. Where an establishment is large, such as HMP Wandsworth (with a population of over 1,500 at the time of writing) where an estimated 900 people are in this 'rapid churn' cohort, it is all the more challenging. These people often have the most complex problems as has been evidenced in the previous prevalence studies (Singleton *et al.*, 1998 and Bebbington *et al.*, 2016). A minimum expectation might be identification and diagnosis of a mental health problem or related vulnerabilities before release. However, the challenge is then being able to achieve continuity of care with community services and communicate any identified need.

There is the additional challenge of receiving information from community services when prisoners arrive. It appears currently to be an unreasonable expectation for a large prison with a constantly changing remand and short sentence population to ever do more than address the 'tip of the iceberg' (and even then, probably not adequately so). It is the firm consensus of those taking part in the consultation that 'small is beautiful' when it comes to prisons (if well-resourced) and that larger establishments make it less possible to deliver the tailored care required. However, it was widely recognised that in this respect,

the Government's direction of travel is quite the opposite, with a desire to build larger establishments, relying on economies of scale and increasing use of technology to produce savings.

Community sentences

There is strong evidence that many people who could have received a community sentence instead of going to prison would have benefited more from this, as would society. There is a strong economic case for community sentences (Wood *et al.*, 2015). The Community Sentence Treatment Requirement (CSTR) programme is of particular importance here. Where a CSTR service operates, it gives magistrates and district judges a sentencing option whereby a community sentence including one or a combination of three treatment requirements (drug, alcohol and mental health) can be applied (with the person's consent). There are now 15 sites delivering CSTRs covering 20% of England's population, which are usually a combination of psychological interventions alongside wraparound support provided by a peer support worker. The Mental Health CSTR will typically involve on average 10-12 psychological intervention sessions, largely delivered by primary care practitioners (supervised by a clinical psychologist). The services involve a great deal of inter-agency collaboration and, critically, are established so that they can offer timely interventions to magistrates and judges, often during the first appearance in court. Sentencers were thereby satisfied that appropriate care was in place and that the defendant was less likely to remanded to prison. Evidence presented from the programme to date reveals that CSTR sites:

- Focus on reducing delays and adjournments and therefore court and other costs (e.g., possible remands), as 80% of sentences occur at the first court appearance

- Focus on improving compliance before reducing breach rates: CSTRs have an 8% breach rate compared to 13% for community sentences generally (Department of Health and Social Care, 2019)

- Sentencers are highly satisfied with them
- Most of those who receive them are satisfied with these sentences (Clinks, 2018).

The move to revisit problem-solving courts is also of relevance in the potential for diverting people from short custodial sentences (see Centre for Justice Innovation, 2016 and Durcan, 2014).

Recommendations 129 and 130 of the Independent Review of the Mental Health Act (2018) address one of the issues influencing remands by recommending magistrate's courts have powers equivalent to Crown courts (see box below). These are now presented in the Government white paper 'Reforming the Mental Act' (HM Government, 2021). The Government is considering recommendation 129 alongside the Law Commission's 'Unfitness to Plead' report (Law Commission, 2016), and is considering developing guidance to achieve the ambition of recommendation 130.

Place of safety/Own protection warrants

The Bail Act 1976 has a provision that allows the sentencer to deny release on bail and remand a person to prison for their "own protection". However, when this applies and in what circumstances is unclear. The Griffins Society have reported on this for women (Patterson, 2015) and the review received evidence from Low Newton (a women's prison in the North East) on data collected between 2017 and 2019. In the case of Low Newton over this three-year period, 18 women had been remanded for their own protection, three of these on more than one occasion with an average stay of 88 days, ranging from one day to one year. The primary reason appears to be for self-harm. Of the 20 courts that sent women to Low Newton, only eight made use of these warrants.

No evidence on how often this warrant is used with men was provided to the review, and establishing this would not appear to be an easy task. (The review was told, however, that the General Director of Prison has commissioned a further review that will include six men's prisons.) The evidence submitted to the review took 30 hours and the review of 1,000 paper-based prisoner records to establish.

It is concerning that prison can and is being used in this way and that health resources were not found instead. The CSTR programme and Liaison and Diversion services clearly have a role to play, and it would be interesting to know if such decisions were made without recourse to the latter. The recommendations of the Independent Review of the Mental Health Act will provide sentencers with some options that might help to prevent use of the Bail Act in this way, but amending the Mental Health Act and guidance alone may not be sufficient.

Independent Review of the Mental Health Act: Recommendations 129 and 130

129. Magistrates' courts should have the following powers, to bring them in line with Crown Courts:

a. Remand for assessment without conviction under section 35 of the Mental Health Act (MHA)

b. Remand for treatment under section 36 of the MHA

c. The power to commit a case to the Crown Court for consideration of a restriction order following an 'actus reus' finding

d. The power to hand down a supervision order following an 'actus reus' finding (where a person is not fit to enter a plea but has been found to have committed the offence) under S1a of the Criminal Procedure (Insanity) Act.

130. Prison should never be used as 'a place of safety' for individuals who meet the criteria for detention under the Mental Health Act.

Prison Staffing and Training

Prison staff numbers and recruitment

The Prison Reform Trust (2019), citing the Ministry of Justice, reported that frontline prison staff were cut by 26% between 2010-2017. Another source (Ismail, 2020) states the reduction was 30% between 2014 and 2017. Yet the prison population remained high, thus increasing the number of prisoners for each staff member to 4.6: twice the number of other comparable European countries.

"Although prison healthcare funding by England's National Health Service has been relatively ring-fenced at £400 million since 2013, day to day health care delivery is highly dependent upon a stable prison regime which is deteriorating." (Ismail, 2020, page 626)

The cuts have been acknowledged as a mistake and the Government has recently invested £100 million to recruit 2,500 staff. However, the Prison Reform Trust reports that whilst this recruitment has been achieved, it is still 9% short of the 2010 staffing figure, and there is significant turnover in prison staff and newly recruited prison staff in particular: over half the staff leaving the prison service in 2018 had worked in prisons for less than two years (Prison Reform Trust, 2019). Critically, the cuts removed a significant cadre of the most experienced staff, those with the most 'jail craft'. It may take years to rebuild the critical level of experience to offer effective mentoring to newly recruited staff.

Both for this exercise and previous Centre for Mental Health prison review work, it has been reported that the decreased staffing has resulted in staff taking on responsibility in prison sooner than might previously have been expected.

Prison staff training

Durcan (2008) reported poor mental health awareness and poor take-up of mental health awareness training by front line prison staff. The very same was reported again in Durcan (2016) and we report this here again in 2020. How a person in prison thinks, comprehends and behaves should matter, and it should

be of concern to all those managing and working in prisons. How this might vary and be impacted by mental illness, learning disability, autism, acquired brain injury, attention deficit hyperactivity disorder, personality disorder and trauma should also be of concern, as most people in prisons will have at least one of the above vulnerabilities. This was widely commented on in both verbal and written evidence submissions: we should "not have to make the case" that a significant part of prison officer basic and ongoing mandatory training ought to be in understanding these vulnerabilities and their impact. The minority of prison officers that work in Planned Psychologically Informed Environments as part of the Offender Personality Disorder programme receive training in understanding personality disorder (the Knowledge and Understanding Framework). Our contributors felt that this, and much more, ought to be provided to all staff. Some contributors felt the culture clash mentioned in the introduction was a barrier to accepting the case for training, and not only amongst prison staff.

There were some impressive exceptions, one being a prison in the North of England where successive governors had encouraged trauma-informed training among all staff. This had reportedly had a significant impact on that prison's culture. This was a male prison, and these are often deemed the establishments with the most entrenched punitive culture. However, though slowed by the pandemic, the charity One Small Thing has now launched its trauma-informed programme in the adult high secure estate as well as across the women's estate.

There is currently no nationally accredited training for mental health practitioners (including mental health nurses, the most populous part of the qualified workforce) in working in prisons and other justice settings. This was seen by several nurse leaders at our events as a gap that needs filling. Skills for Justice (2018) have produced a career and competence framework for staff working other parts of the justice system, i.e., in liaison and diversion services.

Coming into prison

Information

It was disappointing to receive a consistent message from all those establishments represented at the consultation events (around 25% of English prisons) that communication and information sharing with community primary and secondary care services remains challenging.

We heard accounts from people with lived experience who had enormous difficulties in receiving medication after arrival in prison, with communication failures between prison health care and community health care services, causing marked distress whilst in prison. It is not possible for the review to assign blame based on the accounts we received. However, evidence from the Offender Health Research Network shows that, in some cases, prison teams had not sought relevant information. The likelihood is that on some occasions community health care services are at fault and on others prison health care services are at fault. The latter may result from there often being quite small, pressured teams working with limited technology and large liaison demands.

Screening and reception

It is estimated that screening in reception misses about 75% of mental health need (House of Commons Committee of Public Accounts, 2017).

Screening people for mental health problems after they have arrived in prison should be done in two stages. The first is completed as part of the 'First Stage Health Assessment on Reception to Prison' screening (NICE, 2017a, pages 7-15). The recommended format (NICE, 2017b) consists of a schedule of 20 topics, nine of which cover issues surrounding mental health (including questions on conviction/sentence length, alcohol and drug issues, self-harm and history of suicide attempts). One question covers a mix of physical and neurodiverse issues, and the remaining questions cover physical issues. This screening does not require a mental health practitioner to complete it and can be conducted by a 'trained health care

assistant' if supervised by a registered nurse. The schedule mainly covers historical issues and current service use and does not require much in the way of the screener's observation on apparent mental health state, or require the person being screened to self-report on their mental state. There is a reasonable cause for concern here. Firstly, the screener may not have the knowledge and skills to conduct the most robust initial screening. Secondly, the second stage screening (see below) might not take place for up to seven days after arrival in prison; the first few days in prison are a well-established high-risk period, particularly in relation to suicide (e.g. see Pope, 2018 and Shaw *et al.*, 2004).

Our contributors felt improvements needed to be made to reception screening. However, it is highly unlikely that screening at this point can be expected to pick up 100% of need, even if improved. Our contributors gave several reasons why reception screening can be difficult. These included those given above, i.e. the current screening tool is not sensitive enough, and many staff conducting screenings do not have significant mental health training; but contributors also stated:

- Reception to prison is a particularly stressful time for newly arrived prisoners and this may mask issues
- Substance misuse, aftereffects and withdrawal can mask issues
- Some prisoners may be reluctant to retell their story "…yet again…"
- There can be time pressures on screening during prison reception
- People coming into prison may be reluctant to reveal vulnerabilities and may not trust how the information is used
- Hunger, thirst, tiredness and other factors may influence how much is divulged at reception
- Some problems are not apparent at that point or might emerge later
- Some people coming into prison are not aware of their vulnerabilities.

Hence the need for a second stage screening after arrival.

The second point at which mental health issues are screened, the 'Second-Stage Health Assessment in Prisons' (see page 15), is also referred to in NICE Guidelines (2017a) as the 'Second-Stage Mental Health Assessment in Prison' (see page 7). This "should normally be done within 7 days" (page 7). It does not appear from the guidelines that the secondary screening needs to be conducted by someone "competent to perform assessments of mental health problems", but particular mental health screening tools are recommended for use by the screener (i.e., CMHS-M for men and CMHS-W for women[1]; see Ford & Trestman, 2007 and Dietzel *et al.*, 2017, which provides a comparison of several screening tools in the UK custodial context).

Some prison receptions do sometimes have qualified mental health nurses involved in screening, and many will have such staff involved in secondary screening. However, the evidence presented to the review suggests that at both stages, screening is still often done by nurses who are not mental health qualified and may have very limited training in mental health. Additionally, there are a range of vulnerabilities that are overrepresented in prisons which are highly unlikely to be identified in the reception screening, including the whole range of neurodiverse conditions, and particularly so if the screener is not knowledgeable enough.

The QNPMHS has clearly taken the view that at the very least, the second stage screening should be completed by a competent mental health professional. In its annual report for 2019 (Georgiou *et al.*, 2019) it reported that in 42% of English prisons it covers, screening checks were not conducted by a competent mental health practitioner.

The first two QNPMHS standards address the reception (and secondary) screening:

Standard 1

"As part of the formal reception and induction process, every person receives a first and second stage health assessment that incorporates a mental health screen... Guidance: This includes questions and actions relating to learning disabilities and neurodevelopmental disorders."

Standard 2

"The mental health screening assessment is carried out by a competent mental health professional with experience of working with people within the criminal justice system with mental health problems." (Georgiou, 2018, page 10)

QNPMHS membership and commitment to its standards are voluntary, and the standards are of course aspirational. However, their intention is to standardise provision around evidence-based approaches and best practice. QNPMHS test their standards through a rigorous peer review process and their membership during the last published review cycle covered around a third of all English prison establishments. The overall impression given by the evidence submissions to this review suggested that secondary screenings by competent mental health practitioners may be even rarer than the QNPMHS report indicates, and it is likely that any robust screening for learning disabilities and other neurodiverse vulnerabilities may be rarer still.

On a positive note, there were several reports of information from court-based liaison and diversion teams arriving in the prison in a timely way. The roll-out of SystmOne (a health record information system, used by widely in community primary care, by some secondary care NHS trusts and all English prison health services) across England's liaison and diversion services can only increase this and make the timely arrival of information more likely, prompting enhanced screening and assessment.

[1] CMHS = Correctional Mental Health Screening

Secondary screening is a follow-up screening process within seven days of arrival in prison, when the newly arrived person is more settled. Our evidence contributions indicated that secondary screening is at best a hit and miss process. The QNPMHS standard clearly states that all people arriving in prison should be given both a reception *and* a secondary screen, and it is also stated as a requirement in the primary care service specification[2]. This will be challenging with some remand prisoners, whose stays may be very short. We received evidence which clearly indicated that not all prisoners received a secondary screening, and that practices varied considerably by establishment and even within establishments.

Evidence from the Offender Research Network, based at the University of Manchester, collated evidence on screening and confirmed the impression of less-than-robust processes across the prison estate.

Notions of 'watchful waiting' and monitoring of potential mental health risk often seem to be on the 'wish list' for many mental health services rather than currently part of core practice. For example, we were largely unpersuaded that, if we were to enter most prisons with Type 1 diabetes or cardiac disease, we could expect to be routinely monitored for depression.

Mental health care in prison

Centre for Mental Health will be surveying and quantifying the level of mental health provision in a separate exercise in 2021. The findings here largely discuss the 'state of play' issues, experiences and impressions on mental health care given by our contributors, and some models of particular aspects of care.

The national specification for prison mental health care outlines that all prisons should provide a stepped-care model, with self-help at the bottom step and specialist mental health services for those with marked mental illness at the top. However, the overall impression given from both written and verbal evidence is that there are large disparities in what is provided across the English prison estate. We found variation of mental health provision even within a single provider across different establishments. So, in addition to any continuity of care issues from community to prison and prison to community, there can also be issues in providing continuity of care when a person is transferred from one prison to another.

Some prisons had single providers delivering both primary and secondary mental health

care, while others had several providers. The latter was regarded as a complicating factor in working together effectively in some establishments, but not in all.

The review found evidence that integrated mental health services were very limited in their offer to people who did not meet the criteria for secondary mental health care, and even then the offer was limited (typically little or no psychological intervention). However, most were able to present more of a stepped care offer – though with quite significant variation in what was on offer, for the lower steps in particular. The VCS are a significant provider of mental wellbeing services and offered a range of evidence-based, creative, alternative approaches across England. Our lived experience contributors found such services to be engaging and have less stigma attached than attending a 'conventional' mental health service. Whilst there are some national VCS providers (e.g. Rethink Mental Illness) attempting to make similar offers across different contracts, many VCS providers are regionally or sub-regionally based, doubtless adding to the variation in provision.

[2] The 2020 version requires that all patients must be offered a more in-depth health assessment, which if accepted, must be completed within 7 days of reception (in accordance with PSO 3050 and NG57). All reception screening information must be recorded on SystmOne in line with the National Clinical Template.

The use of peer support roles is growing, but some services have made greater advances in this area and could provide the template for others: HMP Swaleside is one such example.

We received mixed reviews regarding effective collaboration between mental health and substance misuse services. Many people reported continuing difficulties in joint working when prisoners had comorbid mental health and substance misuse issues (so-called 'dual-diagnosis'). Disputes over 'ownership' and whether the 'primary problem' is mental health or substance use remain common.

It also appears to be the case that most people with personality disorder are not particularly well served. Excluding those in the Offender Personality Disorder (OPD) programme, the picture of provision for those posing low or medium risk was "some service for some people some of the time", i.e. very patchy provision. Some of the psychological provision such as Dialectical Behaviour Therapy (DBT) and Mentalisation Based Treatment (MBT) were targeted towards people with personality disorders. Although we were given several examples of such provision, the overall view from the evidence is that these were not widespread.

It was also apparent that there is a general paucity of psychological intervention across the English estate, with very limited offers in some prisons. However, we were given some encouraging examples of psychological intervention, such as, psycho-educational groups, the equivalent of IAPT services, and a range of more intensive psychological offers, including to people with personality disorder and people suffering from psychological trauma.

Rethink Mental Illness

Rethink Mental Illness works in prisons across England and is particularly well established in the North East prisons, where it works in close partnership with Tees, Esk & Wear Valleys NHS Foundation Trust. Rethink offers a range of services from steps 1 to 3 of the stepped care model, offering CBT and low-intensity psychological interventions one to one, and group interventions through its Psychological Wellbeing Practitioners and Wellbeing Coaches. It has also provided therapy dogs in some of the North East Prisons (see Durcan, 2018) and has developed 'through the gate' support for people leaving prison, supported by Mental Health Navigators. This latter development is now part of the RECONNECT programme supporting young people, those on short sentences and women released from prison.

The Reader

The Reader has programmes in over 30 secure settings (as well as community-based services) and delivers services in Psychologically Informed Planned Environments as part of the Offender Personality Disorder Programme. It works across England, Wales and Northern Ireland, and 650 people participate in its prison-based programmes.

Contrary to what its name might suggest it does not offer a literacy programme, but instead uses carefully selected literature and readings to form the basis of discussion and reflection. The Reader aims to support self-development in its participants and change how they see themselves and the world around them. It is typically delivered through weekly 90-minute sessions to small groups.

The Reader is well received, both by those who attend it and by prison and clinical staff. It is working in partnership with the University of Cambridge and the University of Liverpool to develop its evidence base.

Devon Cluster Psychological Services

Devon Cluster Psychological Services provides a stepped care model across three prisons (HMPs Exeter, Dartmoor and Channing Wood).

Step 1 is typically delivered with the help of a Support Worker and will involve short-term interventions and guidance for self-support around managing mood, anxiety and sleep hygiene.

Step 2 offers a range of groups delivered in particular to HMPs Dartmoor and Channing Wood. The group offers include:

· Anxiety management

· Mood management

· Dialectical Behaviour Therapy (DBT)

· Acceptance and Commitment Therapy (ACT)

· Trauma

· Mentalisation-Based Therapy (MBT).

The DBT, ACT and MBT are all quite intense offers, with the DBT groups particularly so, with four modules each running for six weeks.

At Step 3, one-to-one Cognitive Behaviour Therapy (CBT) intervention is offered, proving anything from 6-12 sessions.

Step 4 will involve multi-disciplinary support for people with a mental health diagnosis, some of whom receive one-to-one psychological intervention or attending a Step 2 group.

Step 5 is for people with the most severe mental illness, who may require transfer to hospital under the Mental Health Act.

We were provided with a number of models of psychological intervention, including that of Oxleas NHS Foundation Trust's Bradley Therapy Service, provided to the Kent Prisons. It provides a similar model to that provided in the Devon Cluster.

The four primary challenges in psychological interventions services were:

• Providing intervention offers to prisons with significant remand and short-sentence populations, due to the unpredictable nature of prisoners' stays

• Recruiting adequately trained staff in some parts of the country

• Vulnerability to staff sickness, as relatively few staff are skilled enough to provide therapies

• High levels of need amongst prisoners for some form of psychological intervention

• Some services were able to arrange for people on a waiting list to access another service, such as peer support (see EWB mentor service at HMP Swaleside later).

Discussions at evidence-giving events centred on the development of shorter psychological interventions that might meet the needs of remand and short-sentenced prisoners with unpredictable stays. Such services had been developed in the Immigration Removal Centre estate at the time of a previous Centre for Mental Health review (Durcan *et al.*, 2017) although the evidence base for rapidly deployed therapies (e.g., interventions delivered in one or two sessions) is limited.

Other discussions concerned how the critical mass of practitioners capable of delivering a range of psychological interventions might be raised. There are a number of new role innovations in the psychological professions that are starting to address this in other parts of the mental health system. There are now several graduate entry roles within which practitioners deliver brief evidence-based psychologically informed interventions in different settings, with pay at NHS Agenda for Change Band 5. A new graduate wellbeing practitioner role for mental health is in development for national roll out which will build on these innovations. In addition, some services have developed Clinical Associate in Psychology (CAP) posts in a range of settings. These posts focus on psychological formulation within a broad competence framework, and are paid at a higher level than the wellbeing practitioners, with further review of pay band pending. Extending CAPs to work in prison and justice services is somewhat controversial given current uncertainties over nationally recognised pay banding. The attraction of graduate roles in the psychological professions is that the critical mass issue can be resolved relatively quickly – there are approximately 20,000 psychology graduates produced each year for example, many of whom would like to enter a career in the psychological professions.

Specialist Mental Health Units

We received details of two units, each targeted to meet very different needs.

HMP Durham Integrated Support Unit (ISU)

HMP Durham has piloted a new approach to working with prisoners with marked mental health needs, which is being evaluated with the support of Northumbria University. The university kindly submitted their phase one evaluation report, which details the development of the ISU, the model and some changes to this, and details of use up to April 2018 (referrals commenced in October 2017).

The unit is housed at HMP Durham and is a regional resource for prisons in the North East. It has 11 single cells for those admitted and an additional cell for prisoners who are providing a support role (one being a cleaner and one managing a patient information desk). During this first phase of the unit, there were 53 referrals and approximately 48 of these were admitted. The average stay was 43 days, but with a range of 1 to 137 days. Both remanded and sentenced prisoners can be referred. Most of the admissions are from Durham, but three other establishments have also referred cases and had these admitted.

The unit accepts people from category B and C establishments, but not high-risk prisoners and those from category A establishments. It is aimed at those with acute, severe and complex mental health problems. People with personality disorder are not excluded, though where the Offender Personality Disorder Programme is more suitable, a referral to that is recommended. Where mental illness has been substance-induced, admission is also possible.

The unit has a multidisciplinary staff team of mental health practitioners that included (at the time evidence was collated) a speech and language therapist and vacancies for psychological and occupational therapist posts. This report was compiled early in the life of the ISU.

It is clear from the evaluation report that the ISU serves at least two functions. Firstly, it provides a more intensive unit-based treatment and care regime for people with marked mental health problems who might otherwise require transfer under the Mental Health Act to a secure mental health hospital, averting this possibility and allowing the return to an ordinary prison location. Secondly, it provides more intensive treatment and effective management for patients awaiting transfer.

It appears that a minimum of 29% of those admitted were transferred to a hospital and around 36% returned to a prison location. However, around a third of data was missing and so proportions for each could be greater, as could those released from custody altogether.

The feedback we received about the ISU from those at our events was very positive. There was also considerable interest in this model outside the region. Specifically, such units might avoid the need for transfer to hospital for some people and provide a more humane and therapeutic regime for those who will ultimately be transferred.

Wellbeing wing at HMP Swaleside

The work by Oxleas NHS Foundation Trust in partnership with HMP Swaleside provides a very different model to that of the ISU at HMP Durham. It is targeted at people who fall below the secondary care threshold and who may not meet the entry requirement of the prison's mental health teams. It too provides a residential therapeutic programme and also trained peer support workers (Emotional Wellbeing Mentors) to provide support to those on the wing and to a larger group of people across the prison. The programmes provided on the wing have a waiting list and those on the list will be supported by the mentors.

HMP Swaleside serves a population largely on life sentences and stays on the wing are not time limited. The unit is quite large and has 46 residents (42 mentees on the wing and 4 mentors).

Mentees are provided with one-to-one support by a mentor and around 12 attend a programme of psycho-educational courses. The duration of these courses is about a year. The remaining residents are supported in attending standard prison education and work activities.

Care Programme Approach

Our contributors reported that people with the most acute or severe mental health problems managed via the Care Programme Approach (CPA) were arguably the best served cohort, although it was also reported their access to psychological intervention was variable.

The QNPMHS in partnership with Tees, Esk & Wear Valleys NHS Foundation Trust has recently produced guidance on care management using CPA and submitted this to the review (see Georgiou *et al.*, 2020).

A note on commissioning

A small number of discussions were with commissioners and in the main these were from NHS England and NHS Improvement. NHS England and NHS Improvement commissions health services within the prison walls and, with the exception of some other health and justice services and the RECONNECT programme, community service commissioning is much more localised and falls into the realm of the 131 or so Clinical Commissioning Groups (CCGs). It is widely agreed that CCGs do not, on the whole, prioritise people leaving prison or understand arguments for providing them with an enhanced service; they have a great many other commissioning priorities. This was discussed at length during some evidence-giving events.

Changes to the commissioning scene in England could offer opportunities for addressing continuity of care issues, particularly for those leaving prison, but possibly also for providing more niche specialist in-reaching to prisons and addressing transfers and remissions. Integrated Care Systems (ICSs) are statutory bodies that are replacing clinical commissioning groups and taking over responsibility for how NHS funds are spent. They are collaborations between local NHS and social care. Linked to this reform, NHS trusts are required to form into Provider Collaboratives (PCs); essentially, alliances between NHS organisations (and possibly also independent sector providers) to foster closer cooperation between them. These collaboratives could be amongst neighbouring mental health trusts or with local acute and community trusts. NHS-led PCs are in place across the country managing specialised mental health, learning disability and autism pathways. This 'collaborative' model sees providers working together to plan and deliver care for their local population. It has the potential for closing gaps in and between mental and physical health care, and in connecting better with social care to address more complex need. To ensure continuity of care for people who come into and leave prison, it is vital for these new bodies to consider them part of their agenda.

Transfers from prisons

Examples of significant delays in transfers and their marked detriment to prisoners' mental wellbeing were given at most of the events and in written evidence. It was also stated at several events that there was no one held accountable for this. The only consequence of a transfer not taking place in a timely way was to the person needing transfer, and the prison and health staff looking after them. It was also commonly reported that "official counts of waiting times" miss out significant parts of the actual delay.

Evidence given to the Independent Review of the Mental Health Act clearly indicated that, whilst there can be delays at the referral stage and at other points, much of the delay in most transfers lay within the realm of the NHS and its often convoluted assessment process. Centre for Mental Health is very much of the view that implementing the recommendations made by the Independent Review would significantly address these and, at the very least, would make some current practice unlawful and therefore challengeable. It should be noted that new transfer and remission guidance is due to be published by NHS England and NHS Improvement for prisons (and separate guidance for Immigration Removal Centres) around the time of the publication of this report. Publication of these had been delayed by the pandemic.

The white paper largely accepts the Independent Review's recommendations, or at least the ambitions behind each. As stated earlier, the Government are considering developing guidance to achieve recommendation 130. They agree with establishing the independent role envisaged in 131 and are consulting on whether this should be an Approved Mental Health Practitioner-type role or one based with NHS England and NHS Improvement, or one based jointly with HMPPS as well. The Government accepts recommendation 132: *"We accept the time limit set out by the Review (28 days), and agree that this should be statutory, but do not plan to legislate in relation to this immediately, to allow time for the new NHS England and NHS Improvement guidance on secure transfer and remission to be properly embedded. We are consulting on what other safeguards need to be in place before we can implement this"* (HM Government, 2021, page 170). With regards to recommendation 133, the white paper states that this is likely to be achieved through work already being conducted by Ministry of Justice and HMPPS. The Government accepts recommendation 134 and is consulting on how this will be achieved. The only of the above recommendations not to be accepted is 135, and the Government proposes that tribunals instead have the power to make statutory recommendations on leave but that decision-making powers remain with the Secretary of State.

Independent Review of the Mental Health Act: recommendations 130-135

130. Prison should never be used as 'a place of safety' for individuals who meet the criteria for detention under the Mental Health Act.

131. A new statutory independent role should be created to manage transfers from prisons and immigration removal centres.

132. The time from referral for a first assessment to transfer should have a statutory time limit of 28 days. We suggest that this could be split into two new, sequential, statutory time limits of 14 days each: i) from the point of initial referral to the first psychiatric assessment; ii) from the first psychiatric assessment until the transfer takes place (this incorporates the time between the first and second psychiatric assessment and the time to transfer).

133. Decisions concerning leave and transfer of restricted patients should be categorised by the Ministry of Justice according to risk and complexity. Straightforward or low-risk decisions should be taken by the responsible clinician. The Ministry of Justice would have 14 days to override this decision.

134. The new statutory Care and Treatment Plan should include a plan for readmission and consider what factors should be taken into account concerning use of informal admission, section 2 and recall.

135. The powers of the Tribunal should be expanded so that they are able, when deciding not to grant an application for discharge, to direct leave or transfer.

Section 117 Aftercare and remission back to prison

The Offender Health Research Network based at the University of Manchester provided evidence from its own research in this area (Leonard *et al.*, 2020). Their research focused on the people returned to prison after a period of transfer to a mental health hospital ('remittal') in England and Wales. It describes the findings from a study of a prospective cohort of 96 individuals returning from 33 medium secure services, over a period of six months.

The entitlement to Aftercare following admission under a section of the Mental Health Act is a legal right for many of those who have been detained and applies equally to a proportion of those transferred from prison and then returned. Leonard and colleagues found that 88% of the cohort studied had such an entitlement but that only 18% of these had such care in place under the Care Programme Approach (CPA). To phrase it more starkly, 82% of people with a legal right to an Aftercare care plan did not have one at the point of follow-up. This is particularly concerning given the level of difficulty in achieving transfer for many people in the first place. It also appears to amount to a breach of Article 5 of the European Convention of Human Rights, and the Human Rights Act 1998.

What is Section 117 (Aftercare) of the Mental Health Act?

Section 117 applies to people who have been detained under sections 3, 37, 45A, 47 and 48 of the Mental Health Act.

"The duty to provide aftercare services does not end because patients happen to return to hospital, even if they are detained under the Act. The duty applies when patients are transferred back to prison or other place of custody after being detained on the basis of a transfer order under section 47 or 48."

(Department of Health, 2015, Page 280-283)

"Some people who have been in hospital under the Mental Health Act 1983 ('sectioned') can get free after-care when they leave hospital. This is called section 117 ('one-one-seven') after-care. 'After-care' means help you get after you leave hospital that:

- Meets needs that you have because of the mental health condition that caused you to be detained, and

- Reduces the chance of your condition getting worse, so you don't have to go back into hospital.

Section 117 begins when you leave hospital, but hospital staff should start planning your after-care as soon as you go in to hospital."

(Rethink Mental Illness, 2021)

Leaving prison

Leaving prison is a difficult and risky time for anyone. It is a common experience to move from prison to unstable housing circumstances, to have delays in being able to access finances (e.g., benefit payments), and to have inordinate difficulty in finding work. Those with health needs may no longer be registered with a GP and thus face barriers to having these needs met. Many people leaving prison in the past may have been able to access support from VCS services. However, these services have reduced as a result of spending cuts due to austerity policies.

Such cuts also affected probation services, which were additionally hampered by a failed reform policy, 'Transforming Rehabilitation', which commenced around 2013. The reform had potential benefits, and one was that for the first time, anyone with a prison sentence (including those with less than 12 months to serve), would serve some of their sentence in the community and thereby receive supervision and the possibility of support. It is questionable whether this increase in probation's responsibility ever received the financial uplift required. Certainly, the funding formula for Community Rehabilitation Companies (the independent sector-led providers for those in the community posing low or medium risk) was flawed (Audit Office, 2016), and "has achieved poor value for money for the taxpayer" (Audit Office, 2019, page 10). So, what would ordinarily be a high risk and difficult time (leaving prison) has become all the more difficult in recent years. All probation services are being taken back into the public sector, but it is reasonable to expect that it will take some time for them to settle, and difficulties associated with accessing their service and support may not immediately abate.

If we factor in poor mental health and the other vulnerabilities with which this review is concerned, the pathway out of prison becomes riskier still. This is highlighted by the cross-sectional survey (based on the 2014 Adult Psychiatric Morbidity Survey) conducted by Bebbington and colleagues (2021) with a random sample of 7,546 people in England. Former prisoners accounted for 1 in 70 of the sample and had significantly greater current mental health problems across the full spectrum of mental health diagnosis than the general public, alongside greater suicide risk, typically multiple mental health problems including dual diagnosis, and also lower verbal IQ, higher rates of history of childhood adversity and greater current social problems (e.g., housing insecurity). They estimate that the former prisoner population in England is 625,000 individuals. Bebbington and colleagues (2021) conclude that "Prison experience is a marker of enduring psychiatric vulnerability, identifying an important target population for intervention and support. Moreover, the psychiatric attributes of ex-prisoners provide the context for recidivism" (page 1).

Thresholds for accessing community mental health services have always been deemed high by prison mental health services, but evidence given to this review reinforces a generally held perception that the threshold for entry to secondary mental health care has risen higher still in recent years. Some people leaving prisons, though having multiple and complex need, may not reach the thresholds for secondary care in the community. But because of the complexity of their need, they are equally unlikely to meet the criteria of most Improving Access to Psychological Therapies (IAPT) services, which are largely for people with depression and anxiety.

Our contributors saw a need for something akin to the offer given by the Community Sentence Treatment Requirement (CSTR) programme with a combination of practical 'wraparound' support and some form of psychological intervention for a limited time period, perhaps until the person leaving prison could be bridged into what mainstream support is available. Previous research suggests that helping people with mental health and related vulnerabilities to leave prison and move into employment is possible (using evidence-based approaches such as Individual Placement and Support) but that some form of wraparound support is vital for success (Durcan *et al.*, 2018)

NHS England and NHS Improvement's RECONNECT service (currently being rolled out nationally) appears, from interviews conducted during the review, to have the potential to address this need. The RECONNECT programme (which is being funded as part of the NHS Long Term Plan, up to £20 million per annum in 2023/24) provides support during the transition period from prison or immigration detention centre to the community, for those who have vulnerabilities and who would otherwise struggle to engage with community-based health and support services. The RECONNECT services include pre-release engagement, 'through the gate' support, and time-limited tailored support for several weeks post-release, which includes the help of care navigators.

The programme had 11 live pilot sites operational in the autumn of 2020, although the pandemic and lockdowns have slowed its progress. To date, each pilot has been able to operate according to local need and to decide which of the people being released it will prioritise. A national evaluation of the programme's service model was commissioned but this too has been impacted by the pandemic, and instead a 'lessons learned from the pathfinders' report was delivered.

In addition to the £20 million funding described above, NHS England and NHS Improvement is receiving £2.5 million from the Government's £148 million programme to cut drugs crime (in 2021-22), to deliver pilots of an enhanced RECONNECT service. This service would focus on people who have high complexity of needs or are a high risk to themselves or others, and who might require longer term support to consistently engage in community health and support services. This Enhanced RECONNECT service is currently in the design phase and the model will be developed with expertise from people with lived experience, partner organisations and experts.

NHS England and NHS Improvement is sponsoring the pilot programme, which is planned to cover all of England by 2023/2024. It is not clear whether NHS England and NHS Improvement will retain commissioning responsibility beyond this point or whether it might pass on to ICSs.

The RECONNECT services can target a person with any health vulnerability who might otherwise struggle to get help from community-based health and support services. During the pathfinder stage, the service trialled providing support for different groups, with those in the North East prioritising young people, women and those on short sentences leaving prison.

It could be argued that people with severe mental health problems meeting community secondary mental health care entry criteria should fall outside of the remit of RECONNECT. However, given this is a high-risk group and the degree of difficulty some community services may have in making a timely offer (ideally within days of release), at least some people might require a 'holding' service until successfully engaged. There is little research data (or evidence provided to the review) on which to base any calculation of which groups of people, and how many, might benefit most from this service. And social as well as clinical factors might raise a person's risk, such as not having settled accommodation on release (an experience faced by 24.8% of all people released and 18.6% of women – HM Inspectorate of Probation, 2020).

As there is no hard data on which to base an estimate, we have chosen to use a broad range below for illustrative purposes; namely, 10% and 25% of all those released per month qualifying for such a programme.

Statistics on prison leavers reveal that somewhere in the region of 69,500-72,000 people leave prison each year in England and Wales (based on figures for 2017 and 2018, Ministry of Justice, 2019a). If we take the upper figure, that represents 197 prisoners a day. If we extract people in Welsh prisons this leaves 185 people released on average each day in England. Based on the area a typical ICS might cover, and just as an example, the average number of people released per area each month is 128. Using the broad range above (10%-25% of people leaving prison who might be offered such enhanced support), then the number of people requiring the service would be in the region of 13-33 per month per area. Obviously, this is an average; some areas might need to serve more people and some less.

The needs of specific groups and communities

Older people

A trend towards longer sentencing (Prison Reform Trust, 2020) has resulted in a rise in older prisoners. Life in prison (and the lifestyle that might lead to repeated periods of imprisonment) is prematurely ageing, and we might expect prisoners aged 50-55 to have the characteristics of people aged 60-65 in terms of health issues, frailty, etc.

According to Her Majesty's Inspectorate of Prisons (HMIP, 2018) the care of older prisoners provided across the estate is inconsistent. They noted that there was a lack of planning for this growing part of the prison population, and the evidence we received echoed this. There were several examples of good practice, and several sources provided evidence of pathways for prisoners with dementia and other conditions. One example is HMP Norwich, where the regional NHS England and NHS Improvement team has invested in training mental health staff in Cognitive Stimulation Therapy. (Cognitive Stimulation Therapy is typically practiced with small groups of people with mild to moderate dementia. It has been shown to increase cognitive functioning of those treated.)

Older prisoners tend to have more physical health problems and increasing frailty. Some physical health problems increase their risk of poor mental health, but also increase potential challenges in effectively treating both at the same time (e.g. potential risks of taking different medications). This makes the case even further for effective screening and systems of effective monitoring and watchful waiting.

St Andrew's Hospital kindly reviewed the evidence and suggested to the review the following recommendations:

- Identify – create processes and mechanisms to seek out older prisoners with mental health problems

- Treat in the most appropriate setting (prison versus mental healthcare provider); have a coordinated approach between mental health, physical health and social care services

- Train staff, and recruit and provide the appropriate clinical expertise, including the provision of psychiatrists with knowledge of older prisoners' mental health needs

- Equip prisons with the expertise to meet the wellbeing needs of older prisoners, including the provision of allied health professional input, e.g. physiotherapy, speech and language therapy, dietetics, and occupational therapy.

There was a strong consensus at events where the needs of older prisoners were discussed that those with moderate and more severe symptoms of dementia should be transferred to appropriate hospital or care facilities in the community and should not be kept in prison.

Young adults

Young adults (18-24 years) account for 15.4% of the total prison population (Ministry of Justice, 2020a). They reoffend at a higher rate than older adults and are more likely to be convicted of violent crimes, and this is particularly true for those aged 18-20 years (NOMS, 2015). Young adult brains, under normal development, do not achieve maturity until their mid-20s. An immature brain may result in a young person:

- Being more impulsive
- Having greater difficulty controlling their temper
- Taking greater personal risk
- Being less aware of consequences
- Being less aware of the needs of others
- Being more easily influenced by others (adapted from NOMS, 2015).

Poor mental health, personality disorder and the various neurodiversities (see below) are highly prevalent in this population and complicate the picture in terms of maturity. Screening, assessment and diagnoses are also therefore more complex in this group.

HMP Isis, which serves adults mainly under the age of 30, provided evidence on some of the above and on programmes they run targeted at this age group. This included Dialectical Behaviour Therapy (DBT) and Mentalisation-Based Therapy (MBT) programmes, and also a dedicated pathway for those with Attention Deficit Hyperactivity Disorder (ADHD).

Racialised communities

Approximately 27% of the prison population is from a racialised community (Prison reform Trust, 2019) and they are considerably more likely to serve more of their sentence in prison than white people receiving the same sentence (Ministry of Justice, 2019c). Over the last two decades, there has been a rise in the number of Muslim prisoners, who account for 16% of the prison population (House of Commons Library, 2020). Gypsy, Roma and Traveller groups represent about 5% of the prison population, a vast overrepresentation given that they only account for 0.01% of the general population.

The Lammy Report (2017) visited the issues of overrepresentation of people from racialised communities in the prison system and their experience of prisons. The report laid out some stark statistics. People from racialised communities represent:

• 14% of the general population

• 25% of the prison population

• 40% of young people in custody.

People from these communities, and particularly young Black men, have higher arrest rates. They are also more likely to receive prison sentences for drugs offences, and to report having a poorer experience of prison, when compared to people from white UK backgrounds (Lammy, 2017).

We did not receive a great deal of evidence (beyond reviews of the literature) on the met or unmet needs of people from racialised communities, and no examples of good practice. The impression among contributors who commented was that there was probably an underrepresentation of people from racialised communities on prison mental health service caseloads, but no hard evidence of this. There was also a view that, where psychological intervention was available, there would be underrepresentation on these caseloads too. The latter appears to be borne out by the research conducted by McKenzie and colleagues (2019) in two London prisons (Pentonville and London's now closed women's prison Holloway).

Deaf prisoners

Submissions of evidence on Deaf people in prison illustrate the difficulty that all services in prison appear to have in tailoring care to individuals with less common needs. It is not clear exactly how many people in prison are Deaf. The British Deaf Association (2016) reported that approximately 400 people had self-disclosed hearing loss or some form of deafness, but state this is an under-reporting of the numbers. In this report, we are describing issues for Deaf people in prison as opposed to those with hearing loss. Prisoners with hearing loss are likely to be a much larger group than those who identify as Deaf but will also be disadvantaged.

Marked isolation coupled with communication deprivation is the general experience of Deaf people in prison. Only a minority of prison staff have training in British Sign Language (BSL) and BSL interpreters are not routinely provided. Deaf prisoners may have no greater literacy levels than the average prisoner (which are often low) and therefore written communication may also be difficult. This inhibits their ability to take part in almost any activity, such as work or education. It also impedes health and mental health assessments and what can be offered in the way of intervention. We were provided with one case study of a person who spent virtually

no time out of their cell because they did not know that the cell had been unlocked (most people would know due to the noise made), and often only finding out when they were told it was due for locking. Prison officers and other staff are very unlikely to have any training or knowledge in managing and supporting Deaf prisoners (British Deaf Association, 2016).

Dr Alexander Hamilton, a Consultant Forensic Psychiatrist for the Deaf, reported to the review that the lack of access to specialist mental health support was problematic: "there are significant problems with misdiagnosis, over-diagnosis, under-diagnosis, and diagnostic overshadowing. There are also significant errors in risk assessments both over and under-estimating the risks that a Deaf person presents with".

There are some examples of good practice: Dr Hamilton cited the outreach to prison support provided from Rampton Hospital's National High Secure Deaf Service, where a specialist nurse is able to visit Deaf prisoners in prisons in that region and "support them with their isolation, communication, and undertake work to address their risks up to a certain level of complexity. This both supports the Deaf prisoners to be able to integrate into the mainstream prison service, and to avoid unnecessary transfer into the secure hospital system".

Women

Women represent about 4% of the prison population with just 3,231 women incarcerated on 11 December, 2020 (Ministry of Justice, 2020b). As the number of women in prison fell and then stabilised in recent times, the women's prison estate has also shrunk and there are now fewer women's prisons than previously. The result is that women tend on average to be located further from home, family and community than men (an average of 64 miles, according to Prison Reform Trust, 2019). At the beginning of December 2019, there were 3,783 women in prison, but in the same year nearly twice that number (7,278) had entered prison, many on remands and short sentences. Of those remanded by magistrates, 60% would not ultimately receive a custodial sentence. For those given custodial sentences, 58% would be

reconvicted within a year, and for those given sentences of less than 12 months, 73% would be reconvicted within a year of release (Prison Reform Trust, 2019).

Our review once again highlighted the particular disadvantages for women in prison and in particular the even greater negative impact of short sentences, both on women and on society (e.g. children entering the care system).

It is also important to note (see below section on 'Suicide and self-harming') that the most recent statistics reveal there has been a marked increase in self-harming amongst women prisoners (Ministry of Justice, 2021).

However, many of the examples of positive practice and whole system approaches given to the review came from the women's estate. The establishment of Enabling Environments and trauma-informed approaches was perceived to be further developed than it is in the larger men's prison estate. Differences in culture were highlighted too: the cultures in women's prisons were seen as being more receptive to understanding vulnerability.

Some women in prison will be pregnant or have young infants, and some of these may experience varying degrees of poor mental health. HMP Low Newton has developed a perinatal mental health pathway, and such a development is to be commended. Whether other women's prisons follow suit or develop alternatives, it seems reasonable that women with a need for specialist perinatal mental health support should be able to access some degree of inreach from the national programme of these services, developed in the community. The numbers with this marked need are not likely to be high and it might be unreasonable to expect prison mental health services to develop this level of specialism.

A number of community-based services offering a pathway post-release, including women's centres, were mentioned in our evidence-giving events and in written evidence, both by professionals and those with lived experience. It was not known how many were able to offer a 'meet at the gate' service. Regardless, they were all deemed very positive services due to

their gender-specific offer and because at least some workers also had "a lived experience understanding". These were associated with providing what was seen as a safe service for women who had often experienced multiple traumas. The impression from our evidence-giving events, however, is that such services are relatively rare and will therefore not be an option for many women leaving prison.

The National Women's Prisons Health and Social Care Review has just been launched. This is a joint review between NHS England and NHS Improvement and HMPPS with an independent chair (Jenny Talbot OBE). The review is set to complete in January 2022 and aims to improve health and social care for women in prison and on release, improving outcomes and reducing inequalities.

Anawim Women's Centre, Birmingham

Anawim is a well-established women's centre that provides a range of programmes including support for women referred from courts and prisons. These programmes are designed to build resilience and confidence, improve employability and allow creative expression, in a safe space. Additionally, they provide accommodation onsite for some women, with stays of 6-9 months and support to move on. They also provide inreach to two women's prisons in the West Midlands and therefore pre-release engagement for women released from prison.

Neurodiversity and learning disability

Neurodiversity covers a range of variations in cognitive functioning that are different to what we might call typical cognitive functioning. Neurodiversity includes autism, ADHD, dyslexia, dyscalculia, Tourette's syndrome, Developmental Coordination Disorder and a range of other neuro-divergences. Some definitions include intellectual functioning and therefore learning disability. Other definitions include mental illnesses such as schizophrenia and mood disorders, and additionally include 'acquired neurodiversity' and therefore acquired brain injury (ABI). In this section of the report, we are primarily discussing the four neurodiverse areas that featured prominently in the review:

• Autism

• Learning disability

• ADHD

• ABI.

We received a wealth of contributions and evidence regarding autism and learning disability. These are also areas for which there is a wealth of guidance. One of the events was dedicated to both of these areas and had 20 contributors, and several experts submitted additional evidence.

General points from the evidence provided in the review on all four of the neurodiversities covered in this section include:

• With the possible exception of autism, these neurodiversities are overrepresented in the prison population compared to the general population

• Being in prison with any one of these neurodiversities poses challenges above and beyond that for neuro-typical people, and correspondingly requires adjustments within the regime

• Overall, there is a dearth of physical and mental health staff with knowledge in these areas across the prison estate

- Care, treatment and support is generally limited and will vary by establishment

- Prison staff do not receive much training to support their management of neurodiverse people

- Screening and identification processes are weak for all four neurodiversities

- There is very limited specific support for people with these neurodiversities leaving prison.

Autism spectrum disorders (ASD)

We are grateful to Richard Mills of the University of Bath for reviewing much of the evidence on autistic people in prisons.

Currently the screening of ASD lacks precision, and tools tend to over-screen and in some cases under-screen. Underwood and colleagues (2016) conducted a cross-sectional study in London men's prisons and used the 20-item Autism Quotient (AQ-20) and the Autism Diagnostic Observation Schedule with 240 men. They found quite high levels of autistic traits (16%). Having autistic traits is not the same as being autistic, and Underwood *et al.* found that 2% met the criteria for ASD and this level matched that from research in the general population.

The lack of understanding of ASD in prisons can place autistic people at greater risk of:

- Over-medication

- Deprivation of liberty

- Bullying

- Prolonged detention

- No access to treatment programmes

- Restraint

- Seclusion.

This is not an exhaustive list. Additionally, the court process will likely be discriminatory if an autistic person is not able to understand the non-verbal aspects of a court proceeding.

On the horizon

As is stated above, screening tools for ASD have limitations.[3] Nevertheless, their usage plus skilled practitioner observation and a search of available records should be employed to identify possible ASD at the point someone enters prison. The ability to identify and diagnose may be filled by a new version of the Diagnostic Interview for Social and Communication (DISCO – approved by NICE as a diagnostic tool), which is due to be published in 2021. DISCO is useful in complex presentations and the new version has an emphasis on 'forensic' populations.

Learning disability

People with learning disabilities are arguably the best served of these four neurodiversities across the justice services sector. Both prisons and Liaison and Diversion services seek to employ nurses with this speciality. However, 'best served' does not in this case equate to 'well served', as this is a comparatively rare speciality. On 30 September 2020, the Nursing and Midwifery Council had a total of 17,494 learning disability nurses registered in the UK compared to 91,215 mental health nurses (NMC, 2020); a ratio of 1:5. A minority of each discipline might be interested in working in the challenging environment of a prison. The result is that access to learning disability expertise is varied, and many of our contributors reported vacant posts.

Our contributors felt that those with the most marked learning disability were likely to be identified, though there were concerns that some people with learning disability were being missed by the screening process. People with learning disability are a particularly vulnerable group and are at greater risk of exploitation and bullying whilst in prison. During the review, concerns were raised over the capacity of prisons to make and deliver reasonable adjustments, with prison staffing levels and staff awareness being presented as two key

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[3] This includes NICE approved screening tools such as AQ10, AQ20 and the AQ50

challenges to this. This was made more difficult where specialist knowledge within the mental health teams was lacking.

Some psychological interventions and some prison offender behaviour programmes (courses that prisoners may have to attend as part of the sentence management plan) are adapted for people with learning disability. The evidence presented to the review, which mainly concerned interventions offered by mental health services in prisons, suggested access was limited at best.

ADHD

Research suggests that ADHD is vastly overrepresented in the prison population.

Whilst this was discussed in several of the evidence-giving events, there was little knowledge of good practice in this area. The feeling of our contributors and the research evidence suggests a significant proportion of men in prison have ADHD. It was noted that there is also a paucity of services for adults with ADHD in the community.

Our contributors felt that people with ADHD were more likely to have their behaviour attributed to being difficult, awkward and challenging than to an aspect of their neurodiversity.

Responses to their behaviour may therefore be punitive, including loss of privileges and time in segregation units. This may result in more of a sentence being served in custody.

HMP Isis had recruited an ADHD practitioner with lived experience to a role in screening, assessing and monitoring medication. The post is seen as having been very successful, not least because the practitioner's history appears to enable significant engagement with young people with ADHD.

Acquired Brain Injury (ABI)

A very similar picture was presented on people in prison with ABI. A lack of knowledge about ABI meant that people with this diagnosis were often categorised in the rather unhelpful 'behaviour not mental health' category by both prison and health care staff. This means they were more likely to be 'adjudicated' and punished for 'bad behaviour', without curiosity being raised by the frequency of incidents and the possibility of an underlying cause. ABI is also likely to be significantly overrepresented in the prison population: it is estimated that around 60% of prisoners have a history of head injury (Parsonage, 2016 and Williams *et al.*, 2018).

Long and life sentences, Imprisonment for Public Protection, and segregation

Longer sentences and longer tariffs have helped create a rise in the proportion of older prisoners, as discussed earlier. It also has resulted in a growing number of young adults who will serve significant periods of their life in prison. Our contributors expressed concerns over the mental wellbeing of this group over time, particularly a growing sense of hopelessness and depression but also aggression and challenging behaviour. Similar problems are reported in another cohort of prisoners, those who received Imprisonment for Public Protection (IPP) sentences. The Prison Reform Trust (see Edgar *et al.*, 2020) provided evidence on this group. The sentences themselves were abolished in 2012 and no one has received one since. However, as this change was not applied retrospectively, there remain 1,969 people who have never been released and 1,359 who have been recalled under their IPP sentence to prison.

Harris and colleagues (2020) conducted interviews with prisoners who had been recalled and found three themes:

• 'A perpetual state of anxiety' relating to the risk and actuality of recall and spending additional years in prison

• A tendency to withdraw into themselves and avoid contact with others

• An overwhelming sense of hopelessness.

The Prison Reform Trust also raised concern about a large proportion of remaining IPP prisoners who are not making progress through their sentence and have developed entrenched challenging behaviours. Most of these have served more than their minimum tariff, some are years past this. Prisoners on IPP sentences with personality disorder can be catered for within the OPD programme, which has robust processes in place likely to satisfy a parole board, including on release. Prison Reform Trust identifies a gap for IPP prisoners with

mental health problems other than personality disorder, and there is poor data on the number of people in prison on such a sentence with a mental health diagnosis.

It is possible that the RECONNECT programme could provide post-release support, but longer-term support may be required. Good connectivity with prison-based mental health treatment would also be required in order to provide the equivalent to that provided within the OPD programme. It is possible that some IPP prisoners may fall below the thresholds of prison mental health teams, which may make achieving post release support more difficult when they leave.

The review received evidence from a small number of contributors about people in prison in segregation units. These are units where people in prison can be placed as a disciplinary measure for challenging behaviours, for placing other people in danger, for their own protection and, on occasion, whilst waiting for a prison adjudication[4] to prevent communication with other prisons. Being placed in segregation generally means being confined, apart from other prisoners, in what is often a 'spartan' environment.

Our contributors were concerned about the mental wellbeing of people in segregation and particularly those who have long stays in segregation. One prison with a population of people on long sentences reported having a significant cohort of people who exceeded stays of 42 days, the point at which the Secretary of State reviews the decision and decides whether to sanction a continued stay. This prison had over 30 people that had been in segregation for continuous periods of three months or more since the summer of 2019. The mental health needs of these people were perceived to be so marked that they felt it warranted a dedicated mental health resource but were not able to currently provide this.

[4] An adjudication is an internal prison hearing as part of its disciplinary process, overseen by the prison's governor.

Suicide and self-harm

In 2016, suicide or 'self-inflicted death' in prison reached an all-time recorded high but has been reducing in the period since. Recorded incidence of self-harm, which had also reached record levels at that time, continued to rise and in the year up to March 2020 there was an increase of 11% on the previous 12 months, with 64,552 incidents (Ministry of Justice, 2020c). The most recent statistics at the time of writing were for the 12 months leading to September 2020, and these reported that there had been an overall 5% decrease in reported self-harm incidents (a 7% decrease amongst male prisoners), but an increase in female prisoners self-harming of 8% (Ministry of Justice, 2021). In the most recent quarter (July-September 2020) there had been an overall increase in self-harming of 9% (a 5% increase for men) and a 24% increase amongst women, when compared with the previous quarter (Ministry of Justice, 2021).

The Offender Health Research Network provided the review with a description of the research it had conducted on how suicide and self-harm are identified and managed across criminal justice services.

Using a mixed method approach to review the 285 self-inflicted deaths occurring between 2016 and 2018 (in English and Welsh prisons) they found:

- 26% occurred within the first 28 days after arriving in prison, confirming that this is a high-risk period

- 67% had their reception screening carried out by a nurse without mental health qualifications

- 53% did not receive a second stage mental health assessment in the days after arrival in prison

- 63% had a mental health diagnosis recorded

- 32% had a diagnosis of depression

- 18% had a diagnosis of personality disorder

- For those known to have had mental health service contact before coming into prison, records from those services were not sought in 39% of cases.

The prison system for managing prisoners that are deemed to pose a risk of self-harm or suicide is known as Assessment, Care in Custody and Teamwork (ACCT). As part of their review, the Offender Health Research Network conducted a review of ACCT documentation (337 in all) and found the following common flaws:

- ACCT process closure flaws (e.g., no post-closure interviews or second attempts for missed interview)

- Poor records of risk and possible risk triggers

- Poor recording of observations.

The review uncovered some barriers to good practice within ACCT:

- A lack of confidence in risk management and risk aversion

- Low staffing levels

- High levels of staff turnover

- The inexperience of staff

- Cross-deployment of staff, potentially impacting on continuity of care and knowledge of the person at risk

- High levels of scrutiny

- Prison officers' uniform acting as a potential barrier to people disclosing risk or developing trust

- Poor prison design.

The audit did flag some examples of good practice:

- Engaging with family and friends

- Good liaison with mental health teams (or other key professionals)

- Positive interventions including psychological interventions and those focusing on trauma, but also therapy dogs, in-cell packs designed to provide distractions from negative thinking, and systems to support people who self-isolated

- Good management oversight (ACCT data analysis actively being used to provide learning)

- Provision of a 'rehabilitative' environment (e.g., language use, privileges, improved decor)

- Use of peers at different stages such as in the reception process but also later to deliver support.

ACCT is currently under review and those at HMPPS responsible for developing the new version of ACCT have been provided with the Offender Health Research Network findings.

Personality disorder

It is very well established that, though largely undiagnosed in the prison population, personality disorders are highly prevalent among both male and female prisoners. The last significant large-scale prevalence study in the late 1990s demonstrated this (Singleton *et al.*, 1998). Bebbington *et al.* (2016) found somewhat lower prevalence levels in their study of a single male prison and single female prison, but nevertheless found that 34% of their sample met the criteria for one or other of the personality disorders and this rose to 39% for remanded prisoners.

We heard from several people across the regions who were involved in or familiar with the OPD, which replaced the much-criticised former Dangerous and Severe Personality Disorder programme in 2011. The programme provides direct intervention for both people inside prison and those released into the community at much higher levels than its predecessor: in the region of 1,700 individuals (in prison) could be receiving direct interventions at any time, particularly those on intensive treatment programmes, in Therapeutic Communities (TCs) and in Psychologically Informed Planned Environments (PIPEs). A much larger number of people are screened into the programme: approximately 30,000 in both prison and the community, of whom between 13,000 and

14,000 have at least a basic short summative formulation of their issues and needs. The OPD is gradually attempting to have more active intervention with the broader group of people screened into the programme through an outreach model, i.e., working with people in ordinary prison locations and not just in special units.

Some of the direct intervention in prison is via special units, regimes and environments, such as PIPEs, TCs and Enabling Environments (the latter can apply to a whole establishment and therefore a broader group of people can benefit). A feature of PIPEs and TCs is the training all staff (including prison officers) receive to effectively work with people who have personality disorder. Understanding how a person with a personality disorder might understand the world (i.e., how they mentalise) is seen as key to effective intervention and successful management. What is also key is that a PIPE aims to provide a positive social environment and promote a rehabilitative culture.

For people who have been through the more intensive parts of the programme, there is an aim to provide seamless 'through the gate' care on release. For these, community-based OPD programmes will engage with the prisoner six months ahead of release and provide a wrap-around service on release.

The more intensive programme is focused on people who pose a high risk and who are thought to have a 'severe personality disorder', and this limits its reach in terms of direct intervention. This was the primary concern of those providing evidence who were critical of OPD. Many prisoners who pose low or moderate risk will also have personality disorder and most will receive little or no intervention and will be managed by staff who are often not adequately trained for this task.

Trauma-informed and psychologically-informed approaches

Several contributors used the phrase "all behaviour is communication" when explaining the philosophies of interventions, often linked to trauma-informed or psychologically-informed approaches. It encapsulated for these contributors the notion that understanding behaviours, motivations and thinking processes, and how these might be impacted by poor mental health, personality disorder, substance misuse or neurodiversity, is pivotal to good practice in a prison setting. Our contributors noted a tendency among some prison staff and health care providers to dismiss challenging behaviour as just 'bad behaviour', and not see the value in exploring further. Sometimes this reluctance is influenced by work pressures. Of course, some behaviours may not have a deep underlying meaning, but the failure to recognise the potential for the existence of one has resulted in staff adopting a punitive response to vulnerable people and losing opportunities for rehabilitation.

Trauma-informed prisons

Prisons are traumatising environments, and they have a very high prevalence of people who have experienced adverse childhood events (ACEs) and multiple other psychological traumas (Cherie, 2012 and Facer-Irwin, 2019).

Whilst prisons can be traumatising and retraumatising environments, there is a growing body of evidence that these effects can be mitigated, and that individuals suffering from psychological trauma can be helped (Petrillo, 2019). The charity One Small Thing has developed successful programmes across the women's prison estate but has also now made inroads into the male high secure estate (albeit somewhat slowed by the pandemic). And our evidence-giving events provided several other examples independent of these.

The reported examples were mostly women's prisons, but there were at least two examples of male prisons attempting a whole prison trauma-informed approach. In the case of one of these, successive governors had embraced trauma-informed approaches and many prison and other staff had undergone training in this. Those

reporting this stated that the wide embracing of trauma informedness was associated with significant cultural change. This was also associated with a prison taking on more ownership of a wider wellbeing agenda, which itself was associated with more joined up and less siloed working. It was reported in at least one case that the quality and nature of referrals to the prison mental health team had changed, and the degree of joint working across agencies within the prison had improved.

Some contributors highlighted that embracing trauma informedness across an establishment (rather than just delivering specific trauma interventions) offered benefits not only for the people incarcerated in them, but also for staff. Prison staff work in an immensely challenging environment, witnessing and directly experiencing violence and other potentially traumatising events, coupled with the daily routine of their work being stressful. Centre for Mental Health and the Howard League for Penal Reform found this in a recent review (Stubbs and Durcan, 2018). We found that whereas mental health staff in a prison have a built-in recourse to reflective practice through clinical supervision, prison officers, who are arguably more exposed, largely had no such recourse. This is still reported to be the case.

Psychological informedness

Though not an identical notion to 'trauma informedness', 'psychological informedness' is a highly compatible one and augments such an approach. As several of our participants pointed out, the contribution psychology can offer a prison goes beyond specific psychological interventions. Psychological informedness can offer a methodology for understanding thinking, motivations and behaviours that can be tested and refined, and offer interventions to bring about change where that is desired. Psychological informedness would seem to lend itself to individuals with complex and multiple need. The findings from this review were almost identical to those of a previous review and are summed up in the box overleaf, adapted from the previous publication (Durcan, 2016).

Adopting a psychologically informed approach (adapted and updated from Durcan, 2016)

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). However, a psychologically informed approach has much wider application in a prison. A key tool to the approach is the 'formulation', which has 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, page 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 to just 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.

Obviously not all those working in a prison require the in-depth level of training that would enable them to formulate and design interventions. Most people working in prison require an awareness training and grounding in the basics. An example of such a differential training programme is the Knowledge and Understanding Framework (KUF) as part of the OPD programme (Institute of Mental Health, 2018), which provides a range of training from short awareness courses to master's degree level courses.

Peer intervention

Peers were described at one evidence-giving event as an 'untapped resource'. This, of course, is not strictly true and there is a long history of prison-based peer interventions.

'Listeners', trained to provide the prison equivalent of the Samaritans and trained by them, have been with us for 30 years, being first introduced to HMP Swansea in 1991 (Samaritans, 2021). 'Insiders' (see Prison UK, 2014) are another such intervention, typically targeted at working with new arrivals to prison or a wing, providing information, reassurance, befriending and ensuring basic needs are met. They are seen as having a role in reducing the risk of self-harm and suicide (Safer Custody Group, undated). The evidence for peer interventions has been systematically reviewed (Bagnall *et al.*, 2015 and South *et al.*, 2015) and reviewed by HM Inspectorate of Prisons (2016). The evidence is limited but the available research suggests it can be of benefit for both the support recipient (including increasing engagement with services, improving attitudes and behaviour) and the peer worker (including increasing self-confidence and employability), and also to the prison regime.

There were several examples given by VCS services, including RECOOP's trained buddy support workers. These work with older prisoners, supporting them to remain active and maintain physical and mental wellbeing, and reduce isolation. Some of the buddy workers have been trained to provide end of life care. RECOOP provides this service to the Devon Cluster and has worked collaboratively with Devon County Council and the prisons to develop a prison adaptation of the National Care Certificate Standards for its buddy worker team. There were also several examples given of peer support workers in prison mental health services, including in special units such as Durham's ISU and those in HMP Swaleside (see below).

However, there was a view that this resource could be tapped into much more and particularly to support mental wellbeing and mental health care in prisons.

HMP Swaleside emotional wellbeing mentors

Mentors are trained by Oxleas NHS Foundation Trust and work with their peers on the Wellbeing Wing. They also provide outreach peer support across the prison. They are available for call-out 24/7 to support people in crisis within the prison. Such support is usually provided in pairs, with prison staff escorting them to the cell of the person in need.

Like all peers, mentors can have more success in engaging with people in prison than those with a professional role and are seen as understanding the prison experience.

Mentors provide support to individuals and co-work with mental health professionals and therapists in facilitating courses on:

- Mindfulness
- Personal resilience
- Facing up to conflict
- Self-help
- Yoga
- Exercise courses (wellbeing related)
- CBT for low mood and depression.

Mentors do receive pay for their role after serving six months as volunteers.

Covid-19 and the first lockdown

At the time of writing a second national lockdown is under way. This report covers the first lockdown and the period after this to early September 2020, when the review closed. Prisons are always highly restricted environments, but the lockdown brought about the most stringent restrictions, essentially enforcing solitary confinement for much of the prison population. Meaningful activity, such as education and work, ceased. It was apparent from numerous contributors to the review that most prisons and those who reside in them remained as restricted, even after the lockdown was lifted elsewhere.

In the wider community, major lessons have been learnt on how to employ and expand the use of digital technology: in primary care, secondary care and in the voluntary sector. For example, in many areas, mental health crisis cafes were quickly replaced with virtual alternatives. Some of these alternatives to face-to-face contact may stay with us longer term. Sadly, the experience in prison is probably best described as a huge opportunity lost. In the few establishments where in-cell telephony exists, there was some reported good practice, but these appeared to be exceptional. HMP Exeter was one of these exceptions, where pre-existing in-cell telephone points were used for psychological interventions provided by psychology assistants during the crisis. Two additional phone pins were provided to prisoners to enable this service, each therapy call costing just a few pence.

Some of our contributors stated that psychological interventions and even group interventions could have continued if done digitally, and huge lessons could have been learned in how to provide a limited resource (psychological interventions) to a greater number of people. Digital technologies could have been used for assessment and ongoing monitoring, and to maintain and even enhance contact with families. At the very least, such technologies could have reduced isolation. Some specialist services and pathways could, at least in part, be delivered digitally, and the lockdown provided an ideal opportunity to test and pilot these.

A positive note is that NHS England and NHS Improvement has invested in the purchase of 2,000 digital licenses and approved equipment for use in prisons in England that will provide equipment and means of delivering a range of services digitally, including assessments and where appropriate, Mental Health Act assessments. This provides a vehicle to explore digital as an adjunct to mental health care.

The notion of digitally providing health care and mental health care in prisons is not new. The UK's first reported telepsychiatry service to a prison was established on the Isle Wight in 2001 (Leonard, 2004). Nearly 20 years on, and despite the huge leaps made in technology since, we have failed to harness its potential.

Our contributors reported that most therapy and interventions, especially talking therapies, just stopped at the start of the first lockdown and had often not restarted by the end of consultation.

At the outset of the national lockdown, there was a huge concern that people in prison may be particularly impacted by Covid-19. This was understandable, as evidence from the World Health Organization points out that infectious disease can spread with speed in a prison population and then act as a 'hot house' for secondary spread in the community (2014). The fact that the first wave was not as devasting as predicted in prisons is the result of the swift and effective partnership working between HMPPS, the NHS and others, and the regime changes. To reduce the spread of Covid-19, HMPPS attempted to increase the single cell capacity of the estate. At least one closed prison was recommissioned to support this. The slowing down and even closing of courts helped by reducing the flow of people coming into prison for a period. People arriving in prison, who might ultimately go on to share a cell, had a period of quarantine in line with national guidance. As stated, face-to-face contacts were reduced and most activities, including the routine running of health care and mental health care, changed dramatically.

As necessary as these changes were, in the almost total absence of interventions that might have mitigated the negative impacts, harm may have been done. Isolation can significantly damage an individual's mental health, even relatively short term (Metzner *et al.*, 2010). Many people in prison, and all those held in single cells over the lockdown in prisons, have been held in conditions that meet the Mandela definition of solitary confinement (being locked in cell for 22 hours - United Nations, 2016). We were given several examples where people in prison had not been out of their cells, even to have a shower, for several days. It is therefore arguable that there may have been some unacceptable breaches of human rights, at least some of which may have had a negative effect on mental health.

Certain groups will have been more negatively impacted, and these include people from racialised communities (who may have experienced more bereavements due to the higher prevalence of the virus), older people (who our contributors felt had less to stimulate and maintain their mental capacity in a more restrictive regime) and women (with even less contact with family and children).

There were numerous examples of innovative and good practice provided to the review. Many health care and mental health care teams did wellbeing checks via the cell door hatch for people with known pre-existing health and mental health needs but also for the wider population. Several VCS providers created and distributed in-cell packs that helped people in prison to cope. Clinks provided the review with some examples, including RECOOP and Project 507, who created in-cell packs to provide a distraction and relieve boredom and frustration. RECOOP's trained buddy support workers were also able to maintain their presence and peer support by moving on to wings to continue their support for older prisoners, whilst thereby reducing the risk of cross-contamination.

Conclusions

In evidence provided by those working in the OPD programme, two key phrases were used to describe the environments they aim to create: 'positive social environments' and 'rehabilitative culture'. It is fair to state that all our contributors desired the very same thing, but for prisons as a whole.

Mental health and mental wellbeing are everyone's responsibility and not just the responsibility of the NHS. Indeed, we would argue that the prime responsibility for mental wellbeing sits with HMPPS and the prisons as the host organisation. Providing a positive social environment and a rehabilitative culture includes ensuring that the mental and physical wellbeing needs of the prison population are attended to. This is integral to an effective regime.

For this to happen we need a sustained commitment to achieve significant cultural change. In the few examples given where such cultural change has reportedly been witnessed in a prison, this was associated with significant buy-in from prison leadership and the adoption of trauma informedness on a wider scale. Where staff had received training in this, it was associated with culture change. The few examples we were given, where such buy-in was to any scale, were also associated with effective multi-agency working and a move from more siloed working.

The most significant impediments identified by our contributors were the preparedness of all those working in prison for such a task, and staffing levels. Centre for Mental Health concludes from the evidence provided to us that there is a need for a wholesale reform of basic prison officer training, to significantly increase knowledge of the range of vulnerabilities that they will encounter daily. There is a need to train existing prison staff similarly too, and to develop a programme of multi-agency training so that the range of professions working in a prison are best equipped for the task. The

preparedness of prison staff is a significant first step in creating a different and more rehabilitative culture. If delivered correctly it would also enhance security, as a better understanding of vulnerabilities allows for a better understanding of the population served, and therefore of dynamic security.[5] This, in turn, is dependent on adequate staffing levels and stability in staffing.

Reducing the number of short sentences and preventable remands is another key ambition for our contributors. Coming to prison on remand and especially on a short sentence, where an acceptable alternative could have been possible, involves unnecessary disruption in people's lives, often further disadvantaging already disadvantaged and marginalised people and their families, with no advantage to society or to justice. Robust community sentencing that features Community Sentence Treatment Requirements, if available to all courts, could aid in reducing remands and short sentences. Revisiting problem-solving courts will also likely impact on both. Empowering magistrates and district judges with similar powers to those of crown court judges in seeking assessments is also likely to help. This is important because the cohorts of remanded and short sentenced prisoners are consistently found to be those with the most acute needs, arguably with the greatest risk to self. Yet prison-based services find it hardest to offer them support, and continuity of care (in either direction) between the community and the prison is the most difficult to achieve for this group.

The national specification for NHS commissioned mental health services in prison emphasises stepped care and meeting a range of needs. Whilst this is being revisited and does require review, it has gone a long way to achieving the 'blueprint' for prison mental health care that was lacking for so many years (HMIP, 2007). It goes beyond just providing for secondary care need and recognises that even

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[5] Sometimes referred to as 'relational security' and distinct from but complementary to physical security and procedural security'. It is "...the knowledge and understanding staff have of a person and of the environment, and the translation of that information into appropriate responses and care..." (adapted from Department of Health, 2010).

prisoners with so called 'common mental health problems' present with much more complexity than the majority of people presenting with similar needs in the community. The main challenge appears to be the considerable variability in provision and particularly in delivering a comprehensive psychological offer of sufficient scale across the English prison estate.

Whilst short stays in prison are harmful and should be avoided, developing quick-to-deliver psychological interventions for prison settings where people will have unpredictable or short stays is still desirable. One-off or short group interventions such as IAPT style psycho-education courses (see previous examples from Kent prisons and Oxleas NHS Foundation Trust) offer promise. There is a case for developing the evidence base in this area.

There remains, with some exceptions and 'islands of excellence', a paucity in the offer to the wider range of neuro-divergences.

The ability of prison, health and mental health services to identify need across the full range of vulnerabilities described in this report is limited. More vulnerability could be detected at the prison reception and through prison induction processes, and still more could be identified if secondary screening processes for all newly arrived prisoners were developed and

robustly adhered to. We recommend having a range of ways for prisoners to engage, such as those that involve alternative and creative offers, often delivered by VCS partners and through expanded peer support. Peer support can benefit both the person being supported and the peer worker themselves, and has potential for delivering cost-effective care. There is a need to have a greater understanding of what is available, what good practice looks like and where there are gaps.

Digital cannot and never should replace face-to-face contact. But during the current crisis, prisons could have used (and still could use) digital as a means of continuing the provision of support. These are likely to increase the reach of wellbeing services in more normal times and act as a significant adjunct longer term.

In addition to this current review, NHS England and NHS Improvement has already commissioned a Mental Health Needs Analysis of services in the prison state that will attempt to quantify both need and service availability. This, combined with this consultation, will inform the development of pathways for the vulnerabilities described in this report and any revisions to the national prison mental health care specification, as well as advising on gaps in provision. This will be published later this year.

Recommendations

1. All prisons must work to become trauma-informed environments, and HMPPS should work with its partners to develop a programme of training encompassing the needs of all those working in prison.

   a. There is a compelling case for making significant changes to the basic training that all newly recruited prison officers receive. This should include a significant focus on the vulnerabilities that many prisoners are likely to present with, and on understanding trauma.

   b. Similarly, there is also a compelling case for providing all existing staff with the equivalent knowledge, as a graduated roll-out programme of mandatory training.

   c. All staff in prisons, regardless of agency, should receive at least a basic grounding in common vulnerabilities that present in the prison population. Some of the training in recommendation B could be provided as multi-agency training.

   d. All staff working directly with people in prison should have access to supervision to encourage formal reflective practice.

2. The Government should take steps to minimise the use of short sentences and remands through the following actions:

   a. Rolling out the Community Sentence Treatment Requirement programme to all courts.

   b. Supporting the full implementation of the Independent Review of the Mental Health Act (2018), and the Government's subsequent white paper 'Reforming the Mental Health Act'.

   c. Amending the Bail Act which allows the use of prison as a 'place of safety'. This could be achieved through primary legislation (for example within the forthcoming Mental Health Bill) or through guidance on its implementation to exclude prisons from being used for a person's 'own protection'.

3. The Government should commit to implement recommendation 131 of the Independent Review of the Mental Health Act, to create a new statutory independent role to manage transfers from prisons and immigration removal centres:

   a. This role should have oversight of Section 117 aftercare for people returning to prison from mental health hospitals.

   b. NHS England and NHS Improvement should review compliance with section 117 and provide guidance to providers of prison mental health care to ensure compliance.

4. Integrated Care Systems (ICSs) and Provider Collaboratives (PCs) should be made responsible and accountable for providing continuity of care for people entering or leaving custody from or to their geographical areas.

   a. ICSs will have the range of partners and scale to provide sustainable collaborative care arrangements that people leaving prison require, as envisaged in the RECONNECT programme. This must become a core part of the Community Mental Health Framework as it is implemented over the next three years across England.

   b. Expected legislation to place ICSs on a statutory footing must establish clear responsibility and accountability for the provision of adequate support to people who are leaving prison who have health care needs.

   c. ICSs should develop models whereby specialist services meeting specific needs that cannot be provided at scale within prisons can reach in. This may include perinatal mental health care and support for Deaf prisoners with mental health needs.

5. NHS England and NHS Improvement should initiate a review of the mental health needs and access to care for people from racialised communities in prison. This review should also explore effective approaches in engaging and supporting people from racialised communities.

6. The NHS should develop its digital service capacity in the prison mental health estate. NHS England and NHS Improvement's investment in licenses for all secure settings has already made significant progress in making this a possibility. This programme could test initiatives such as:

   a. Delivering a range of assessments

   b. Extending the reach of psychological interventions

   c. Enabling the delivery of specialist services for people with specific needs.

7. NHS England and NHS Improvement should explore the potential to expand peer support models across the English prison estate. (As a first step, the commissioned Mental Health Needs Analysis will attempt to quantify what is available and where there are gaps in provision.)

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Appendix 1: Resources for ASD and learning disability

Reasonable Adjustment Flags

These form part of a national record and indicate that reasonable adjustments are required for an individual. They may include details of their significant impairments and key adjustments that should be considered.

https://digital.nhs.uk/services/reasonable-adjustment-flag

Dynamic Registers and Systems

The link below leads to resources supporting a more dynamic and proactive approach to providing for the needs of autistic people and people with learning disability, including Care and Treatment Reviews.

https://www.england.nhs.uk/learning-disabilities/dynamic-registers-and-dynamic-systems/

Care and Treatment Reviews

Page 31 details the justice pathway for Care and Treatment Reviews

https://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf

Reasonable adjustments for those in substance misuse services

A useful guide both for substance misuse services and more generally

https://www.gov.uk/government/publications/substance-misuse-and-people-with-learning-disabilities/substance-misuse-in-people-with-learning-disabilities-reasonable-adjustments-guidance

STOMP

Guidance on preventing and stopping the overmedication of people with learning disabilities

https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/

Oliver McGowen Mandatory Training in learning disability and autism

The link below leads to an overview of a new training for all those working with autistic people and people with learning disability. Health Education England put out a tender for training providers with a deadline around the time of the first lockdown.

https://www.hee.nhs.uk/our-work/learning-disability/oliver-mcgowan-mandatory-training-learning-disability-autism

Comorbid long-term health conditions in autistic people

A peer reviewed article reporting comorbidity in autistic people across a whole nation (Scotland)

https://bmjopen.bmj.com/content/8/8/e023945

Building Happier Healthier Longer Lives

A very useful overview of issues around autism

https://www.autistica.org.uk/downloads/files/Building-Happier-Healthier-Longer-Lives-The-Autistica-Action-Briefings-2019.pdf

Learning Disabilities Mortality Review (LeDeR)

This link takes you to LeDeR website and developing resources

http://www.bristol.ac.uk/sps/leder/

A Spectrum of Obstacles

A review of access to health care for autistic people

https://westminsterautismcommission.files.wordpress.com/2016/03/ar1011_ncg-autism-report-july-2016.pdf

The future of prison mental health care in England

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REPORT

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The future of prison mental health care in England

A national consultation and review

Dr Graham Durcan