CENTRE FOR MENTAL HEALTH

PRISON MENTAL HEALTH SERVICES IN ENGLAND, 2023

Prison & Young Offender Institution Mental Health Needs Analysis

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EXECUTIVE SUMMARY

Nine out of ten prisoners have at least one mental health or substance misuse problem. Commissioned by NHS England, this report compares current levels of need with prison mental health provision. Centre for Mental Health conducted a survey of current English prison mental health caseloads, staffing, skills and gaps in need, and processes. With the support of regional commissioners and local leads, this involved the distribution of three surveys to all English prisons, young adult Young Offender Institutions (for over 18 year olds) and Young Offender Institutions (YOIs) (under 18) provision in the summer of 2021.

Just over three quarters of England's prisons and YOIs returned at least one of the survey forms. This exercise followed on from a consultation and evidence gathering review on the future of adult prison mental health care, also commissioned by NHS England.

THE FINDINGS

The survey collected data on 7,704 of those on prison and YOI mental health caseloads, representing 14% of the prison and YOI population (13.4% of males and 27.4% of females in prison).

Outside of London the most common diagnoses were anxiety and/or depression, and talking therapies were the most commonly offered main intervention. A diagnosis of personality disorder (after anxiety and/or depression and psychosis) was the next most common presenting problem (17.3% nationally). Attention deficit hyperactivity disorder accounted for nearly 9% of main presenting problems nationally and post-traumatic stress disorder and other trauma diagnoses accounted for 8%. Those with a recognised neurodiverse issue on the caseload accounted for 17.4% (including those for whom this was not the main presenting problem), and research of the prevalence of various neurodiverse issues suggest the numbers of people with one or more in the custodial population will be much higher.

London's prisons and YOIs have quite a different profile to that of other regions, as those returning data from London largely consisted of large local prisons (all prisons in London are for male prisoners), with significant remand and short sentence populations. The proportion of prisoners on mental health caseloads with a main presenting problem of psychosis was significantly higher here than for other areas, and the proportion of those in custody accessing talking therapies was much lower.

In terms of age 17.2% of the caseload was under the age of 25 (compared to 16.1% representation in the prison population) and 12.6% were aged 50 or older (compared to 17.6% in the prison population). The East and the South West had the highest proportions of their caseloads aged over 50 years. Those under 18 accounted for 1.5% of the overall caseload.

Custodial mental health caseloads appear to be broadly representative in terms of ethnicity, i.e. the proportions of people from different ethnic groups largely appear to reflect the custodial population. This also appears to be true for access to talking and psychological therapies, (although previous research has suggested otherwise). However, missing data confounds drawing any firm conclusions.

Black adults and young people in custodial settings, just like their counterparts in the community, are more likely to have a main presenting problem of psychosis, than white people in prison (36.6% and 19.2%).

Missing data made it difficult to report on other equality issues and protected characteristics.

At least 27% of the caseload were due to be released within 12 months, and a significant proportion of these have high levels of need/vulnerability. This highlights the critical need for 'through the gate' support such as NHS England's RECONNECT service.

Histories of self-harm and suicide attempts were common within the population (54% and 40% respectively), and 39% of the caseload had a combined substance misuse and mental health or related problem (i.e. a dual diagnosis). This means that a significant proportion of people on custody mental health and wellbeing caseloads carry significant potential risk. Those on ACCT (Assessment, Care in Custody and Teamwork, the care planning process in His Majesty's Prison Service (HMPS) for those identified as being a self-harm and or suicide risk), accounted for 13% of the caseload.

Transfers under the Mental Health Act remain problematic, with around a quarter of those in custody waiting more than 28 days for an assessment or a transfer to a mental health hospital, and some of those in custody with very significant delays.

A minority establishments use people with mental health expertise in the reception screening or in supporting the processes. Doubtless, this means some needs are missed.

Our self-reported findings on the remittals back to custody from hospital suggest a small proportion of those in custody do not have a Section 117 aftercare plan in place.

There are widely reported gaps in need for those with neurodiverse issues and particularly in supporting those with speech and communication problems and acquired brain injury.

The make-up of mental health teams in custody and resourcing levels vary considerably by region, with the North West seemingly worse off when compared to other regions with regards to multidisciplinary mix. Resourcing also varies by type of secure setting. Children in YOIs have a higher ratio of staffing across most disciplines when compared to those in the adult estate. Those young people who transition to the adult estate may face something of a 'cliff edge' in terms of the support available and yet are likely to have complex need and be highly vulnerable.

There are some challenges in grouping together and considering both adult and under 18 YOIs. Findings on under 18 YOIs must be considered with caution as culture, staffing disciplines and ratios, training, systems, assessment criteria and processes, data collection activity differ for children. Furthermore, the data collection process used in this survey has primarily been designed with adults in mind; this is important as under 18 year olds are less likely to present with florid mental health difficulties or more entrenched substance misuse difficulties and are more likely to present with emerging or less clear cut, sub threshold health presentations. They are also more likely to present with some neurodevelopmental difficulties (e.g. ADHD). Finally, some recommendations may not be applicable to, or suitable for, the different systems in the Children and Young People Secure Estate (CYPSE). For this reason, under 18 YOIs were included mainly to consider issues of relevance to children who may transition.

RECOMMENDATIONS

Centre for Mental Health has been reviewing and supporting improvements in mental health care in custody since around 2005 and has observed significant improvements in the volume and quality of care offered – particularly since NHS England's creation and it being the sole commissioning body for health care in all English prisons and in almost all CYPSE settings in 2013. The level of need within custodial settings remains high and there are some issues that remain to be addressed. The recommendations below (and those previously made in the national consultation report – Durcan, 2021) are made to address these.

1. NHS England should ensure the greater involvement of mental health trained staff in the first night in reception, secondary screenings and the screening of people with long-term physical conditions.

    a. NHS England should commission the development of training to support non-mental health staff members in screening. To further this:

        - A system of supervision by mental health staff of non-mental health trained staff involved in screening should be developed
        - Piloting of training and supervision should take place, with an evaluation of both to establish the best model.

    b. NHS England should support the development of a screening tool and process such as used across the CYPSE, i.e Comprehensive Health Assessment Tool (CHAT).

    c. All young people transitioning from YOIs to adult prisons should be subject to a comprehensive assessment and crossover working process between the teams in the CYPSE and adult estate.

2. NHS England should commission improvements in data collection and, in collaboration with HM Prison & Probation Service (HMPPS) and Youth Custody Service (YCS), ensure better data sharing between custodial settings and health systems.

    Improving the quality and use of data could be done through:

    a. NHS England, HMPPS and YCS continuing to develop the system of data sharing between SystmOne, PNOMIS and wider YCS data (eAsset)

    b. NHS England, in conjunction with HMPPS and YCS, reviewing IT equipment, software running systems, software and internet connection across England's custodial healthcare services, to ensure IT is both efficient and accessible for staff

    c. Addressing deficits in data collection (as identified in this report) as a priority

    d. Developing standardised reporting that would allow for better monitoring (the representativeness of the caseload when compared to the establishment's population, the risk profile of the caseload, and knowing who is due for release and needing resettlement support).

3. The Government should reform the Mental Health Act so that:

    a. Offering an assessment is not dependent on whether a bed is available, and once the need is established a bed must be sought, preferably within region but nationally to avoid delay and if clinical necessity supports this. People transferred out of region, if appropriate, can be transferred into region when there is availability.

    b. Commissioners of secure mental health beds are held accountable for delays and further beds are commissioned if delays remain an issue.

c. The proposed 28-day period for assessment and transfer starts from receipt of referral and (if the need for transfer is agreed), this ends when that transfer is achieved, without gaps or 'stopping the clock.'

d. The model and process for assessment of adults for transfer under the Mental Health Act is revised. One model might be a rota of expert clinicians from each region, with sufficient expertise to be able to decide if a person requires high, medium or low secure placement, and knowledge of the resources within region and nationally. In other words, the first part of the assessment process should determine the need for transfer and ideally find a suitable be bed. If further assessment is required in determining the suitability of a bed, then this must take place and be completed within the consecutive 28-day period. Multiple and duplicate assessments should be avoided.

4. Access to housing, employment and benefits are critical to successful resettlement and transition especially so for children and adults with vulnerabilities. We therefore recommend that adult RECONNECT services must have access to expertise in housing, employment and benefit advice. Transitional care for children and young people should reflect their particular needs.

5. NHS England should address regional disparities in the provision of particular skills, including psychiatrists, nursing staff, social workers, occupational therapists and support workers, and expertise in speech and language therapy, talking therapies, neurodiversity and acquired brain injury. To achieve this:

   a. NHS England should revise the national specification(s) for mental health care and care for those with neurodiverse need to include an ideal model of provision for different custodial setting types with specified staffing of each mental health and related discipline per 1,000 custody population – based on optimal levels of resourcing by region and custodial setting type in this report.

   b. Where the recruitment of particular disciplines is more difficult in some regions or particular custodial settings, alternative means of achieving intervention should be described in the specification, such as a combination of:

      - Training other staff to deliver interventions
      - Live and digital supervision of such staff be provided
      - Digital interventions
      - Collaboration with the relevant professional bodies to address recruitment difficulties and agree alternative means of delivering interventions.

   c. NHS England should review recruitment to mental health roles in prisons and YOIs. This review should involve some piloting and evaluation of:

      - Training nurses and other disciplines to deliver psychological intervention and other therapies
      - The development of preceptorship schemes specific to prison (and other justice settings)
      - The extension of digital technology to provide interventions (e.g. psychological)
      - The development of models of career development within Health and Justice
      - How gaps in skills in identifying and supporting those with neurodiverse conditions might be addressed. This will include recruiting actual staff appropriately skilled and also exploring digital intervention and clinical supervision.

6. NHS England should commission a robust study of the prevalence of mental health problems and neurodiversity within the custodial and probation populations (in partnership with the Ministry of Justice) replicating and extending on the Office of National Statistics work in the late 1990s (Singleton et al., 1998). YOIs, and possibly other secure children's provision and Youth Offending Teams (YOTs), should also be included but should have a design that reflects the specific needs of children.

The findings of this report lend support to the recommendations of the consultation report (see the appendix).

1 INTRODUCTION

NHS England commissioned Centre for Mental Health to complete two pieces of work, which collectively would help to give a picture of the state of prison and YOI mental healthcare in England and which would guide its development in the future. These were a national consultation and evidence review conducted over the summer of 2020, and published in April 2021 (Durcan, 2021), and a National Prison Mental Health Needs Analysis, reported on here.

The former collected published research and directly submitted written and verbal evidence to provide evidence and impressions of the state of prison mental healthcare in England.

Findings in this publication include those from YOIs for children (under-18s). These must be considered with caution as culture, training, staffing ratios, systems, assessment and data collection processes vary considerably in children's settings compared with adult prisons. Furthermore, the data collection process used in this publication was designed primarily with adults in mind; this is important as under 18 year olds are less likely to present with clear mental health difficulties or more entrenched substance misuse difficulties, and more likely to present with less clear-cut, sub-threshold and emerging mental health presentations. They are also more likely to present with some neurodevelopmental difficulties (e.g. ADHD). As a result of these differences, some recommendations may not be applicable to YOIs in the Children and Young People's Secure Estate (CYPSE) or may need adaptation to reflect the very different needs of children and the systems that sit in the CYPSE.

The needs analysis involved surveying all 112[1] English prisons and YOIs (both those for young adult and for children) in the summer of 2021.

Three survey tools were sent via regional commissioners to each custodial setting. The three surveys were:

1. A survey of all mental health and wellbeing caseloads commissioned by NHS England. The data was collected at the individual patient level and asked 42 questions on each.
2. A survey of the teams, skills, vacancies and gaps in service for mental health and wellbeing services in each prison.
3. A survey of processes and how they are managed in each custodial setting.

The surveys were originally due to be sent in February 2021 but were delayed until the summer of 2021 due to Covid-19 and the particular burden on custodial settings and their healthcare teams at that time. However, even during the summer of 2021, healthcare teams, including mental health teams, were still extremely stretched by the demands of the pandemic (including vaccine roll-out). Ultimately, all surveys were completed between July and September 2021.

1 It could also be argued that there are 111 or 113 prisons in England, as some prisons are co-located, as is the case of HMPs Grendon and Springhill (who took part in the exercise), which are on a single site and have one mental health service serving both.

It is fair to say that individually and collectively, completion of the surveys was a very demanding task – particularly the caseload survey. In some cases, this meant collecting data from different systems and some custodial settings found the collection of data from non-healthcare systems very challenging. We would therefore like to acknowledge the significant efforts of the regional commissioners, managers, clinicians and administrators that supported this exercise across England.

The term 'Young Offender Institution' (YOI) is used in this report to describe secure settings which hold children (i.e. those aged 17 and under). The prison service uses the label to apply both to establishments holding children and also those holding young adults. However, culture, systems, training, specifications, staff resourcing, responses and children's needs and presentation in children's settings can vary considerably compared with young adult YOIs and adult prisons. YOIs for under 18 year olds and the broader CYPSE (which includes Secure Children's Homes and a Secure Training Centre) would benefit from a needs analysis specifically focused on children. Furthermore, in terms of recommendations, a recent Safeguarding Review in the CYPSE made the case for minimising blanket imposition of guidance and recommendations for adults on children's settings, since this had potential to undermine children's safeguarding and wider outcomes (HMPPS & YCS, 2019). The current needs analysis only includes YOIs in this exercise for comparison purposes, which might be useful for commissioners and providers alike, particularly around considering transition from the CYPSE to the adult estate.

It is important to note that this needs assessment exercise is not a prevalence study. For the most part, the various tables presented provide detail of diagnostic categories and other factors relating to the current total mental health and wellbeing service caseload for each establishment. Prevalence studies for adults are referred to in this report, and comparing these figures with those of the current caseload presented can give some indication of the degree to which need is being met and of potential gaps in need. However, the best quality custodial prevalence evidence for adults is based on data collected over two decades ago (Singleton et al., 1998) and the best data we have on various neurodiverse conditions tends to be based on smaller scale research.

RESPONSE RATE AND REPRESENTATION

The response rate for the caseload survey was 77%, with 86 establishments returning survey forms. In terms of returning all three survey forms the response rate was 69% and for returning the patient survey with one of the other survey forms (i.e. returning two of the three forms), the response rate was 72%. So, most custodial settings were able to take part in the exercise and just over three-quarters provided data on their mental health caseloads. Many of England's custodial mental health and wellbeing services have more than one provider, and in a small number of cases only one of those providers submitted data.

The response rate gives us reasonable confidence that what is true for the custodial mental health and wellbeing services that responded to our surveys is likely to also be true for the 23% of establishments for which we received no information. This is all the more so as we appear to have at least reasonable coverage of all categories of custodial setting, and in most regions of England a majority of custodial settings took part. Indeed, in only one region of England (the East) did a minority of establishments take part (39%), and even there, the learning nationally and from other regions is likely to apply. We therefore feel the data provided gives us a good picture of those using mental healthcare in adult prisons, the gaps in service and the nature and types of service across England.

Anonymised data was collected on 7,704 individual English custodial mental health care patients. The total English and Welsh prison population in September 2021 was 78,830, of which 73,937 resided in English custodial settings and 54,889 resided in the English custodial settings that completed our patient survey. The custodial settings for which we have patient data at that time represented, in total, about 74% of the English custodial population. The patients we received data on represent about 14% of the custodial population (i.e. 7,704 is 14% of 54,889). This implies that 13.4% of males and 27.4% of females are on a custodial mental health and wellbeing caseload at any one time.

Does the 14% of people in custodial settings on the mental health and wellbeing caseload represent all those in custody with mental health wellbeing and neurodiverse vulnerabilities? Doubtless it does not. The Office of National Statistics research in the late 1990s (Singleton et al., 1998; Lader et al., 2000), whilst now dated, is still the most robust prevalence study of mental illness in the over-16 custodial population in the UK to date (although it should be noted that Lader's sub analysis of 16-18 year olds has since been criticised on the basis that it approached children's mental health using an adult screening lens) (Dimond and Misch, 2002). Singleton and colleagues' analysis (1998) indicated 90% of the population have at least one mental health or related problem. The largest groups of adults within this 90% are people with a diagnosis of personality disorder and those with substance misuse problems.

Research conducted in the first decade of this century (Inreach Review Team, 2007) suggested that at least 23% of the adult prison population would meet the criteria for secondary mental health care alone.

Our sample includes those on all tiers of mental healthcare, including those with primary mental healthcare needs as well as those with marked and severe mental illness, and so the national caseload of 14% might seem low in this light. However, this was the caseload on a particular day, and does not reflect the likely significant churn in caseload population, especially amongst those on remand, short sentences and those on wellbeing and primary care caseloads (who are likely to be on the caseload for short durations) – just as the daily custodial population does not reflect the churn in population over the course of a year.

2 METHOD

The three survey tools were designed in collaboration with NHS England and with the support of a Consultant Forensic Psychiatrist and a Consultant Clinical Psychologist, both of whom were familiar with adult prisons and adult criminal justice mental health services. Each of the tools went through several iterations before coming to their final form.

As previously stated, the needs analysis' launch was delayed until the summer of 2021. Regional NHS England commissioners advised on this delay, as all healthcare teams were very stretched due to the Covid-19 pandemic, restrictions and vaccine roll-out.

In each region the survey pack was distributed by regional commissioners, and this included guidance on completion and details of where to seek further advice.

In the event, 25 calls/emails were received from several establishments, and Centre for Mental Health contacted 40 establishments' custodial mental healthcare teams to better understand their data returns. These conversations were useful in detailing the challenges some establishments had in accessing data for the surveys.

The survey in each case was based on a particular census date and each establishment was given between 4-6 weeks after this date to complete and return the data. Regional commissioners, custodial mental health providers and individual teams negotiated extensions for data return in some cases.

The data provided was based on things as they stood on a particular day – 'the census day' – and in terms of the caseload survey this meant providing data on individual patients that were open to one or more of the mental health teams on that day (and not just those seen on that date).

The model for adult custodial mental health care across England is that of the Integrated Mental Health Team, i.e. a single integrated service that provides a range of types of care dependent on need. Some of the data returns therefore provided a single caseload for an establishment, and the type of service offered each individual was indicated by the interventions they received. However, many adult custodial settings do have different types of caseload ("inreach", "primary mental healthcare", "wellbeing", "ADHD", "learning disability", "enhanced care", "complex needs" and so on) – indeed, there were around 40 different caseload labels. Some of these were quite commonly used and some only occurring in one or two establishments.

Some people will appear on more than one caseload within an establishment. For example, they may be seen by both the part of the Integrated Mental Health Team that provides secondary mental health care (often called "inreach" in adult settings) and also by the part providing psychological intervention. Instructions were given on how to provide data on such cases without duplication.

LIMITATIONS

From follow-up conversations with administrators, managers and clinicians completing the survey, we learnt of challenges in collecting the data. Perhaps the most common challenge was where a survey required information that was not held on SystmOne, the health information system, but instead from PNOMIS, the prison service information system. This would apply to data on the nature of a sentence, whether determinate or indeterminate, and earliest date of release. Access to such data varied considerably by region and even by establishment and explains some of the missing data reported on below. At the time of writing there is a national project trying to address the transfer of data from the different systems. In some cases, data was missing from SystmOne and the person completing the caseload survey could not provide it (e.g. data on ethnicity).

In a small number of cases, where different organisations provided different aspects of mental health and wellbeing care, there were gaps in information, where the person completing the survey was unable to answer questions that applied to services provided by a different provider.

Our survey design process, testing and follow-up conversations helped ensure that, where possible, our survey questions were interpreted as we intended. However, in some cases it was apparent that questions had been misinterpreted.

A very small number of custodial settings misunderstood the purpose of the survey and supplied only a list of main presenting problems, just completing the part of the survey immediately visible on their computer screen. In most cases this was rectified but three custodial settings were unable to do this.

3 FINDINGS FROM THE MENTAL HEALTH CASELOAD SURVEY

Table 1: Proportion of custodial setting responding from each region in England

Region	% of custodial settings from region returning data	% of 7,704 patients
East of England	39%	3.7%
London	75%	7.7%
East and West Midlands	77%	29.6%
North East, Yorkshire (NEY)	70%	16.4%
North West	87%	13.4%
South East	95%	18.4%
South West	95%	10.7%

The survey covered at least 70% of prisons and YOIs from all regions except for the East of England. The region with the greatest proportion of the mental health caseload was the Midlands, which is the region with the most custodial settings.

Below are presented the number of establishments per type of custodial settings as they are commonly categorised. Of course, not all custodial settings within the same category are identical and some will have a different regimes and services within them. This is particularly the case for YOIs housing under 18 year olds who have implemented a trauma-informed approach (The Framework for Integrated Care, SECURE STAIRS – Anna Freud Centre for Families and Children, 2022) and a range of different child-specific processes, assessment tools (e.g. the Comprehensive Health Assessment Tool (CHAT) and requirements and standards (RCPCH, 2019).

Other examples in the adult prisons of these are 24 hour healthcare units (inpatient facilities, often predominantly used for people with mental health problems or related crises) of which there were 25 identified within the prisons returning data, PIPEs (Psychologically Informed Planned Environments – units providing residential care as part of the joint HMPPS and NHS England Offender Personality Disorder (OPD) programme) and Therapeutic Communities (also part of the OPD programme/pathway but some of which predate this). The different regimes can occur in different categories or types of custodial setting. These along with some other units and services are listed (and briefly described) by region and custodial setting type later.

Table 2: Types of custodial settings covered in this mental health and wellbeing survey

Category/ Type of establishment	Number of establishments	Number of patients	% of 7,704 patient
Category A (high secure)	7	632	8.2%
Category B	25	2,934	38.1%
Category C	30	2,731	35.4%
Category D	9	352	4.6%
Female Prisons (all ages)	10	713	9.3%
Young Offender Institutions (male children age 15-17yrs)	2	115	1.5%
Young Offender Institutions (young adults males)	4	227	2.9%

The vast majority of those in custody in England are boys and men. It should be noted that YOIs housing boys aged 15-17s have different culture, training, staffing ratios, responses, assessment systems and processes, and standards – and are predominantly included for the purposes of considering transitional issues. Some young adults will also be held in separate YOIs (listed as a separate prison type in table 2) or on separate units within an adult prison.

The total number of adult female prisoners in England[2] around the time of the survey was 3,186. The female prisons that responded to the survey contained around 2,500 women (or 78.5% of the total female prison population). The 713 female patients on mental health caseloads represent 28.5% of the total female prison population (i.e. of the prisons that responded to the survey), and there were no girls in YOIs (under 18) at the time of data collection. Men of all ages in custody on mental health caseloads account for 13.4% of the male English custodial population. So, female prisoners are approximately twice as likely to be on a prison mental health caseload compared to male prisoners at the time of the survey. This is not a surprise, as the Office of National Statistics' prison prevalence survey of the late 1990s (Singleton et al., 1998) found higher prevalence of mental illness in women compared to men (see also O'Moore & Peden, 2018).

CHARACTERISTICS OF THE TOTAL ENGLISH CUSTODIAL MENTAL HEALTH AND WELLBEING CASELOAD

Table 3: Custodial mental health caseload by age band

Age band	Number	%
15-17 years	89	1.2%
18-21 years	476	6.2%
21-24 years	754	9.8%
25-29 years	1233	16.0%
30-39 years	2411	31.3%
40-49 years	1417	18.4%
50-59 years	691	9.0%
60-69 years	210	2.7%
70 years and older	69	0.9%

There was small amount of missing data on age (4.6%). Children (those under 18 years) and young adults (i.e. 18-25 year olds) account for 17.2% of the caseload population and 12.6% are aged 50 and older. Prisoners aged over 50 years are an increasing part of the prison population. People aged 60 years and over appear to be somewhat underrepresented on the caseload, when compared to

[2] There are no female prisons in Wales.

the representation in the prison population, and especially those over the age of 70 years, although missing data may account for some of this difference.

"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" (page 26, Durcan 2021)

Children aged 15-17 appear to be overrepresented in the caseload. A range of wider evidence has referenced the multiple and complex needs and higher vulnerability of children in custody (for example see Lennox and Khan, 2012; Khan et al., 2021). There has also been greater activity to divert children from entering the Children and Young People's Secure Estate over the last decade compared with adults (resulting in a 68% drop in numbers entering custodial settings reported in 2019-2020 statistical reviews) (YCS, 2022). The converse of this reduction in children entering the CYPSE is that now, only children with the most complex needs and those presenting with the very highest risk of harm to self and others, are likely to be entering these settings – resulting in a greater concentration of children with greater and multiple risks and needs.

Table 4: Age band by region (%)

Age band	East	London	Midlands	NEY	North West	South East	South West
15-17 years	0.0%	0.0%	1.6%	4.2%	0.0%	0	0%
18-21 years	0.0%	7.7%	8.9%	7.1%	3.5%	5.8%	2.2%
21-24 years	7.7%	15.3%	10.9%	10.3%	7.1%	9.3%	7.0%
25-29 years	18.2%	16.5%	17.9%	15.4%	14.4%	14.2%	15.8%
30-39 years	31.8%	26.1%	30.6%	32.5%	32.6%	29.9%	35.9%
40-49 years	23.1%	18.0%	19.7%	18.5%	15.6%	16.0%	21.0%
50-59 years	10.5%	9.2%	7.6%	8.1%	10.0%	9.2%	11.8%
60-69 years	4.2%	2.5%	2.3%	2.4%	2.6%	2.6%	4.5%
70 years and older	3.8%	0.8%	0.5%	0.7%	1.1%	0.6%	1.7%
Missing	0.7%	3.9%	0.0%	0.9%	13.3%	12.6%	0.1%

The East of England has the highest proportion of prisoners aged 50 or over (closely followed by the South West) and especially aged 70 or over. This may be reflective of the prisons from the East that took part rather than the region as whole (only 39% of prisons in the region returned data) but it is also the region that provided evidence of dementia pathways for the national consultation and for which the diagnosis of dementia was highest in this exercise (see later). The South West also had a very high proportion of prisoners aged 50 and over. The average age of prisoners is likely to be raised where significant proportions of prisoners are convicted sex offenders (due to longer sentences and conviction for historical offences) and in the case of the South West, two establishments taking part in the needs analysis provide specialised services for these prisoners.

Table 5: Age band by custodial setting type

Age band	Cat A	Cat B	Cat C	Cat D	Female
18-21 years	1.1%	4.8%	4.7%	0.2%	2.8%
21-24 years	7.1%	10.6%	10.3%	5.5%	7.9%
25-29 years	16.6%	17.3%	17.3%	10.7%	14.3%
30-39 years	34.8%	32.8%	31.7%	28.6%	36.0%
40-49 years	19.9%	17.7%	18.2%	24.9%	25.6%
50-59 years	10.8%	8.5%	8.3%	21.1%	8.9%
60-69 years	3.2%	2.5%	2.6%	6.7%	3.1%
70 years and older	0.8%	0.7%	1.2%	2.0%	0.3%
missing	5.7%	5.2%	5.7%	0.2%	1.2%
					1.2%

Neither type of YOI (children and young adult) are included above for obvious reasons and no one under the age of 18 was on a female prison mental health and wellbeing caseload.

ETHNICITY

Table 6: Ethnicity of caseloads by region

Region	White UK	White other	Black	Asian	Mixed	Other	Missing
All England	62.0%	4.9%	9.8%	5.8%	5.0%	1.2%	11.2%
East	58.7%	3.8%	14.7%	8.0%	6.3%	2.1%	6.3%
London	28.4%	9.4%	28.4%	12.9%	9.9%	5.0%	5.9%
Midlands	61.6%	4.0%	9.6%	6.4%	5.7%	1.2%	11.6%
NEY	76.9%	2.9%	5.1%	3.7%	2.8%	0.7%	7.8%
North West	67.2%	2.2%	3.3%	5.7%	2.9%	0.5%	18.2%
South East	53.7%	7.6%	13.1%	4.4%	4.8%	0.6%	15.9%
South West	72.8%	6.4%	5.5%	4.5%	5.6%	1.1%	4.1%

Table 7: Ethnicity of caseload by custodial setting type

Custodial setting type	White UK	White other	Black	Asian	Mixed	Other	Missing
Cat A	59.7%	5.9%	12.8%	6.8%	7.3%	0.6%	7.0%
Cat B	55.4%	5.45%	11.4%	6.5%	5.1%	1.8%	14.4%
Cat C	66.4%	4.1%	7.1%	5.8%	4.2%	1.0%	11.3%
Cat D	77.1%	4.5%	8.0%	3.0%	5.0%	0.7%	1.7%
Female	69.2%	4.8%	7.9%	3.4%	3.7%	0.5%	10.7%
YOI	57.4%	1.7%	21.7%	7.8%	8.7%	0.9%	1.7%
Young Adult	52.4%	8.7%	17.0%	6.8%	9.2%	2.4%	3.5%

Missing data on ethnicity was 11.2% across England, but three regions exceeded this and the North West and South East have 18.2% and 15.9% missing respectively. Ethnicity and mental health service use was raised as a concern in the National Consultation that preceded this needs analysis (Durcan, 2021, page 27), in particular a perception that people from racialised communities are underrepresented on mental health caseloads and in their access to talking therapies. Indeed, there has been some research to support the latter point (McKenzie et al., 2019). It is therefore especially important to have good quality data for monitoring purposes.

We reviewed both representation on the mental health caseload and representation in terms of receipt of talking or group therapy (comparing Black patients with white patients).[3]

Table 8: Representation of ethnicities in the English prison mental health caseload compared to their representation in the custody population

Ethnicity	Custody population %	Mental health caseload %
White	70.9%	66.9%
Black	13.5%	9.8%
Asian	8.6%	5.8%
Mixed	5.0%	5.0%
Other	1.4%	1.2%

*Note: these ethnicity categories are from Ministry of Justice data (2022a)

Our analysis found that representation of Black people on caseloads appeared to be proportionate to their representation in the custodial population (using publicly available Ministry of Justice data for mid-September 2021 – Ministry of Justice, 2022a). Only seven custodial settings had an underrepresentation of Black people on the mental health caseload by 10% or more, and which might not be accounted for by missing data. Table 8 above, looking at the all-England prison population and mental health caseload, appears to show underrepresentation for those categorised as 'white'¬ (-4.0%), 'Black' (-3.7%), 'Asian' (-2.8%) and 'other' (-0.2%). The total apparent underrepresentation is 10.7%. However, missing data on the caseload is 11.2% (missing custodial population data, i.e. Ministry of Justice data, was marginal at 0.5%), and while this may not be divided proportionately, it does not at present support the view that Black people or those from 'Asian', 'mixed' or 'other' ethnic groups are underrepresented on the mental health caseload when compared to white people.

We compared the proportion of Black and white people accessing any talking therapy (one-to-one or in a group) provided by mental health practitioners, by region. Only the North West showed an underrepresentation (0.8% of Black people accessing talking therapy vs 3.3% on mental health caseload). However, the North West had significant missing data both for ethnicity and interventions, making it impossible to draw any conclusions. We also compared white people on the caseload with people categorised as Asian, Mixed and Other, and were equally unable to draw conclusions. While white people appear to receive talking interventions as a primary intervention at a higher rate than all other ethnic groups at the national level, and especially compared to those categorised as Asian (29.9% vs 22.4%), the large amount of missing data confounds this.

Research and national data on the general population shows racial differences in the rates of some mental health diagnoses, and differential rates in diagnoses of psychosis between white and Black men in particular (e.g. Sharpley et al., 2018; UK Gov, 2021). We reviewed the main presenting problem and ethnicity and, again, compared Black and white patients by region and nationally. Across England, 36.6% of Black patients have psychosis as their main presenting problem compared to 19.2% of white patients. Similar differences are seen across all the regions.

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[3] Publicly available prison data does not separate out 'White UK' from 'White Other' and so for this part of the analysis we combined these categories in order to make a like for like comparison.

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RELIGION

We asked the stated religion for each person in custody, but 59% of this data was missing (i.e. left blank).

Religiosity would appear to be on the decline in the UK: fewer people describe themselves as religious, and as being brought up in a particular religion, and more people identify as agnostic or atheist (see British Social Attitudes, 2019). This question may therefore seem increasingly redundant. However, there are instances where knowledge of religious affiliation may be important. For instance, there has been a reported increase in incidents of Islamophobia in the UK (e.g. Faith Matters, 2020). Islamophobia is often included within definitions of racism, and so knowing more about the religious affiliation of people in prison is important to understanding issues such as equity of access to services, as well as ethnicity and other elements such as gender identity.

SEXUALITY AND GENDER IDENTITY

In terms of sexuality, at least 96% of the caseload identified as heterosexual. However, about a quarter of the data on this was missing, rendering further analysis of limited value.

In terms of gender identity, 0.5% (37 people) were reported to identify as a different gender to that assigned them at birth, and some of these were being supported by healthcare services for gender identity issues. We did not specifically collect data on people who were receiving mental health support while transitioning their gender, but data on this was supplied under the 'other presenting problem' and 'issues being supported with' parts of the survey. Approximately 7% of data was missing. The data did reveal a small number of people who identify as female on the male estate (8) and those who identify as male on the female estate (7). People identifying as non-binary, being supported for gender identity issues, and those who identified as male in a female prisons (and vice versa) had significant risk histories: 73.4% had previously self-harmed, 49% had previously

tried to take their own life and over a quarter were under ACCT (Assessment, Care in Custody and Teamwork – a case management system for those in custody at risk of suicide and self-harm) at the time of data collection.

When reporting on gaps in skills, one custodial setting stated it had a gap around supporting trans people and that it was aware of 10 people in its establishment in need of this support.

SENTENCED OR REMAND, DETERMINATE OR INDETERMINATE SENTENCE, AND DUE FOR RELEASE IN THE NEXT 12 MONTHS

Table 9: Regions

	England	East	London	Midlands	North East & Yorkshire	North West	South East	South West
Sentenced	74.8%	92.7%	31.3%	75.0%	82.7%	78.6%	72.5%	86.7%
Remand	19.2%	0.0%	41.3%	24.0%	16.6%	12.9%	16.6%	13.2%
Other	0.3%	0.7%	0.0%	0.8%	0.0%	0.0%	0.3%	0.0%
Missing	5.6%	6.6%	27.2%	0.2%	0.9%	8.5%	10.6%	0.1%
	England	**East**	**London**	**Midlands**	**North East & Yorkshire**	**North West**	**South East**	**South West**
Determinate	54.0%	56.3%	24.4%	56.5%	61.2%	53.9%	46.5%	70.5%
Indeterminate	11.0%	16.4%	3.0%	11.4%	9.8%	12.8%	7.6%	19.1%
Missing	29.1%	27.3%	72.6%	12.9%	29.0%	33.3%	45.3%	10.4%
	England	**East**	**London**	**Midlands**	**North East & Yorkshire**	**North West**	**South East**	**South West**
Release within 12 months	27.3%	17.8%	15.1%	27.8%	36.3%	29.9%	23.2%	27.2%
Missing	27.3%	2.1%	67.1%	13.2%	20.0%	33.1%	48.0%	14.9%

Status in custody (i.e. whether sentenced or not, whether on a determinate sentence and when they might be released) has some bearing on possible mental health need, and even risk. For example, those on remand are likely to have more acute and unmet mental health needs, and some of those on indeterminate sentences, particularly those on old Imprisonment for Public Protection sentences (Harris et al., 2020), may also have heightened mental health needs. Those due to leave custody within a few months are likely to require additional support and require some resource to support their continuity of need in the community.

Around the time this data was collected, 82.5% of those in custody were sentenced, 16.1% were remanded to prison and 1.3% of prisoners were categorised as non-criminal (this will include foreign nationals held in adult prisons after serving their sentence). A higher proportion of those on remand were on caseloads compared to their proportion in the custodial population. This is entirely understandable as those remanded will often have the most acute and severe mental health issues.

London had the most missing data for all three of these questions; conversations with those completing the survey revealed London had significant difficulties in accessing data from PNOMIS. Most of the London prisons which contributed data are large and busy adult remand prisons and this may have added to the difficulty in amassing data from different systems, and doubtless the significant churn in custodial populations added to the difficulty too.

We asked whether each person on a caseload was due to be released or had an earliest release date within 12 months of the census date. The all-England figure was 27.3%; this is a minimum, as there was a significant amount of missing data.

We estimate that the national figure of 27.3% amounts to a minimum of approximately 3,000 people with marked mental health or neurodiverse needs due to be released within a 12-month period at any point in time. In the case of over 18 year olds, many of these could be a target population for RECONNECT services ('through the gate' support commissioned by NHS England). Those on remand with marked mental health or neurodiverse vulnerability could be added to this figure. Knowing the number of people likely to be released is extremely useful in planning for continuity of care and outreach support.

Table 10: Custodial setting type

	Cat A	Cat B	Cat C	Cat D	Female	YOI	Young Adult
Sentenced	88.3%	48.0%	95.4%	98.3%	78.9%	75.7%	82.0%
Remand	6.2%	42.1%	0.0%	1.5%	19.9%	24.3%	18.0%
Other	0.0%	0.8%	0.1%	0.0%	0.0%	0.0%	0.0%
Missing	5.5%	9.1%	4.5%	0.2%	1.2%	0.0%	0.0%
	Cat A	**Cat B**	**Cat C**	**Cat D**	**Female**	**YOI**	**Young Adult**
Determinate	33.9%	33.0%	82.6%	47.8%	56.3%	30.4%	57.3%
Indeterminate	31.9%	5.0%	10.9%	30.3%	11.1%	2.6%	1.0%
Missing	34.7%	46.8%	6.6%	21.9%	32.0%	67.0%	41.7%
	Cat A	**Cat B**	**Cat C**	**Cat D**	**Female**	**YOI**	**Young Adult**
Release within 12 months	4.1%	18.5%	39.3%	31.6%	28.9%	49.6%	35.0%
Missing	21.2%	49.3%	6.5%	22.4%	21.8%	21.7%	40.3%

FOREIGN NATIONALS ON THE PRISON MENTAL HEALTH CASELOAD

A total of 315 people with a foreign national background were identified in the mental health caseload data, representing 4% of mental health patients. This may be an underrepresentation of the actual number on the caseload, as this data may not have been readily available to those collecting the data. Data was left blank or not recorded for 26.1% of the caseload. Around the time of the data collection, foreign nationals accounted for 12% of the custodial estate population in England and Wales (Ministry of Justice, 2022b), the bulk of whom would have been in England.

Foreign nationals appeared to be more likely to be on ACCT (17.1%) than others in custody on the caseload, and to have a history of self-harm. They also appeared more likely to have a main presenting problem of psychosis (26.3%) and depression or anxiety (34.3%), and slightly more likely to have a main presenting problem of PTSD/trauma (8.9%).

REFERRAL

As might be expected, people were referred to prison mental health services via a range of different referral sources.

Across the sample about 11% had self-referred, with 15% coming from primary care, some possibly as a result of reception to prison screening. A further 17% clearly were referred from reception screening. A range of other referral sources were hard to identify as they were presented as abbreviations in the data, but it was apparent that the bulk of referrals came from within the custodial settings (from prison wings, other departments in the custodial setting and other mental health, substance misuse and health teams in custody), with only a small number being referred from community services.

PRESENTING PROBLEM

Table 11: Primary presenting problem of prisoners on a mental health caseload by region

Primary presenting problems		Region						
	All England	East	London	Midlands	North East & Yorkshire	North West	South East	South West
Psychosis	21.9%	21.0%	41.7%	20.2%	21.6%	26.7%	19.6%	19.6%
Anxiety / Depression	29.0%	24.1%	13.9%	29.8%	32.1%	33.0%	24.0%	38.1%
Personality Disorder	17.3%	25.2%	7.2%	16.4%	20.1%	20.9%	19.4%	12.1%
ADHD	8.9%	4.2%	8.7%	12.6%	6.8%	5.4%	8.9%	7.8%
Substance Misuse	3.4%	1.4%	0.3%	3.7%	0.4%	2.0%	1.5%	15.5%
PTSD / Trauma	8.0%	8.4%	7.4%	7.6%	7.0%	6.2%	11.7%	7.0%
Acquired Brain Injury	0.2%	0.3%	0.0%	0.1%	0.3%	0.3%	0.1%	0.5%
Learning Disability	2.3%	1.4%	1.8%	1.8%	2.6%	2.0%	3.0%	2.5%
Autistic Spectrum Disorder	2.3%	1.4%	3.0%	2.9%	1.3%	0.9%	2.4%	2.8%
Dementia	0.4%	3.1%	0.3%	0.2%	0.2%*	0.8%	0.1%	0.6%
Other	5.0%	0.0%	9.4%	4.7%	4.2%	1.4%	8.2%	1.6%
None	0.2%	2.0%	1.3%	0.0.%	0.0.%	0.1%	0.2%	0.0%
Missing	1.1%	0.7%	5.4%	0.0.%	3.3%	0.3%	0.8%	0.1%

*The NEY region had an additional 10 patients with suspected or actual dementia, identified through other survey questions, bringing the percentage of such patients to 0.9%.

Table 12: Primary presenting problem of prisoners on a mental health caseload by custodial setting type

Primary presenting problems	Custodial setting type						
	Cat A	Cat B	Cat C	Cat D	Female	YOI	Young Adult
Psychosis	24.2%	28.2%	20.7%	8.2%	12.7%	7.8%	6.8%
Anxiety / Depression	28.5%	24.8%	30.15%	49.8%	27.6%	33.0%	37.9%
Personality Disorder	23.6%	15.0%	16.6%	12.9%	31.4%	0.0%	11.7%
ADHD	2.8%	10.1%	9.2%	2.7%	2.0%	34.8%	26.2%
Substance Misuse	5.5%	1.1.%	5.4%	7.5%	2.3%	4.3%	0.0%
PTSD / Trauma	4.7%	6.6%	8.9%	9.2%	14.0%	5.2%	5.3%
Acquired Brain Injury	0.0%	0.1%	0.3%	0.5%	0.0%	0.9%	0.0%
Learning Disability	1.9%	2.6%	2.2%	1.7%	1.5%	3.5%	2.4%
Autistic Spectrum Disorder	1.1%	3.5%	1.5%	1.0%	1.8%	2.6%	1.0%
Dementia	0.3%	0.3%	0.8%	0.0%	0.0%	0.0%	0.0%
Other	4.5%	6.3%	3.0%	3.0%	4.1%	7.8%	8.7%
None	0.3%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Missing	2.5%	1.4%	0.2%	3.5%	2.5%	0.0%	0.0%

Across both regions and custodial setting types there was minimal missing data. The data on main presenting problem obviously presents a partial picture as the survey allowed for up to four presenting problems in total. For example, the proportion of people with neurodiverse conditions is higher than the 13.4% represented in table 10 across England, when factors beyond the main reason for referral are included. In terms of additional diagnoses, 3,945 patients had second presenting problems, 1,863 had a third and just under 1,000 had a fourth.

A final important qualification relates to those under the age of 18 in YOIs. In the case of under 18 year olds in YOIs, diagnostic domains predominantly reflect conditions more commonly identified during adult years (e.g. psychosis and personality disorders, which are less commonly used to describe problems faced by children – because children's presentations are often still changing and crystallising at this age). There was also less focus in the survey on developmental trauma resulting from prolonged exposure to maltreatment, behavioural difficulties such as conduct problems, and attachment-related difficulties which are a major focus of therapeutic and trauma-informed activity in the CYPSE via The Framework for Integrated Care (SECURE STAIRS) with multiagency formulation-based interventions (Anna Freud National Centre for Families and Children, 2022)

Tables 11 and 12 suggest that custodial mental health and wellbeing teams are working with people with a broad range of issues and do not appear to be entirely focused on those with severe mental illness such as psychosis (as has been the case in the past). People on prison mental health caseloads with a main diagnosis of psychosis are a significant group, but not the largest nationally or regionally (with the marked exception of London), nor across types of prison (with the exception of category B prisons). People with either or both anxiety and depression were the largest group nationally and across most regions and custodial setting types. In all regions and for most adult prison populations, people with a diagnosis of or suspected personality disorder were the next most significant group.

For a combination of reasons (see Durcan, 2021 and Prison Reform Trust, 2020) the fastest-growing age group in prisons is older people. This means that there are increasing numbers of more frail people and, in terms of mental health, those with dementia. The region which had the most significant dementia and suspected dementia was the east of England at 3.3%. The likely reason for this is that the East of England may have a greater proportion of older prisoners (see before but note a minority of prisons from the East contributed data) but also it had developed pathways for and training on dementia and evidence of this this was submitted to the National Consultation (Durcan, 2021). So, it is possible that even for this region that the statistic is an underestimate, and for regions where less work has been done on dementia pathway development there is a likely underestimate of the number of patients and the need. Most regions had one or two patients identified with suspected or actual dementia, where this was not the main presenting problem.

NEURODIVERGENT PEOPLE IN CUSTODIAL SETTINGS

Tables 11 and 12 present data on people in custodial settings who had a neurodiverse condition as their main or suspected presenting problem. Attention deficit hyperactivity disorder, acquired brain injury, learning disability and autistic spectrum disorder are the most common diagnoses under the 'neurodiverse' label but there are others. Table 13 gives the total number of people in prisons by region and prison type with one or more of the above neurodiverse diagnoses (and some others, including speech and language difficulties), including those where neurodiverse need was not identified as the main presenting problem.

Table 13: Proportion of people with one or more neurodiverse needs on a caseload by region

	Region							
	All England	East	London	Midlands	North East & Yorkshire	North West	South East	South West
People with neurodiverse needs on a caseload	17.4%	11.5%	19.7%	20.9%	15.6%	10.7%	18.1%	17.6%

Table 14: Proportion of people with one or more neurodiverse needs on a caseload by custodial setting type

	Custodial setting type						
	Cat A	Cat B	Cat C	Cat D	Female	YOI	Young Adult
People with neurodiverse needs on a caseload	10.1%	20.2%	16.9%	10.4%	7.9%	44.3%	35.9%

It is important to note that the data presented in tables 13 and 14 are not the total number of neurodivergent people in custodial settings. This is not known, although there are estimates (see figure 1). Tables 13 and 14 give the number of neurodivergent people who have had their needs recognised and are on a mental health caseload, some having other mental health problems in addition to their neurodivergence. The likelihood is that there are more neurodivergent people on caseloads and certainly more within the custodial settings as a whole.

Over a third of those on caseload in Young Adult custodial settings have an identified neurodiverse vulnerability. Category B prisons also have significant numbers with such needs recognised. However, the custodial setting type with the most significant population of people with recognised neurodiversity was the YOI estate. A variety of reasons may explain this. For example, such problems are routinely and systematically screened for, through the Comprehensive Health Assessment Screening tool (CHAT) when children enter a YOI (RCPCH, 2019). Furthermore, a recent NHS workforce benchmarking exercise across the entire health and justice estate found that 8% of the workforce were from speech and language therapies (SALT), occupational health and physiotherapy backgrounds compared with 2% in the wider health and justice secure estate. This may contribute to better identification as wider staff awareness is raised. This study also found the highest ratio of mental health professional to patients (see later). Finally, a recent study of children entering the wider CYPSE noted that a significant number of children were identified with communication needs but particularly with special educational needs and disabilities (SEND) at the point that children entered custody (Khan et al., 2021. p 17).

Figure 1: Estimates of people in adult prisons with different diagnoses (adapted from Durcan 2016 & 2021)

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
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)

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

Figure 1 provides the best estimate of the likely prevalence of various conditions in adult prisons. It should be noted that much of the best quality prevalence data presented above for adults is around 25 years old, from the Office of National Statistics study conducted in 1997 (Singleton et al., 1998).

In the case of 16 to 20 year olds, Lader and colleagues (2000) completed a separate analysis of findings for this age group but there was significant criticism of the use of adult diagnostic criteria with this younger cohort – which means its findings may misrepresent the actual needs of this age group (Dimond and Misch, 2002). Dimond and Misch then went on to do their own pilot prevalence study for children (2002). The other prevalence study for children in custodial settings was an assessment of the mental health needs of children in 2005 by Chitsabesan and colleagues (2005).

Centre for Mental Health has previously recommended that these studies be repeated and indeed be extended to understand the needs of the wider population in contact with youth and criminal justice services (Durcan et al., 2014).

TYPES OF MENTAL HEALTH INTERVENTIONS

Table 15: Mental health interventions by region

Intervention		Region						
	All England	East	London	Midlands	North East & Yorkshire	North West	South East	South West
Group therapy	3.3%	1.0%	2.0%	0.6%	2.2%	0.2%	3.7%	17.6%
Psychiatrist	11.1%	7.7%	27.2%	20.0%	5.6%	4.1%	4.9%	3.5%
Talking therapy	21.6%	23.8%	5.2%	32.9%	18.3%	12.9%	18.6%	22.8%
Trauma therapy	2.0%	10.5%	0.7%	1.1%	1.3%	3.0%	2.5%	1.2%
Assessment	16.7%	22.0%	19.8%	11.6%	33.4%	13.6%	8.7%	19.1%
GP	1.1%	0.7%	0.7%	3.2%	0.2%	0.1%	0.2%	0.2%
Self-help	2.2%	0.3%	0.3%	0.8%	0.4%	5.8%	2.5%	6.1%
Medication	13.4%	8.4%	6.7%	7.6%	25.4%	12.9%	9.7%	24.9%
Other	3.3%	2.1%	0.0%	3.0%	1.0%	0.2%	9.3%	4.2%
MIssing	25.2%	23.4%	37.3%	19.2%	12.2%	47.2%	39.8%	0.4%

Table 16: Interventions by custodial setting type

Intervention	Custodial setting type						
	Cat A	Cat B	Cat C	Cat D	Female	YOI	Young Adult
Group therapy	0.3%	1.3%	3.6%	17.2%	6.9%	0.0%	0.0%
Psychiatrist	14.9%	14.9%	7.5%	5.0%	13.0%	4.3%	1.5%
Talking therapy	10.9%	20.8%	19.1%	41.3%	25.4%	13.0%	53.4%
Trauma therapy	2.5%	1.5%	2.3%	3.2%	1.8%	2.6%	0.5%
Assessment	15.5%	20.2%	17.9%	7.2%	6.3%	25.2%	3.9%
GP	4.4%	0.6%	0.6%	0.2%	3.4%	0.0.%	0.0%
Self-help	2.7%	2.2%	2.2%	4.0%	2.0%	0.0.%	0.0%
Medication	8.1%	13.1%	14.6%	12.9%	14.5%	10.4%	18.4%
Other	0.6%	1.5%	2.6%	1.7%	14.2%	27.8%	0.0%
MIssing	40.0%	23.8%	29.5%	7.2%	12.6%	16.5%	22.3%

Nationally and across four regions, some form of talking therapy was the most commonly offered intervention. The region that most markedly differed in this was London. This might be explained by the significant differences between London and other regions in the proportion of people with an actual or suspected psychosis, and by the fact that the London custodial settings which responded to this exercise predominantly had large remand and short sentence populations. As a result, we might expect there to be more acute and unmet needs, including more severe mental illness, and it is likely that talking therapies would be more difficult to facilitate. This latter point was suggested in the national consultation. The significant churn in the remand and short sentenced population likely necessitates the prioritising of those with the most marked need.

RISK

The following provides data of three historical characteristics that suggest potential risk and particularly to the patient themselves.

A history of self-harm and suicide attempts indicates a potential risk to the person's life, and so also might a history of substance misuse (also called 'dual diagnosis', i.e. misuse of illicit or prescription substances and poor mental health).

Table 17: Three risk factors by region

Risk History	All England	East	London	Midlands	North East & Yorkshire	North West	South East	South West
Self-harm	54.0%	60.8%	39.2%	59.6%	59.7%	53.6%	49.3%	46.8%
Suicide attempt	40.0%	52.1%	28.4%	41.2%	48.1%	42.9%	33.0%	36.5%
Dual diagnosis	39.0%	24.5%	45.2%	45.3%	40.3%	36.4%	27.2%	43.3%

Table 18: Three risk factors by custodial setting type

Risk History	Cat A	Cat B	Cat C	Cat D	Female	YOI	Young Adult
Self-harm	59.5%	53.6%	55.8%	31.8%	62.3%	39.1%	44.2%
Suicide attempt	47.0%	40.4%	36.3%	32.8%	57.2%	18.3%	29.6%
Dual diagnosis	44.0%	39.7%	39.4%	40.3%	36.5%	29.6%	17.0%

Tables 17 and 18 provide data on three historical characteristics that are proxies of potential risk in the mental health caseload. All three historical factors pose a potential risk while in custody and post release. There was very little missing data on these proxies for risk.

The proportion of people on caseloads who had these risk factors was high for all three (both across regions and custodial setting types), often over or approaching 50% of the caseload. Nationally, for those with the earliest release date (within 12 months of the survey), the rates were 43.4% with a history of dual diagnosis, 59.5% with a history of self-harm and 43.4% with a history of suicide attempts. The period after release is well established as a high-risk time for those who have left prison in terms of suicide (Phillips & Roberts, 2019 and Pratt et al., 2006). Having a problem with substance misuse adds to this risk and can destabilise someone on release, during a period when, currently, they are likely to receive minimal support (see Durcan, 2021).

All of this suggests, regardless of primary presenting problems, most people on custody mental health and wellbeing caseloads carry significant potential risk.

ASSESSMENT, CARE IN CUSTODY AND TEAMWORK (ACCT)

Assessment, Care in Custody and Teamwork (ACCT) is the care planning process in custodial settings for those identified as being at risk of self-harm and/or suicide. The proportion of the English mental health caseload on ACCT on the census day was 13% (1,025). Not all those on ACCT will be on the mental health caseload, although a member of healthcare staff should attend or contribute to the initial ACCT multi-disciplinary review within 25 hours of someone's placement on this measure. If the person is under the care of the mental health team, representatives of the mental health team should attend or contribute to all ACCT reviews. The regions with the highest proportions were London with 20.2% of its caseload on ACCT and Midlands with 19.9%, the remaining regions ranged between 7.7% and 11.5% of their caseloads on ACCT.

Table 19: Those on ACCT by custodial setting type

Number	Cat A	Cat B	Cat C	Cat D	Female	YOI	Young Adult
ACCT % of caseload	10.1%	13.8%	16.0%	2.2%	10.8%	14.8%	9.2%

Custodial settings with the highest proportions of their caseloads on an ACCT on the census day were Category C prisons and YOIs. It is surprising that the proportion of women on the mental health caseload on ACCT was not higher, given the evidence of higher levels of self-harm within the female populations. For example, in 2020, women accounted for only 4% of the prison population, yet they accounted for 22% of the 55,542 recorded incidents of self-harm in prisons that year (Prison Reform Trust, 2022). The self-harm rate for women rose 16% in the year up to the summer of 2021 (Ministry of Justice, 2021). Both Female and Category B prisons had the highest amounts of missing data, 10% and 12.6% respectively. Category A, C and D each had between 5-6% missing data and there was no missing data for YOIs or Young Adult establishments.

TRANSFERS

Custodial mental health teams cannot provide safe and adequate care for a small proportion of people in custody with mental health problems, particularly those with the most acute symptoms and who require treatment under the Mental Health Act (prisons are not a 'place of safety' under the Act). These people require transfer under the Act to low (including psychiatric intensive care units), medium or high secure hospitals, depending on their status and age. For as long as Centre for Mental Health has been reviewing prison mental healthcare, there have been delays in accommodating the need for transfer and often significant ones, i.e. taking weeks and even months.

For several years there was a non-legislated standard of a 14-day period within which such transfers should be achieved. This standard was often not met. Additionally, individual secure mental health units would conduct assessments (following a direct referral to their unit) and the 'clock' for such assessments would not start until there was a vacant bed; thus the delays were actually longer than recorded. The independent review of the Mental Health Act (Wessely, 2018) and subsequent government proposals and draft legislation propose a 28-day period (allowing for an initial and secondary assessment within the same period) within which transfers should occur. Many custodial settings have adopted 28 days as a gauge of timely transfer, even though it is not yet passed as legislation. In the table below we also use the 28 day as a marker for timely transfer.

Table 20: Transfers and delays by region

Number	All England	East	London	Midlands	North East & Yorkshire	North West	South East	South West
Transfer	166	7	42	21	27	27	31	11
Over 28 days	39	3	11	8	3	7	7	0

Table 21: Transfers and delays by custodial setting type

Number	Cat A	Cat B	Cat C	Cat D	Female	YOI	Young Adult
Transfer	22	102	26	0	13	2	2
Over 28 days	5	27	2	0	4	?*	1

*No data on days waiting was provided for the two children in YOI awaiting transfer.

The 166 people for whom we received data who were in custody awaiting transfer or assessment for transfer under the Mental Health Act might equate to around 200-220 across England at any point in time. The white paper on Mental Health Act reform has followed in significant part the recommendations of the Independent Review, including that patients be transferred within a 28-day period, and that both initial, secondary assessments and transfer (if warranted) occur within this period. As stated, we have used this 28-day period as a 'cut-off' point in our analysis.

Just under a quarter of those in custody awaiting assessment or transfer under the Mental Health Act had waited more than 28 days at the time of our survey. It is important to note that we asked those supplying the data to count from the time of referral and not from the time of assessment, to get as realistic as possible the measure of the wait for transfer and assessment for transfer. Around 50 patients could be waiting beyond 28 days at any point in time. Whilst most of these were a few days or weeks over the 28-day cut off, there were patients who experienced significantly longer delays. These delayed transfers ranged from two days over the 28-day limit to more than a year over.

In addition to the above, the process survey (one of three survey forms sent out) sought details of transfers under the Mental Health Act for the 12 months prior to the census date. 64 of the 82 custodial settings that supplied data had applications for assessments or were awaiting for transfer to take place. There were a total of 919 transfer assessment applications made across England. If this is accurate it could mean around 1,100-1,200 applications for assessment across all of England's custodial settings in this period. Of the 919 applications we received data on, 704 resulted in successful transfers to hospital.

Regional picture:

- East = 28 applications and 14 transfers
- London = 230 applications and 177 transfers
- Midlands = 174 applications and 135 transfers
- North East & Yorkshire = 86 applications and 60 transfers
- North West = 83 applications and 57 transfers
- South East = 216 applications and 187 transfers
- South West = 102 applications and 74 transfers

In a number of cases, data on waiting times was not available and although we only sought waiting times for people who were transferred, some settings supplied waiting times for all applications (successful or not) and for those pending at the time of the survey. Typically, anywhere between a quarter and half of those transferred waited over 28 days for transfer, with a substantial proportion waiting two months and more and some with waits in the hundreds of days.

The reasons for unsuccessful applications included: release from custody before the assessment could take place (with some then being sectioned under the Mental Health Act immediately on release); those referred for assessment being transferred to another custodial setting; not meeting transfer criteria; the death of the person waiting to be assessed; and transfer to another custodial setting (often a 24-hour healthcare unit in another prison).

CHRONIC PHYSICAL HEALTH PROBLEMS IN THE MENTAL HEALTH CASELOADS

More than one in five people (21%) on custodial mental health caseloads also have chronic physical problems, with 4% having two or more such problems. Understandably, older people in prison are more affected by chronic physical problems, and the full range of physical problems is represented in the population, such as musculoskeletal or mobility issues, cardiac problems, diabetes, HIV, and Hepatitis C.

Table: 22 Chronic physical problems and age

Age band	Percentage of those with at least one chronic / long term physical health
15-17 years	7.8%
18-21 years	10.9%
21-24 years	13.7%
25-29 years	16.1%
30-39 years	19.1%
40-49 years	26.6%
50-59 years	39.8%
60-69 years	48.6%
70 years and older	75.4%

Table 23: Chronic physical health in patients on the mental health caseload

Regions		Custodial setting types	
East	30.4%	Category A	26.1%
London	19.2%	Category B	18.2%
Midlands	22.6%	Category C	22.5%
North East & Yorkshire	24.9%	Category D	33.8%
North West	16.9%	Female	21.8%
South East	13.8%	YOI	9.6%
South West	27.7%	Young Adult	9.7%

People on mental health caseloads suffered from a large range of physical conditions. The largest group were those with respiratory type conditions, including asthma (accounting for 33.9% of those with a chronic physical condition on the mental health caseload). The next most significant groups were those with diabetes (12.5%), epilepsy (10.3%), cardiac problems (10.3%), mobility and skeletal conditions (9.6%) and sensory disabilities (audial and visual 2%).

4 TEAMS, SKILLS AND PROCESSES

Some data from the two additional surveys (teams & skills and processes) has already been shared in the previous section. This section provides more findings from both of those surveys. For the teams and skills surveys a total of 77 custodial settings returned data (69% approximately) and 82 returned the process survey (73% approximately).

NATURE OF MENTAL HEALTH SERVICE PROVISION

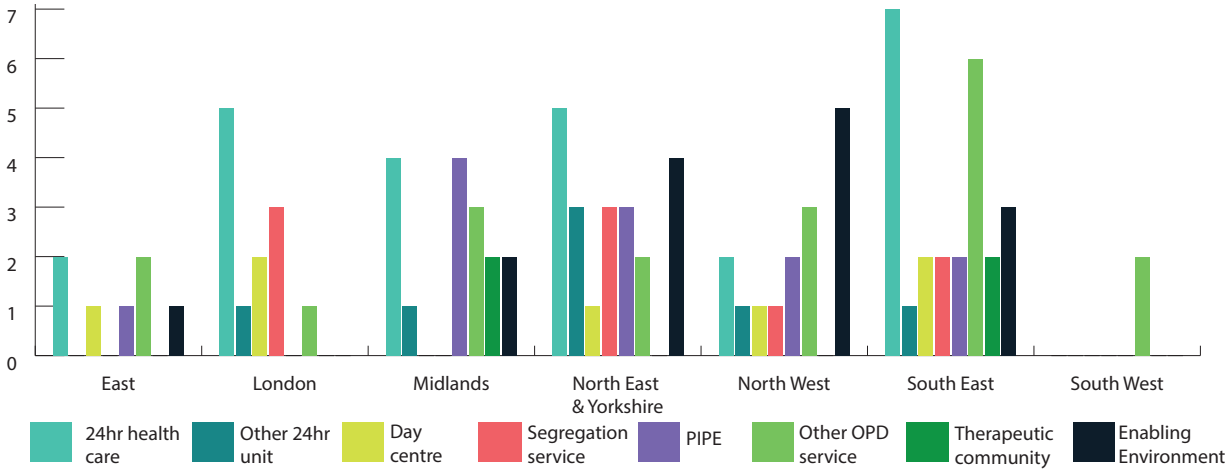
While all services in England are commissioned to national specifications, there is considerable variation in how that specification is delivered. The nature of provision will understandably differ by setting type and the different populations and needs they hold, but there appears also to be considerable variation locally and regionally. This was apparent in both the national consultation (Durcan, 2021) and this exercise.

The vast majority of custodial mental health services have more than one provider – usually two or three in total, with one being the lead. A small number of custodial settings have more than this and in one case there were eight providers. Often the number of providers makes little difference, and the service operates as single integrated service 'on the ground.' However, it was apparent from communication with custodial teams providing the data that this is not always the case, and provision can instead feel disjointed in some settings, with a lack of clarity as to the support offered by another provider. For example, some respondents did not know how reception or secondary screenings were done when this was the responsibility of another provider.

Some custodial mental health services consisted of several discrete caseloads (e.g. inpatient, secondary care/inreach, wellbeing, primary mental health, complex needs), while other services operated a single caseload, meeting a broad range of needs within it.

Many custodial settings will have particular units or regimes where some specialist care is given. These are described below.

Figure 2: Units and services by Region



We asked each custodial setting whether they had one of the following facilities/units/regimes within their setting:

24-hour healthcare units: Residential units within the custodial setting where nursing staff will have a 24-hour, 7-days-a-week presence, and where people with marked mental or physical health needs can be more closely observed or receive additional care. They may have cells/rooms that better provide for people with mobility issues, and a small number have facilities to support end-of-life care. However, they seem to predominantly support those with mental health needs. There were 25 of these in all, usually located in category A and B prisons.

Other 24-hour units: These are not necessarily healthcare units per se but have a 24-hour regime, and at least some of the people supported will have mental health needs. One example is at HMP Durham, which provides more intensive care for people with severe mental health problems. This is described in the consultation report (Durcan, 2021), as is the unit in HMP Swaleside, which provides support for prisoners with a range of with complex needs, including some with mental health problems.

Dedicated services to segregation units: Adult prisoners who display significantly challenging behaviour can be separated from the main prison population held in a segregation unit for a temporary duration, and this can be as a form of punishment following adjudication by prison management. Adult prisoners can be held in segregation units for their own protection or for others'. Segregation units are sparse environments. Some of the people held in them will have mental health and neurodiverse needs and staying in one for longer can in itself pose a challenge to one's wellbeing (e.g. see page 32, Durcan, 2021). All mental health teams will have regular contact with segregation units, but some have a resource that allows them to proactively work with the units and provide support. The needs analysis identified nine of these (three in London, three in NEY, two in the South East and one in the North West).

Rules and regulations affecting separation of under 18 year olds now differ from those used with adults, after concerns were raised in 2020 about the potentially damaging effect of segregation on children's safeguarding and wellbeing (HM Inspectorate of Prisons, 2020). The Rules and regulations which apply to YOI, Secure Training Centres and Secure Children's Homes allow staff to enforce the separation of children from their peers if it is a temporary, necessary, reasonable and proportionate response to protect the child or others from risk of serious harm. Separation should only be used as a last resort, should be temporary and should not be used as a punishment. Guidance reinforces that the impact of separation or isolation on the physical or mental health of each child must be closely monitored and requires that children have continued access to purposeful activities and sustained meaningful interaction with staff. Some children in YOIs may be managed on designated units with more intensive multidisciplinary staffing (ie Enhanced Support Units) designed to support, facilitate purposeful activity with and manage separated children safely and more effectively.

Day Centres – these can provide a range of occupation, leisure and therapeutic support over the course of a day (usually Monday to Friday) for people with mental health and related needs. (Only six were listed in our survey returns.)

PIPEs (Psychologically Informed Planned Environments) – These are residential units providing intensive support for people with a diagnosis of or suspected severe personality disorders who pose high risk to others (and also sometimes themselves) and are part of much broader adult Offender Personality Disorder (OPD) programme, jointly run by HMPPS and NHS England. These units will have high ratios of staff to residents, and all staff (clinical and prison) will have had specialist training to work with people with this diagnosis or suspected of having it. These units and the broader programme are not limited to prisons.There were 12 PIPEs identified and these were in all types of prison with the exception the of category D and Young Adult YOIs that provided data. PIPEs were located in prisons that returned data in five regions, London and the South West being the exceptions.

It is unusual for children to be identified with personality disorders under the age of 18. However, the CYPSE (including YOIs) are also supporting and managing a small number of children presenting with very complex, high-risk , high harm needs (often underpinned by neurodiverse difficulties). All children should also be managed through systematic multidisciplinary formulation and care planning (led by children and young people's stories) as part of The Framework for Integrated Care (Anna Freud Centre for Families and Children, 2022)

Offender Personality Disorder (OPD) Intervention services – Of the prisons that returned the surveys, 19 prisons had OPD Intervention services. These include a range of service types, both residential and non-residential, which are delivered over a number of months or years by specially trained clinicians and criminal justice staff in an environment that is safe, supportive and respectful

Therapeutic Communities – Prison Therapeutic Communities predate the OPD programme but have now been integrated into it. These provide a residential group therapeutic regime and prisoners opt in to these. Four prisons in our sample provided these: two category B prisons in the Midlands and two prisons in the South East (a category C and a female prison).

Enabling Environments – These are environments in prisons that have successfully implemented a set of ten values that support effective social environments and healthy relationships. They also involve joint working with different teams and, critically, with the prisoners. In the case of custody, an enabling environment should be a joint venture between all parties. Such an environment could be established in a particular unit within a custodial setting. These are not easy to achieve in custody, as values include some democratic and shared decision making. A small number of custodial settings have achieved full accreditation. In our sample, some 15 claimed this. It is possible that some of these may not have actually achieved this standard yet but are on a pathway to achieving it.)

Of those that submitted data, all of the category A prisons and over half the category B prisons had 24-hour healthcare units. They also accounted for most of the small number of mental wellbeing services dedicated to segregation units. OPD services (including PIPES) were spread out across the range of custodial setting types, as per a pathway approach.

A service type that was not described by those responding to the survey, but which does work as part of The CYPSE Framework for Integrated Care (SECURE STAIRS) and the Offender Personality Disorder programme is that of the Enhanced Support Services. These work across a number of custodial settings and provide multidisciplinary outreach and support, usually in the short-term for individuals experiencing emotional dysregulation and challenging behaviours.

In the case of 24-hour healthcare units, these are meant to be a resource for a local cluster of establishments as well as the one they are based in. However, these other establishments have often found these difficult to access (Durcan, 2016).

SKILLS GAPS

We asked each custodial setting about what the needs they struggled to meet within the custody population and their skills gaps. We suggested a number of needs and gaps, in part based on the findings of the previous consultation (Durcan, 2021), including learning disabilities, autistic spectrum disorders, attention deficit hyperactivity disorder, speech and communication difficulties, acquired brain injury and dual diagnosis (a combined mental health problem and substance misuse). We also left space for other gaps to be detailed.

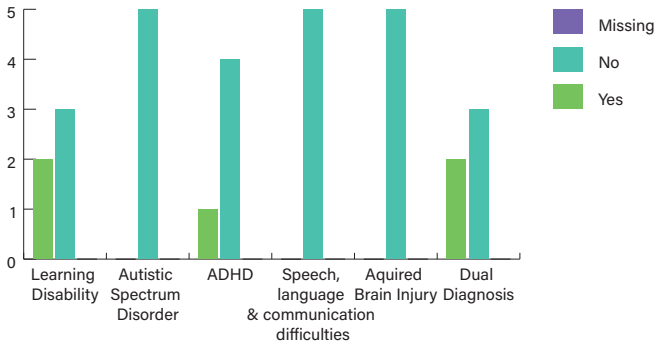
It should be noted that this skills audit primarily takes an adult custodial lens – although some will be relevant for both adult prison and CYPSE settings.

There was regional variation in what gaps in skills were identified, but the most consistent were for supporting people with suspected or actual speech and communication difficulties and acquired

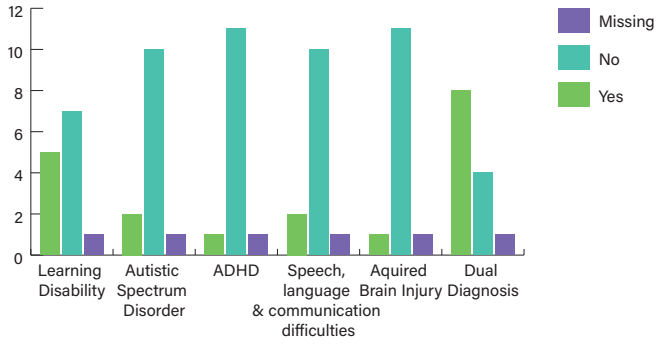
brain injury. For both of these gaps, London and NEY regions were better provided. These two regions appeared to have the least gaps in skills and were seemingly more able to address needs across the listed areas. The region with the greatest perceived gaps was the East, however, this was the region for which only 39% of prisons responded to the survey. There were also significant gaps reported in the North West. The Y axis in the figures below represents the number of establishments in each region.

Figures 3-9: Skills in place and gaps by region

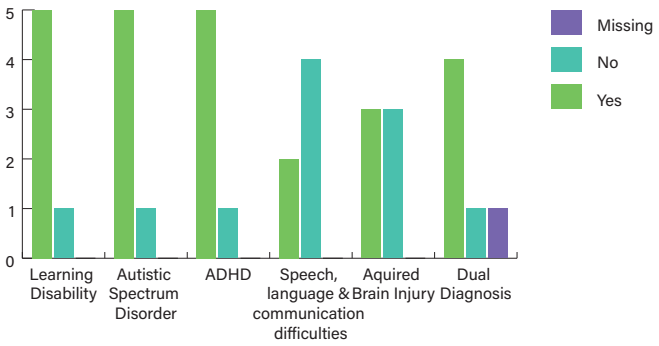
East of England: Skills in place



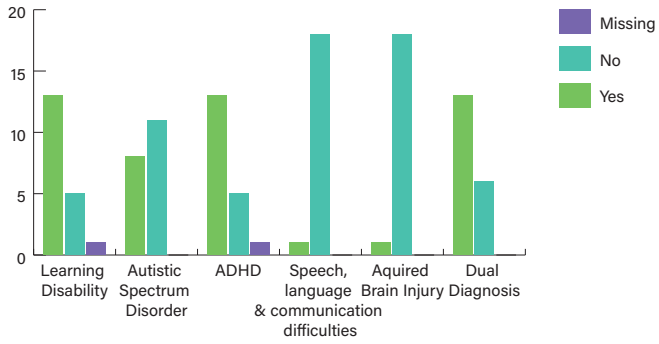
North West: Skills in place by number of establishments



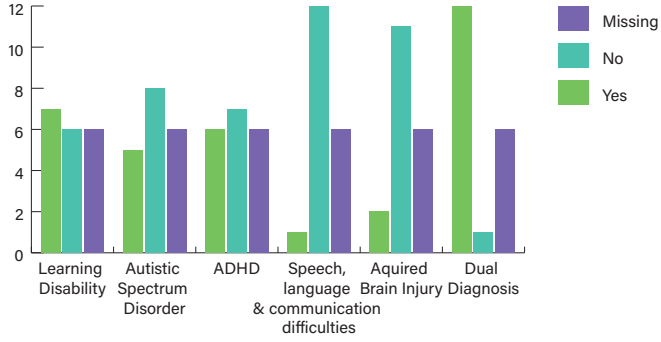
London: Skills in place



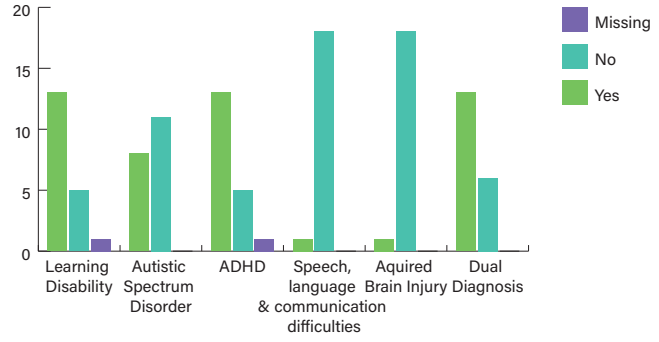
South East: Skills in place by number of establishments



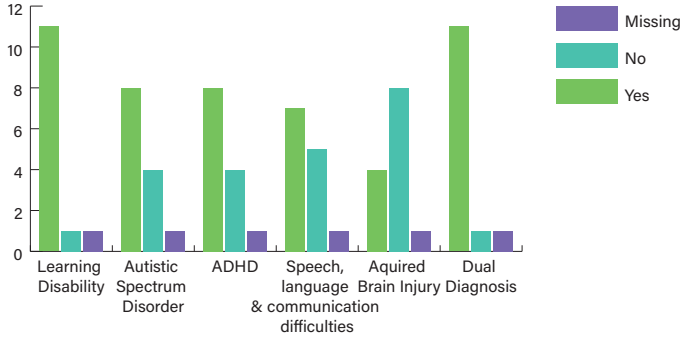
Midlands: Skills in place



South West: Skills in place by number of establishments



NEY: Skills in place by number of establishments



STAFFING IN CUSTODIAL MENTAL HEALTHCARE BY REGION

All custodial settings were asked to list what staff they had in post, their discipline, banding/grading and role, and whether these were substantive posts or currently filled by locum, agency or bank staffing. We also asked custodial settings to detail what posts were currently vacant. We calculated for each type of staff (e.g. psychiatrists, band 6 nurses, speech and language therapists etc.) how many per 1,000 people in custody were in place at the time of the data collection. Where a custodial setting had not supplied this data, we excluded that setting's population from the calculation.

It is important to note that custodial settings within a region can vary considerably in how their mental health and wellbeing team is resourced, with a variety of reasons for this. A recent internal NHS workforce benchmarking exercise in these settings also revealed differences between CYPSE and adult custodial settings (with more psychology, speech and language and occupational therapeutic provision in the CYPSE compared with adult settings). Different types of prisons will, to some degree, influence staffing, as will the presence of different regimes within a custodial setting (e.g. 24-hour healthcare units will require higher numbers of nurses, often at the band 5 level). Some settings within a region are at a greater distance from large towns and cities and may therefore have more difficulty recruiting some professions and retaining staff.

Some custodial settings will have local initiatives and recruit staffing accordingly. It may also be the case that different providers have different models of care that are linked to different patterns of staffing. Such differences will be masked when comparing regions.

Nevertheless, it is apparent from the data that there are very different ways of staffing mental health and wellbeing services across the regions. In some regions, voluntary and community sector organisations provide a more significant level of service than in others. The North East and Yorkshire (NEY) region is such an example, where the charity Rethink Mental Illness provides a number of services across several prisons (7 out of 12 of its services are in the NEY region as of May 2021 - House of Commons, 2021).

Figure 10: Band 5, 6 & 7 nursing and other staff per 1,000 people in custody, by region

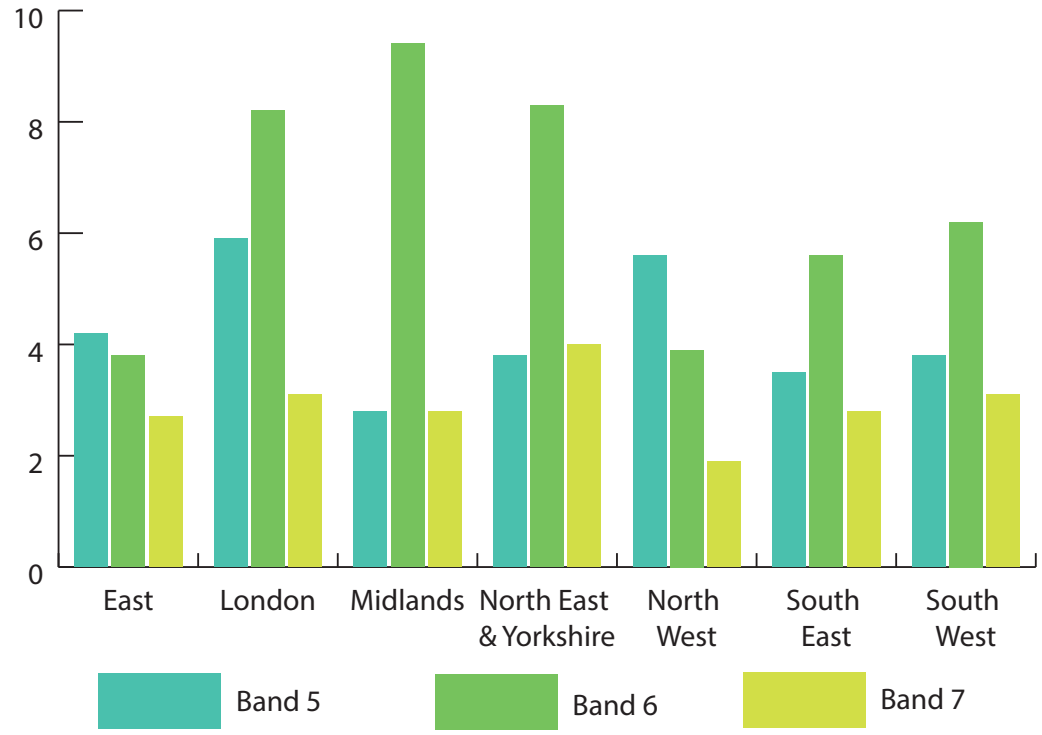


Figure 11: Psychiatrists per 1,000 people in custody by region

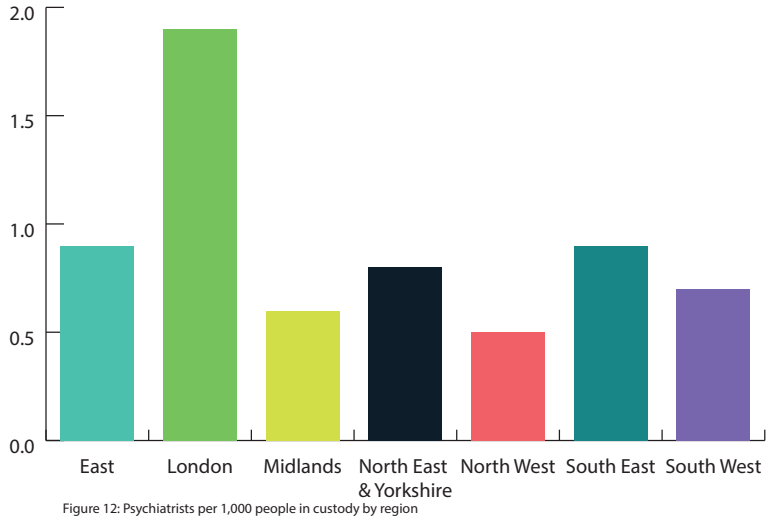


Figure 12: Psychiatrists per 1,000 people in custody by region

Figure 12: Occupational Therapists and Speech and Language Therapists by region

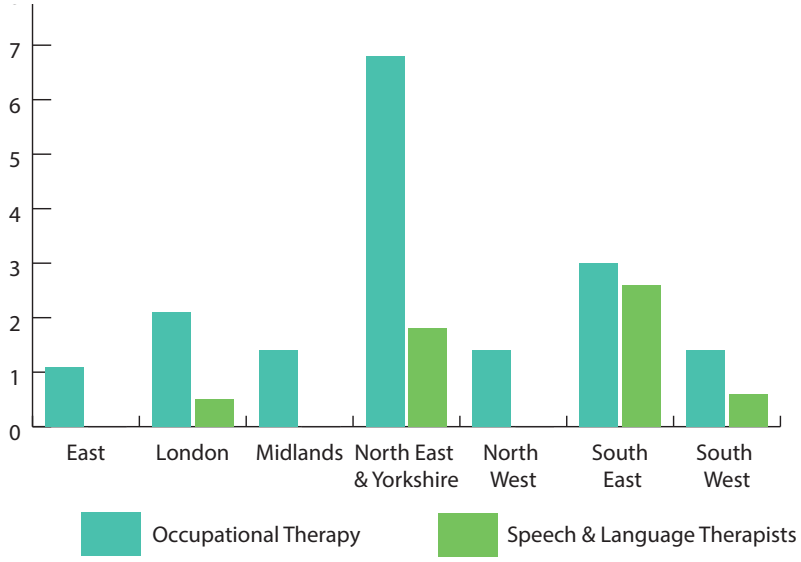


Figure 13: Psychologists, psychology assistants and talking therapists per 1,000 people, by region

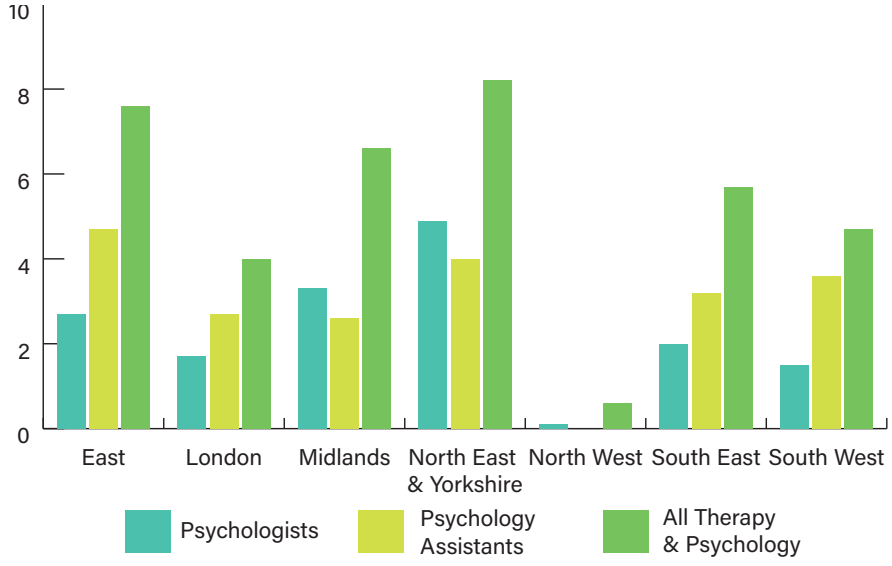


Figure 14: Social workers per 1,000 people in custody, by region

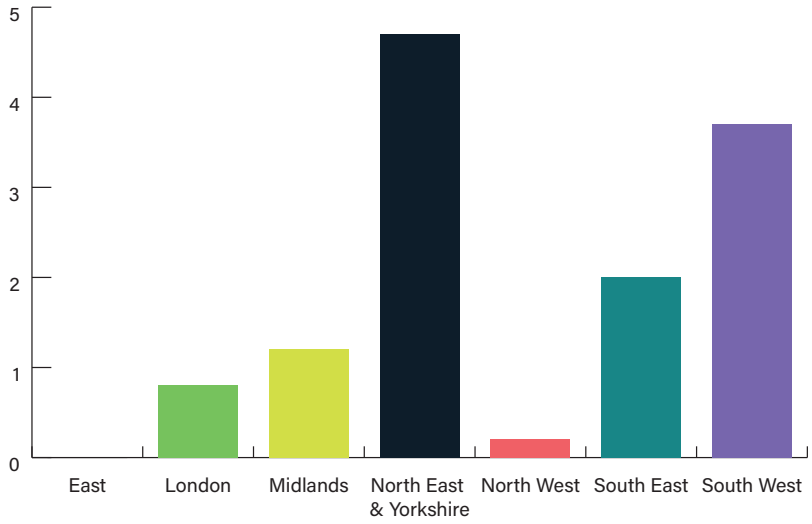
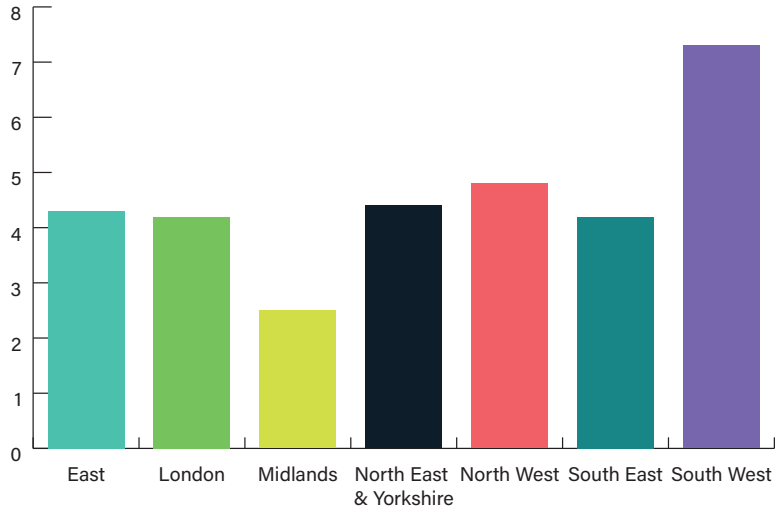


Figure 15: Support workers * per 1000 people in custody, by region



**Note: Figure 16 includes support workers working in any role (excluding psychology assistants), nursing and otherwise.*

Figure 10 presents all those staff banded 5, 6 and 7. Band 7 staff are often in a management role, but are sometimes in a senior clinical role, perhaps leading a particular pathway. These three bands represent the most populous part of the clinical workforce and are usually nurses (mental health, learning disability and less frequently general nurses). Some band 7 staff are occupational therapists and social workers, though not employed in that role and have a team management role instead. And some band 5 and 6 staff are from the voluntary and community sector (as in the example above from the NEY) and are not identified as nurses.

London, the Midlands and the North East have the highest ratio of staff to patients for band 6. The East and North West are the only two regions where the number of band 5 staff per 1,000 population outnumber that for band 6 staff. The North West has fewer band 7 staff per 1,000 population than other regions.

Figure 11 shows the ratio of psychiatrists to patients. London has just over double the number of the next best regions for provision, the East and South East. The North West and the Midlands appear to have lowest ratio of psychiatrists.

All regions have some occupational therapists (figure 12) with NEY having by far the highest ratio. Only London, NEY and the South East reported having speech and language therapists, with the latter having the highest ratio.

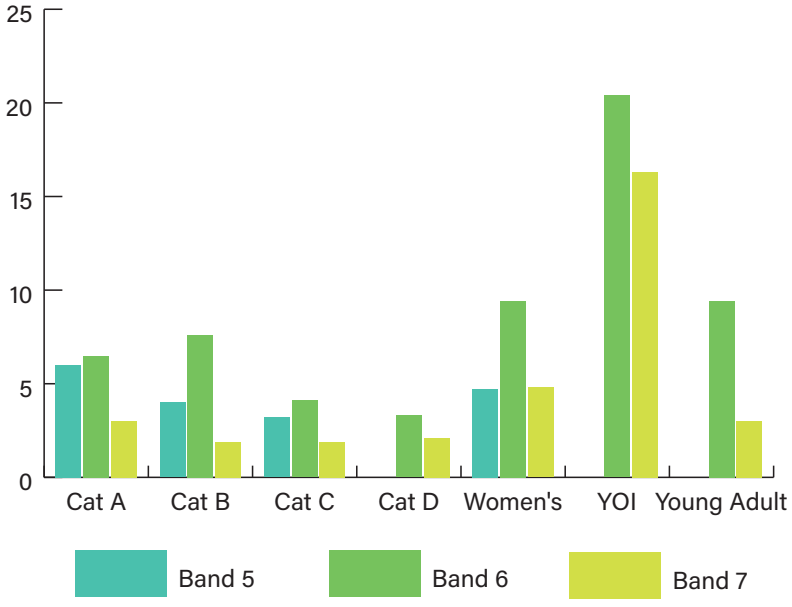
Figure 13 presents staff in talking therapy roles and those providing psychological interventions. The column in grey in this figure combines the total number of therapists and this includes psychologists, psychology assistants and other therapists (e.g. counsellors, drama therapists and art therapists). The North East and East have the highest ratios of staff in talking therapy roles but what is striking in this figure is the apparent near absence of staff in such roles in the North West.

Figure 14 presents the ratio of social workers to patient population. In this figure we have included all those identified as social workers. Some will not work in a social work role and are instead team leaders and managers. However, most of those in this figure will work in such a role. The prisons supplying data from the East region reported no staff in this role. The North West had a low ratio of social workers to patients and the highest ratios were in the NEY and South West regions.

Figure 15 includes support workers in a variety of roles, some specifically working to support other professionals such as occupational and speech and language therapists and those working in generic support roles. All staff in bands 3 and 4 (excluding administrators) are included in this as well as staff specifically listed as support workers. The region with the highest ratio was the South West and that with the least was the Midlands, the remaining regions having broadly similar ratios.

STAFFING IN PRISON MENTAL HEALTHCARE BY PRISON TYPE

Figure 16: Band 5, 6 & 7 Nursing and other staff per 1,000 people in custody, by custodial setting type



For Category D, YOIs and Young Adults only one prison in each category had any band 5 staff (3.7, 10.8 and 3.9 per 1,000 people in prison respectively).

Figure 17: Psychiatrists per 1,000 people in custody by custodial setting type

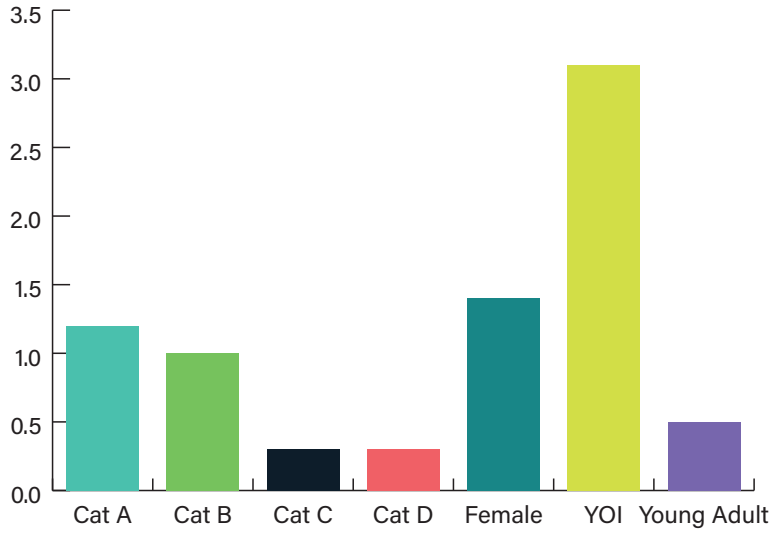


Figure 18: Psychologists, psychology assistants and talking therapists per 1,000 people, by custodial setting type

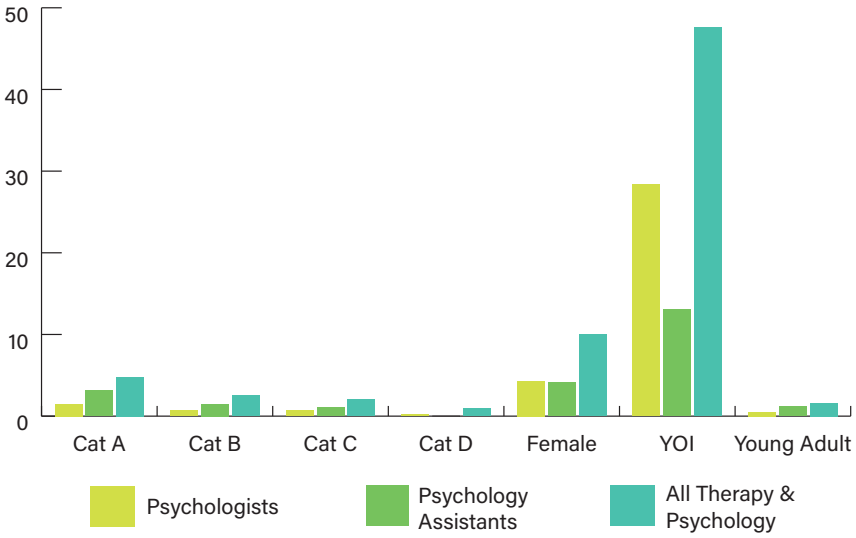


Figure 19: Occupational Therapists and Speech and Language Therapists per 1,000 people by custodial setting type

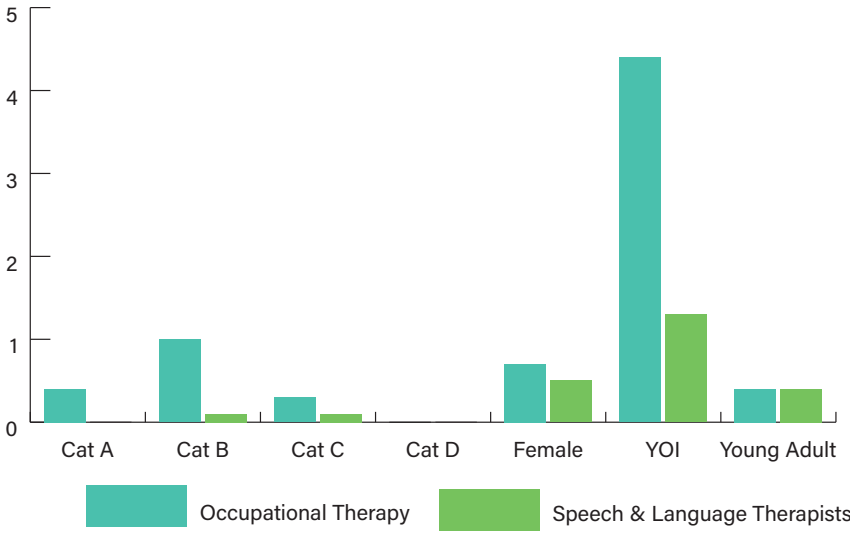


Figure 20: Social workers per 1000 people by custodial setting type

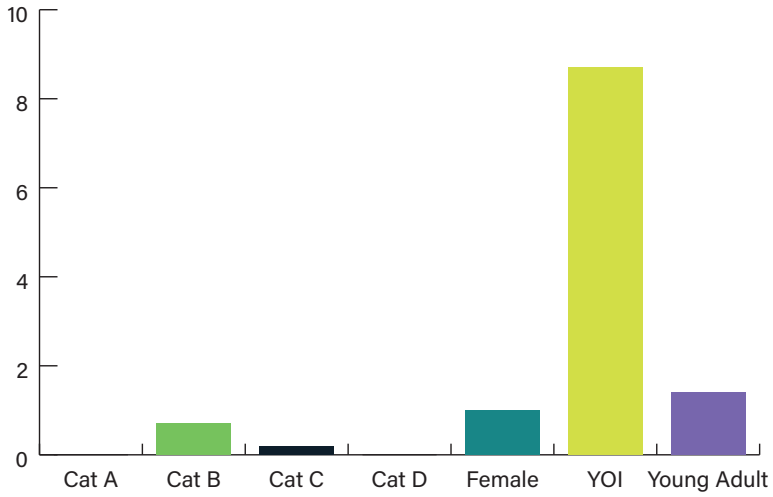
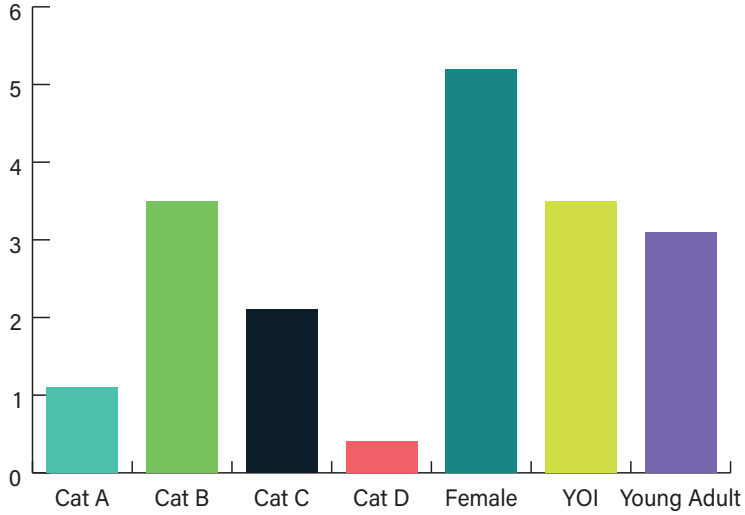


Figure 21: Support workers per 1,000 people by custodial setting type



The custodial setting type with the highest ratio (staff per 1,000 prisoners) for most staff categories is the children's YOI estate. The prison type with the lowest ratios is category D prisons, which once again is in line with expectations. These are open prisons, with many of the men working outside the prison during the day, and are unlikely to accommodate people with the most acute levels of need.

In terms of adult establishments, female prisons and young adult YOIs have the highest ratios of staff to patients for several types of staff. As was reported earlier, a greater proportion of female prisoners are on a mental health and wellbeing caseload when compared to male prisoners.

VACANCIES

Just under half of custodial settings reported vacancies (49%) and obviously some settings did not complete this part of the survey.

Vacancies were reported in the following percentages of responding custodial setting in each region:

Table 24: Percentage of custodial settings by region reporting one or more vacancies in staffing

Region	Percentage of custodial settings reporting vacancies in their staffing
East	80%
London	100%
Midlands	53%
NEY	57%
North West	29%
South East	42%
South West	20%

Vacancies were reported in the following percentages by different types of setting:

Table 25: Percentage of custodial settings by setting type reporting one or more vacancies in staffing

Prison type	Percentage of custodial settings reporting vacancies in their staffing
Category A	43%
Category B	56%
Category C	40%
Category D	11%
Women	60%
YOI	100%
Young Adult	100%

Vacancies relate to the staffing level agreed in the commissioned provider contract, and while this should relate to need, it may not in all cases. Both needs and our understanding of how they can be met can and will change over time. Therefore while an establishment may have a full complement of staff as per the contract's guidelines, they may still not have the necessary resource to meet the levels of need. Indeed, several settings' mental health teams who supplied data made comments to this effect.

RECEPTION AND SCREENING

In adult settings, there is no requirement to have staff with mental health qualifications conducting either reception screening, when a person first arrives in a prison, or secondary screening, which occurs within a few days of arrival. Guidance from NICE (NICE, 2017) is a little unclear on secondary screening, which is sometimes referred to in its guidance as a 'mental health screening', but it does not require that a nurse with mental health training conducts this. Indeed, the reception screening does not have to be conducted by a qualified nurse at all and can be completed by a healthcare assistant if supervised by a qualified nurse. In YOIs expectations are different, with a registered nurse being required to complete the Comprehensive Health Assessment Tool (CHAT) which

includes a screen (within two hours of arrival in CYPSE), an assessment of physical health (within three days of their arrival), mental health (within ten days of their arrival) (Chitsabesan et al., 2015).

There could be some advantages to having staff with mental health training involved in either (or indeed both) screenings. (This is discussed in more detail in the consultation report – Durcan, 2021). There is clear evidence that poor mental health and related vulnerabilities are highly prevalent in the custodial population. Approximately half the questions on the First Night in Reception screening tool are mental health related. Therefore having expertise in mental health and neurodiversity will result in more of these needs being identified in the reception screening or in the secondary screening process. Indeed, the greater identification of speech and language difficulties cited earlier in under 18 YOIs may reflect the more comprehensive screening requirement and higher availability of specialist staffing supporting these tasks.

In practice, nurses with a mental health qualification taking part in reception screening is rare, with only 14% of prisons (12) reporting this. Approximately 21% of custodial settings (18) report that mental health nurses routinely take part in secondary screening.

A further question we asked in relation to screening concerned people with long-term physical conditions and their routine screening for poor mental health. This covered issues such as diabetes and cardiac disease where it is important to screen for depression. Such routine screening was reported by 41% of custodial settings (35).

REMITTALS

Remittals generally refer to the return to prison of people who had been transferred to a hospital under a section of the Mental Health Act. The consultation report (Durcan, 2021) highlighted recent research from the University of Manchester (Leonard et al., 2020) which raised concerns about those remitted back to prison and the fact that only a minority of cases were on the Care Programme Approach on follow-up.

LEAVING PRISON OR A YOI

We asked each custodial setting to tell us if there was a service specifically supporting people with mental health and related vulnerabilities at the point of leaving custody, and providing ongoing support for at least a brief period in the community post release. Given that at least 27% of the caseload (including people posing a marked potential risk to themselves) were due to leave custody within 12 months of the data being collected, this is an important question. Proven reoffending rates for adults leaving prison are 38.6% (57.7% for those released from sentences of less than 12 months and 22.3% of those released from longer sentences) (Ministry of Justice, 2022c).

Very few custodial settings had dedicated teams or professionals working to support people on a mental health caseload leaving prison at the time of the census. If generic adult prison resettlement services, those as part of OPD programme and those exclusively for people with substance misuse problems are excluded, then 18 prisons (21%) had a resettlement service for people on the mental health and wellbeing caseload. Only the East reported no such service; the Midlands reported only one service; and the remaining regions reported three or four each. These services were provided by a number of organisations: Catch 22 in the South West, Nacro in London and Rethink Mental Illness in the North East. RECONNECT, the NHS England service being rolled out nationally for adults, was operating in the Midlands, North East, North West, South East and South West.

When reporting on the challenges they faced in providing mental health care, quite a number of custodial settings reported difficulties in supporting continuity of care for patients on their release from custody. We were told by several custodial settings across England that people in custody with marked mental health problems who were of no fixed abode on release were difficult to refer to community mental health care. Often they could do no more than write to their GP, if they were registered with one.

CHALLENGES TO PROVIDING MENTAL HEALTHCARE

The process survey asked about the particular challenges each custodial mental health service faced in delivering care. Almost universally the following were described:

- Covid restrictions: limiting all contacts with patients and, at the time of data collection, still impacting on group therapy
- Clinical and office space: limited or no space for running groups, lack of rooms that offer confidentiality and safety, and a lack of office space
- Staff shortages and difficulties in recruitment: this was reported by more settings than indicated they had current vacancies, and included reported gaps in nursing, neurodiversity expertise, psychology and psychiatry. Difficulties in recruiting agency staff were also reported and in some cases this was related to changes in tax legislation.

Difficulties in working with non-NHS services in custodial settings, problems with information sharing, and issues with IT (both the nature of equipment and the lack of it) were also commonly reported. A lack of administrative support was commonly cited, as was mental health support not being prioritised by the custodial setting; the requirement to attend ACCT reviews taking up considerable mental health resource; lack of support and facilities for older prisoners and those with dementia; patients not being escorted to appointments; and poor community support (both prior to arrival in prison and on leaving custody).

Some custodial settings described the impact of the rapid turnover (churn) of people in custody on remand and short sentences; one category B prison reported its mental health team received between 525 and 638 referrals per month.

5 DISCUSSION

The national consultation report (Durcan, 2021) raised a number of concerns regarding the adult estate, including:

- The robustness and reliability of screening processes
- Staff training on trauma, and mental health, personality disorder and neurodiversity
- Delays in assessment and transfer under the Mental Health Act
- Remittals to prison with Section 117 aftercare plans
- The equitability of mental healthcare provision particularly for racialised communities
- The variability of provision
- Access to talking therapies
- Services for neurodiverse people
- The use of short sentences and remands
- Suicide and self-harm
- The needs of female prisoners
- The needs of older prisoners
- Indeterminate sentences and poor mental health
- Leaving custody.

Screening at reception, secondary screening and screening for people with long-term conditions remain a cause for concern. Only a minority of adult prisons use staff with mental health expertise in the reception and screening processes. Mental health teams are relatively small and, in some areas, seemingly less resourced than others. Interestingly, where health screening requirements were more comprehensive at the point of entry (e.g. in YOIs), higher rates of neurodiverse needs appeared to be picked up.

It may never be practicable to use mental health qualified staff in screening to any greater degree than at the present. However, as an additional means of addressing this, and as part of the programme of training for all staff recommended in the consultation report, NHS England could commission training for staff involved in screening to support their recognition of mental health and neurodiverse needs. This might be supported by a specific regime of clinical supervision for non-mental health practitioners by clinicians from within the mental health team (such supervision does take place in some custodial settings already). There are also lessons from the CYPSE, where the Comprehensive Health Assessment Tool (CHAT) is used. This type of screening assessment takes more time to conduct which poses a challenge in the adult estate. However, it is more robust and comprehensive and is far more likely, for example, to detect neurodiverse needs than the current tool used in most adult prisons. An appropriate equivalent tool would need to be developed for adults and would require competent staff to administer it. (In YOIs the CHAT is completed by a

registered nurse, of which there are a higher proportion. They also tend to be on higher grades when compared to the adult estate.)

Some of the best prevalence data on poor mental wellbeing in custodial settings was collected around 25 years ago and is therefore dated. It also predominantly looked at adults and considered children through an adult lens. We have no reason to think the 'mental health load' has lightened. Having a more current understanding of prevalence which also looks at neurodiversity can only help in planning and meeting need. And while not an immediate concern of this report, understanding mental health and neurodiversity among the probation and YOT population would also be hugely beneficial.

It is clear from the caseload on the census day and from data on transfers for the 12 months prior that there is a significant number of applications for assessment/transfer from prison to high, medium and low secure facilities in the community (around 1,100-1,200 per year) with a high proportion of these converting to actual transfers. It is also clear, though hard to put an exact figure to it, that there are still large numbers of people with acute and severe mental illness facing lengthy delays for assessments and for beds.

Our needs analysis findings reinforce our recommendations from the national consultation report (Durcan, 2021) on the importance of modernising the Mental Health Act (see Wessely, 2018). Around the time Centre for Mental Health started data collection for this needs analysis, NHS England published guidance on transfers and remissions for adults (NHS England, 2021). This guidance is extremely useful and outlines what standardised practice should look like. However, guidance (albeit less robust and standardised) has existed before and has not resolved these issues. Centre for Mental Health believes that implementing the recommended changes to the Mental Health Act must include developing a model of assessment that is independent of the availability of beds. This would mean that an assessment would take place first, and if the patient meets the criteria for transfer, then a suitable bed is sought. If the need for treatment under the Mental Health Act changes and is no longer required (i.e. the patients can now be treated in prison) then no transfer need take place. Currently the 'clock' on delays can be stopped – or not even started – if a bed is not available. Changing this will expose any real bed shortages and create greater accountability for commissioners to address these. Perhaps having regionally-based assessment teams, as we suggest (see recommendations), could go some way to ensuring that the considerations of particular units are part of the assessment process. However, it is critical that the assessment becomes a bridge to speedy transfer (where needed) and not an obstacle, as has happened in the past.

Our findings appear to indicate a more positive picture in the case of remittals back to custody: only a small number of custodial settings reported having people who had been remitted back to custody who did not have a Section 117 aftercare plan in place. Our findings are based on self-report, and it may be wise to confirm these with independent research similar to that conducted previously by the University of Manchester (Leonard et al., 2020).

The racial equitability of service provision may be less of a cause of concern than was indicated in the national consultation report. Black people appear to be represented on the caseload proportionately to their representation in the prison population, and their access to psychological interventions also appears to be proportionate. However, missing data does not allow us to state this with absolute confidence. Black people do appear to be diagnosed with psychosis at a higher rate than white people in prison. This finding is not unique to prison mental health caseloads.

It is critical that there are improvements in data collection and data sharing between custodial settings and health information systems, to support effective equality monitoring.

A widely-held perception from the national consultation was that there was considerable variability in the resourcing of mental health services. Our comparison of skills in place, gaps in need and staffing appears to confirm this. For example, some regions appear better able to meet the needs of people with neurodiverse conditions. There also appear to be large differences in the make-up of multi-disciplinary teams, with the North West seemingly worse off when compared to other regions.

There does appear to be variability in access to talking therapies by region, and some of this will be driven by the availability of resources. The rate of therapists and staff with psychological expertise appear the lowest in the north west, and access to talking therapies also appears to be significantly poorer than in most other regions. The one exception to that is London, which is not as well-resourced as other regions in terms of therapists, but is also predominated by establishments that have large remand and short sentence populations (and rapid turnover in population), where talking therapies will be more difficult to facilitate. Data particularly from London emphasises the difficulty in working with remand and short sentence populations, in delivering services to this group and in offering continuity of care.

Recruitment, both in general and to fill specific and specialist roles, is far from easy. There is a significant national staff shortage across the NHS, but also specifically within mental health and neurodiversity specialities (House of Commons, 2022). Healthcare in custody will not be an attractive environment for many, and the location of some establishments will add to difficulties in recruiting. The vacancy rate is markedly higher in mental health services across justice settings than it is for community mental health services (see Health Education England & NHS England, 2022). A recent benchmarking exercise by Health Education England (HEE) and NHS England provides useful hints at what aids recruitment and retention, and mentions in particular effective preceptorship outcomes (see also NHS Employers, 2022).). Clearly there is some room for improvement in this area; "Nursing preceptorship programmes were reported within 74% of facilities across the health and justice secure estate, with considerable regional variation reported" (page 4, HEE and NHS England, 2022). It will be necessary to think creatively about how to deliver psychological and trauma-informed care, as well as considering the role digital can play in delivering therapeutic interventions.

Meeting the needs of people with neurodiverse needs presents a mixed picture. These account for 17.4% of people on the national mental health caseload as identified in the needs analysis. In all regions there are gaps in skills to support people with speech and language difficulties and acquired brain injury. People with learning disabilities seemed to be the best supported of all those with neurodiverse needs.

Survey data on services provided for people with a diagnosis of (or suspected) personality disorder mostly fell within the Offender Personality Disorder programme. The programme provides significant intervention for those with suspected severe personality disorder who pose the highest risk, and therefore only covers a small proportion of people in prison with a diagnosis of personality disorder. This point was also stressed in our national consultation (Durcan, 2021), as was the need for more staff training similar to the training given to staff in the OPD programme.

No under-18 YOIs identified children with a personality disorder diagnosis on their caseloads (reflecting the inadvisability of imposing such a label on children who are still developing). However, there are a number of children with very high risk presentations in the CYPSE who may transfer to the adult estate and who will, therefore, need continuity of support. Given the different language used in child and adult custodial settings to describe presentations (which may, in time, crystallise as personality-based difficulties) there is a need to consider how effective transitions can be supported for these children. This requires staff in both settings to understand the different ways of working, different terminology and different cultures in both CYPSE and adult estates. As evidenced in this report and in the benchmarking exercise (HEE and NHS England, 2022), YOIs have significantly more clinical staff per patient, including psychologically trained staff, therapists, psychiatrists and nurses. It is therefore likely that many of those transitioning from YOIs to adult prisons will experience something of 'a cliff edge' in terms of the support available to them in the less well-resourced adult estate. Young people transitioning to the adult estate are likely to have the most complex needs and therefore be the most vulnerable. While it is important that everyone coming into adult prisons receive a more comprehensive health screening assessment, this is especially the case for people transitioning from YOIs.

The needs analysis did seek details on social care provision and initiatives within custodial settings; however, we learnt relatively little, as this part of the survey was often left blank or described in vague terms. Where social care initiatives were described, this largely covered joint working for older people pre-release.

The needs analysis did not collect data on incidents of self-harm or suicide (these are published regularly by HMPPS) but we did collect data on histories of both, and thus on the levels of risk for people on the mental health caseload. We also collected data on those on the ACCT system at the time of data collection (13% of the caseload nationally, but in two regions as high as 20%). And we collected data on patients who have dual diagnosis (a combined substance misuse and mental health problem), which is likely to add to risk. Commendably, this was something that those supplying the data appeared to understand well, as there was very little missing data. The findings indicated that a significant proportion of the caseload nationally and in all regions have histories of self-harm, suicide attempts and dual diagnosis.

Women are far more likely to be on a prison mental health caseload than men, with over a quarter of the adult female prison population (for the prisons that supplied data) being on the caseload. They are more likely to have histories of self-harm and suicide attempts. This greater risk and prominence on the caseload is reflected to some degree in the resourcing, with women in prison having higher ratios of occupational therapists, speech and language therapists, talking therapists, psychiatrists, band 5-7 practitioners and support workers than most other prison types (except under-18 YOIs and some young adult prisons).

Older people are a growing population within the prison system, and those aged 50 and over account for nearly 13% of the national mental health caseload. Diagnoses such as dementia, which are more prevalent in older people, are still relatively rare in the prison population, at 0.4% across England. In the East of England, where 39% of prisons in the region took part in the exercise, 3.1% of the caseload had diagnosed or suspected dementia. As stated, the national consultation identified good practice in pathway development for older prisoners and those with dementia in the East of England. Lessons learned here may be beneficial nationally: while the numbers of dementia sufferers are low, these pose disproportionate challenges to prisons and prison health and mental healthcare teams.

The needs analysis attempted to collect data on the nature of sentences. There was very little missing data nationally on whether people on the mental health caseload were sentenced or remanded, with the latter accounting for around 19% of the caseload. However, on the question of whether those on a sentence had a determinate or indeterminate sentence, over a quarter of the data was missing. Those on indeterminate sentences, particularly those on Imprisonment for Public Protection, have been identified as a group having a higher risk of poor mental health. Thus, having a clear understanding of their numbers is important.

There was also considerable missing data on those leaving custody within the next 12 months. Around 27% of people on the mental health caseload nationally were due to leave custody within 12 months of data submission. However, data was missing for 29% of the caseload. Difficulties in accessing PNOMIS (the prison information system) is a likely explanation for this missing data. Filling these data gaps is a priority. Only a minority of the custodial settings that submitted data had access to a 'through the gate' service that supports people with mental health and related needs when they leave prison. For adults, RECONNECT launched in March 2020 and is now being rolled out nationally, with anticipated 100% coverage by March 2024. However, a lack of ready access to the data does not help in the understanding of the need and the planning for such a service. RECONNECT services, as part of supporting successful resettlement, need to be able to address both housing and employment challenges on release, and may therefore require specialists in these areas within their teams.

6 CONCLUSION AND RECOMMENDATIONS

Centre for Mental Health has been reviewing and supporting improvements in prison mental health care since 2005 and has evaluated on the status and made recommendations periodically since (e.g. Durcan & Knowles, 2006; Durcan, 2006; Centre for Mental Health, 2008; Durcan, 2008; Durcan G, Saunders A, Gadsby B & Hazard A, 2014; Stubbs & Durcan, 2016 & 2017; Durcan, Allan & Hamilton, 2018; Durcan, 2018; Revolving Doors Agency & Centre for Mental Health, 2019; & Durcan, 2021).

When Centre for Mental Health first started looking at mental health in custodial settings, the NHS had recently taken responsibility for commissioning healthcare in custody (indeed, this was not completed nationally until 2006); not all establishments had a mental health service and those that did often had a spartan service with only or mostly mental health nursing. Local NHS commissioning bodies, with rare exceptions, only took an interest in people in the criminal justice system if there was a prison or CYPSE setting within their area. The nature of mental health provision varied dramatically between different establishments. Improvements were being made but the pace of these increased with the creation of a single commissioning body, NHS England, responsible for commissioning health care for all English prisons and most CYPSE settings from 2013.

Lord Bradley's seminal report (Bradley, 2009) envisioned an 'all stages' or 'end-to-end' service within the criminal justice system, and NHS England has brought us closer to this with its national specification for mental health services in custodial settings, the complete roll-out of liaison and diversion to police custody and courts, and most recently the launch of the RECONNECT programme for adults, supporting vulnerable people leaving prison.

There are of course improvements that need to be made, and both this report and its companion (Durcan, 2021) highlight some of the significant changes needed. In making our recommendations, we start form the understanding that the vast majority of people who come into custodial settings have vulnerabilities and often multiple difficulties. So while the NHS has a critical role and there is a case for further investment (particularly to ensure equitable access to talking therapies across all regions, and in neurodiversity expertise), so too does the host service (HMPPS).

1. NHS England should ensure the greater involvement of mental health trained staff in the first night in reception, secondary screenings and the screening of people with long-term physical conditions.

    a. NHS England should commission the development of training to support non-mental health staff members in screening. To further this:

        - A system of supervision by mental health staff of non-mental health trained staff involved in screening should be developed
        - Piloting of training and supervision should take place, with an evaluation of both to establish the best model.

    b. NHS England should support the development of a screening tool and process such as used across the CYPSE, i.e Comprehensive Health Assessment Tool (CHAT).

c. All young people transitioning from YOIs to adult prisons should be subject to a comprehensive assessment and crossover working process between the teams in the CYPSE and adult estate.

2. NHS England should commission improvements in data collection and, in collaboration with HM Prison & Probation Service (HMPPS) and Youth Custody Service (YCS), ensure better data sharing between custodial settings and health systems.

   Improving the quality and use of data could be done through:

   a. NHS England, HMPPS and YCS continuing to develop the system of data sharing between SystmOne, PNOMIS and wider YCS data (eAsset)

   b. NHS England, in conjunction with HMPPS and YCS, reviewing IT equipment, software running systems, software and internet connection across England's custodial healthcare services, to ensure IT is both efficient and accessible for staff

   c. Addressing deficits in data collection (as identified in this report) as a priority

   d. Developing standardised reporting that would allow for better monitoring (the representativeness of the caseload when compared to the establishment's population, the risk profile of the caseload, and knowing who is due for release and needing resettlement support).

3. The Government should reform the Mental Health Act so that:

   a. Offering an assessment is not dependent on whether a bed is available, and once the need is established a bed must be sought, preferably within region but nationally to avoid delay and if clinical necessity supports this. People transferred out of region, if appropriate, can be transferred into region when there is availability.

   b. Commissioners of secure mental health beds are held accountable for delays and further beds are commissioned if delays remain an issue.

   c. The proposed 28-day period for assessment and transfer starts from receipt of referral and (if the need for transfer is agreed), this ends when that transfer is achieved, without gaps or 'stopping the clock.'

   d. The model and process for assessment of adults for transfer under the Mental Health Act is revised. One model might be a rota of expert clinicians from each region, with sufficient expertise to be able to decide if a person requires high, medium or low secure placement, and knowledge of the resources within region and nationally. In other words, the first part of the assessment process should determine the need for transfer and ideally find a suitable be bed. If further assessment is required in determining the suitability of a bed, then this must take place and be completed within the consecutive 28-day period. Multiple and duplicate assessments should be avoided.

4. Access to housing, employment and benefits are critical to successful resettlement and transition especially so for children and adults with vulnerabilities. We therefore recommend that adult RECONNECT services must have access to expertise in housing, employment and benefit advice. Transitional care for children and young people should reflect their particular needs.

5. NHS England should address regional disparities in the provision of particular skills, including psychiatrists, nursing staff, social workers, occupational therapists and support workers, and expertise in speech and language therapy, talking therapies, neurodiversity and acquired brain injury. To achieve this:

a. NHS England should revise the national specification(s) for mental health care and care for those with neurodiverse need to include an ideal model of provision for different custodial setting types with specified staffing of each mental health and related discipline per 1,000 custody population – based on optimal levels of resourcing by region and custodial setting type in this report.

b. Where the recruitment of particular disciplines is more difficult in some regions or particular custodial settings, alternative means of achieving intervention should be described in the specification, such as a combination of:

   - Training other staff to deliver interventions
   - Live and digital supervision of such staff be provided
   - Digital interventions
   - Collaboration with the relevant professional bodies to address recruitment difficulties and agree alternative means of delivering interventions.

c. NHS England should review recruitment to mental health roles in prisons and YOIs. This review should involve some piloting and evaluation of:

   - Training nurses and other disciplines to deliver psychological intervention and other therapies
   - The development of preceptorship schemes specific to prison (and other justice settings)
   - The extension of digital technology to provide interventions (e.g. psychological)
   - The development of models of career development within Health and Justice
   - How gaps in skills in identifying and supporting those with neurodiverse conditions might be addressed. This will include recruiting actual staff appropriately skilled and also exploring digital intervention and clinical supervision.

6. NHS England should commission a robust study of the prevalence of mental health problems and neurodiversity within the custodial and probation populations (in partnership with the Ministry of Justice) replicating and extending on the Office of National Statistics work in the late 1990s (Singleton et al., 1998). YOIs, and possibly other secure children's provision and Youth Offending Teams (YOTs), should also be included but should have a design that reflects the specific needs of children.

The findings of this report lend support to the recommendations of the consultation report (see the appendix).

6 REFERENCES

Anna Freud National Centre for Families and Children (2022) *Independent evaluation of the framework for integrated care (SECURE STAIRS). Full Report*. London: Anna Freud National Centre for Families and Children

Bradley (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.* London. Department of Health

Centre for Mental Health (2008) *On the Outside: Continuity of care for people leaving prison.* London.

Chitsabesan P, Kroll L, Bailey S, Kenning C, Sneider S, MacDonald W & Theodosiou L (2006) Mental health needs of young offenders in custody and in the community. *The British Journal of Psychiatry*, 188(6), pp.534-540.

Chitsabesan, P, Lennox, C, Williams, H, Tariq, O, Shaw, J (2015). Traumatic Brain Injury in Juvenile Offenders: Findings From the Comprehensive Health Assessment Tool Study and the Development of a Specialist Linkworker Service, *Journal of Head Trauma Rehabilitation* 30 (2), 106–115.

Dimond C & Misch P (2002). Psychiatric morbidity in children remanded to prison custody—a pilot study. *Journal of adolescence*, 25(6), pp.681-689. Centre for Mental Health

Durcan G, (2006) Equivalent to What? Mental health care in Britain's prisons. *Journal of Mental Health Workforce Development*; 1 (4): 36-44

Durcan, G. (2008) *From the Inside: Experience of prison mental health care.* London: Sainsbury Centre for Mental Health

Durcan G (2016) *Mental Health and Criminal Justice: views from consultation across England and Wales.* London. Centre for Mental Health

Durcan, G (2018) *Restoring something lost: The mental health impact of therapy dogs in prisons.* London. Centre for Mental Health

Durcan, G (2021) *The future of prison mental health care in England.* London. Centre for Mental Health.

Durcan G, Allan J & Hamilton I (2018) *From prison to work: a new frontier for individual placement and support.* London. Centre for Mental Health.

Durcan, G. & Knowles, K. (2006) *London's Prison Mental Health Services: A review.* London: Sainsbury Centre for Mental Health.

Durcan G, Saunders A, Gadsby B & Hazard A (2014) *The Bradley Report five years on: an independent review of progress to date and priorities for further development.* London. Centre for Mental Health.

Faith Matters (2020) *The Impact of the Christchurch Terror Attack: Tell MAMMA Interim Report* 2019 [giving data UK Police data on incidence]. London. Faith Matters. Available at: **https://www.tellmamauk.org/wp-content/uploads/2020/03/The-Impact-of-the-ChristChurch-Attack-Tell-MAMA-Interim-Report-2019-PP.pdf**

Gov. UK (2021) *Psychotic disorders: Ethnicity facts and figures* Available at: https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-a-psychotic-disorder/latest

HEE & NHS England (2022) *NHS Benchmarking Network Stocktake of the healthcare workforce in the Health & Justice secure estate.* London. NHS Benchmarking Network.

HM Inspectorate of Prisons. 2020. *Separation of Children in Young Offender Institutions. A Thematic Review.* London: HM Inspectorate of Prisons. Available at: **Microsoft Word - Separation of children thematic final draft.doc (justiceinspectorates.gov.uk)**

HMPPS & YCS (2019) *Youth Custody Service Safeguarding Review.* London: Her Majesty's Stationary Office.

House of Commons (2021) Evidence submitted. **https://committees.parliament.uk/writtenevidence/36310/pdf/**

House of Commons (2022) *Workforce: recruitment, training and retention in health and social care. – Health and Social Care Committee: Third Report of Session 2022-23.* London. House of Commons. Available at: **https://committees.parliament.uk/publications/23246/documents/171671/default/**

Inreach Review Team (2007 – Unpublished) *Evaluation of Mental Health Inreach in Prisons.* Conducted by The University of Manchester, The Institute of Psychiatry, University of Southampton & University of Lincoln

Khan L, Harris A, & Sinclair C, (2021) *Out of sight.* London: Centre for Mental Health

Lader D, Singleton N, and Meltzer H (2000) *Psychiatric morbidity among young offenders in England and Wales.* Office for National Statistics. London: Stationary Office.

Leonard, S., Webb, R. and Shaw, J. (2020) Service transitions, interventions and care pathways following remittal to prison from medium secure psychiatric services in England and Wales: national cohort study. *BJPsych* Open6, e80, 1–8. doi: 10.1192/bjo.2020.62

Lennox C & Khan L (2012) Youth Justice. Chapter 12 of Chief Medical Officer annual report: children and young people's health. London. Department of Health and Social Care. Available at: **https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays**

McKenzie, N., Killaspy, H., Jakobowitz, S., Faranak, H. and Bebbington, P. (2019) Assessing needs for psychiatric treatment in prisoners: 3. Comparison of care received by black and minority ethnic prisoners and by white prisoners. *Social Psychiatry and Psychiatric Epidemiology*; 54, 883-886.

Ministry of Justice (2021) *Safety in custody statistics quarterly update to June 2021.* London. Ministry of Justice. Available at: **https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-june-2021**

Ministry of Justice (2022a) *Prison Population Tool* (published 27 January 2022). London. Ministry of Justice. Available at: **https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2021**

Ministry of Justice (2022b) *Offender management statistics quarterly: July to September 2021* (published 27 January 2022). London. Ministry of Justice. Available at: **https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2021**

Ministry of Justice (2022c) *Proven reoffending statistics: April to June 2020: Statistics on reoffending of offenders who were released from custody, received a non-custodial conviction, or a caution* (published 28 April 2022). London. Ministry of Justice. Available at: **https://www.gov.uk/government/collections/proven-reoffending-statistics**

NHS ENGLAND (2021) *The transfer and remission of adult prisoners under the Mental Health Act 1983: Good practice guidance 2021 - Version 1*, 10 June 2021. London. NHS ENGLAND. Available at: **https://www.england.nhs.uk/publication/guidance-for-the-transfer-and-remission-of-adult-prisoners-and-immigration-removal-centre-detainees-under-the-mental-health-act-1983/**

NHS Employers (2022) *Preceptorships for newly qualified staff* **https://www.nhsemployers.org/articles/preceptorships-newly-qualified-staff**

NICE (2017) *Mental health of adults in contact with the criminal justice system* NICE guideline. [Online] Available from: **www.nice.org.uk/guidance/ng66**

Prison Reform Trust (2020) *Prison Reform Trust submission to the Comprehensive Spending Review – September 2020.* London: Prison Reform Trust

Prison Reform Trust (2022) *Bromley Briefings Prison Factfile: Winter 2022.* London: Prison Reform Trust. Available at: **https://prisonreformtrust.org.uk/publication/bromley-briefings-prison-factfile-winter-2022/**

Revolving Doors Agency and Centre for Mental Health (2019) *In ten years' time: Improving outcomes for people with mental ill-health, learning disability, developmental disorders or neuro-diverse conditions in the criminal justice system.* London. Jointly by Revolving Doors Agency and Centre for Mental Health

Royal College and Paediatrics and Child Health (2019) *Healthcare Standards for Children and Young People in Secure Settings.* London: RCPCH.

Sharpley, M., Hutchinson, G., Murray, R., & McKenzie, K. (2001). Understanding the excess of psychosis among the African-Caribbean population in England: Review of current hypotheses. *British Journal of Psychiatry,* 178(40), 60-68. doi:10.1192/bjp.178.40.s60

Singleton N, Meltzer H & Gatward R (1998) *Psychiatric Morbidity among Prisoners in England and Wales.* London: Office for National Statistics.

Stubbs J & Durcan G. (2016) *Preventing prison suicide: perspectives from the Inside.* London. Howard League for Penal Reform

Stubbs J & Durcan G (2017) *Preventing prison suicide: Staff Perspectives.* London. Howard League for Penal Reform & Centre for Mental Health

UK Government (2021) Psychotic disorders: Ethnicity facts and figures. London: NHS Digital Available at: **https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adultsexperiencing-a-psychotic-disorder/latest** [Accessed 30 March 2023]

YJB & Ministry of Justice (2000). Youth Justice Statistics: 2019-2020. England and Wales. London: HM Stationers. Available at: **youth-justice-statistics-2019-2020.pdf (publishing.service.gov.uk)**

APPENDIX

RECOMMENDATIONS FROM 'THE FUTURE OF PRISON MENTAL HEALTH CARE IN ENGLAND'

(National consultation report - Durcan, 2021)

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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