Mental Health in Prisons – Stakeholder Scoping Workshop

Wednesday 3rd September 2014, 10am-1pm

Royal College of General Practitioners, 30 Euston Square, London, NW1 2FB

Group 1

Facilitator: Steve Pilling

Scribe: Cheryl Palmer

General comments

The group agreed that extension of the scope beyond prisons to the broader criminal justice system (CJS) was appropriate. However, the group noted that there are key differences between parts of the CJS (e.g. probation vs. prison) that will need to be considered throughout the guidelines.

The group felt that resource constraints were a large barrier to adequate mental health care in the CJS. It was agreed that the guideline should strive to recommend the best possible practice in this area, despite current shortages, in recognition that policy and context are likely to change over time.

Transition

Although medium secure units are excluded from the scope, the group felt that the guideline should look at transition between services, as many offenders with mental health issues have experienced being transferred to and from prison and medium secure settings.

Resettlement upon release was said to be a particularly difficult time for offenders. Offenders may be at increased risk of suicide and overdose immediately post-release. Community mental health teams may be reluctant to accept individuals with an offending history and those with no fixed abode may not be able to access services.

Interventions

When asked whether there were differences in practice across settings, the group noted that mandatory treatment cannot be enforced within prisons, unlike treatment in hospital settings. Also, pharmacological dosing schedules may be compromised in prisons, as the timing of medication administration needs to be fitted around staff availability.

For preventative interventions, the government have produced a 'healthy prisons' document which was seen by the group to provide good guidance. However, the group felt that this has been neglected in practice due to resource limitations.

Assessment

Assessment was an issue of priority for the group. The group highlighted that assessment was not standardised across settings. Many offenders do not get an adequate assessment of their mental health needs.

Accurate assessment of risk of suicide and self-harm was seen as a particularly difficult area for the group.

Group members noted that misdiagnosis may be a problem with the CJS.

The group highlighted that diagnosis does not always inform sentence plans, and that it is important to integrate assessment and treatment.

Outcomes

The group felt that the rate of uptake of mental health care in the CJS was a particular problem and may be a worthwhile outcome to explore.

Cost was an important outcome (e.g. hospitals much more expensive than prison) and may influence treatment/diagnosis.

Offender subgroups

The group felt that these subsets of offenders may warrant special attention in the scope:

- Those with multiple mental health needs (e.g. personality disorder, major mental health issue and substance misuse) – treatment often fragmented, need for an integrated approach.
- Women – due to unique issues with maternity and high levels of distress.
- Individuals with learning disability – as they may often be excluded from interventions, which has implications for their opportunity to progress. May pose equity issue.
- Older offenders – may have unique mental health needs such as dementia. Likely to be a growing problem due to increasing age of the prison population.

Potential GDG members

The following groups of people were suggested as potential GDG members, in addition to the existing list:

- Prison officers
- Members of 'safer custody' groups (who deal with self-harm, suicide and violence) – may be useful as special advisors, rather than permanent group members.

Group 2

Facilitator: Nick Kosky

Scribe: Sabrina Naqvi

3.1 Epidemiology

- Specifically name Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorder, due to their high prevalence in this population.
- Suicide and suicidal ideation should also be mentioned, not just under the term self-harm.
- Post-traumatic stress disorder.
- Range of responses, including thresholds, response sets.
- Emphasise the link between mental health conditions and criminal behaviour, without stigmatising the former or excusing the latter.

3.2 Current practice

- Commissioning: provide a historical brief and then the current context: for both custody (in prison) and community (contact with criminal justice systems outside of prisons).
- Different commissioning agencies with different approaches and opportunities for improving the development of shared values and co-commissioning.
- The Care Act: this is left open to interpretation in terms of how to apply it; leads to varied practice.

4.1 Population

4.1.1 Groups that will be covered

Very complex population, must consider level of social deprivation, failure to complete normal education and communication problems.

Specific consideration should be extended to:

- learning difficulties, not just learning disabilities
- history of child abuse and sexual abuse
- attachment disorders
- ex-armed forces and gang members *(not sure whether to include these)*

4.3 Management

4.3.1 Key issues that will be covered

- Interface with the legal system
- Treatment orders: punishment orders, which may also be combined with treatment and support orders
- Sectioning process: different for prisoners and less robust than that in community settings
- Prison as a place of safety: for general population or for the prisoner?
- Court, probation and parole board reporting: change in responsibilities
- Training: current lack of standardisation and no minimum standards
- Differences for foreign nationals: prison, IRC, IS91
- Risks: boredom, social isolation, self-harm, vulnerability to radicalisation and low-mood
- Threshold for forensic involvement / referrals / pathway

b) Interventions

- Physical exercise, social interaction, education
- Accessibility to interventions: staff time, logistics, competing interests, focus on 'core day'
- Core Day: offender pathway requirements, logistics, release issues, transfer issues, communication, continuity of care
- Governance of all health, social care, and related processes including third sector and peer delivered services especially escalation of risky situations
- Transitions: medicines management (especially for chronic care), care planning issues, access to local services – pre-registration with GPs, information sharing

Equalities

- Protected characteristics under the Equalities Act
- Lesbian, Gay, Bisexual and Transgender – especially transgender in single sex prison wards
- Women and reproductive issues
- Ethnicity, race, religion

GDG composition

- Commissioners – expert advisors
- Faith related issues such as radicalisation – expert advisors, as needed?
- Magistrate or judge – especially as remit has been widened to entire criminal justice system
- Governor (must not state retired as this is age discrimination): including a deputy governor, or indeed any prison services representative.

Group 3

Facilitator: Richard Byng

Scribe: Odette Megnin-Viggars

General

- Offender definition: happy with 'from arrest'; limiting use of 'in prison' – need to be clear criminal justice system
- Guidance needs to reflect complexity or population and comorbidities
- Increased rates of suicide are likely
- Staff competence and training
- Interface with physical health – poly-pharmacy
- Collaborative working across specialities – multi-agency aspect
- Interface with voluntary sector and social care

4.1 Population

- Older adults – explicit about dementia
- Military – PTSD and drug problems – transfer into mainstream prison for sentences over 1 year
- Sleep disorders – under health promotion issues, and linked to wider environment issues
- Prescribing – security issues and medication management – sold by prisoners (currency value)

4.1.1 Special consideration will be given to:

- N/b over representation of groups…
- 18-25 year olds
- BME groups
- Is 18 the right age? CAMHS 16 cut-off
- Need to include transition – cross-check against social care guidance
    - Issues: transition back into prisons
- Transgender and transsexual groups
- Probation - high risk group for suicide
- Travellers
- Recent migrants
- Women

4.2 Setting ➔ now criminal justice system

- Title does not reflect setting
- Everyone happy with CJS and that it should be included
- Liaison and diversion services: court and police cells, voluntary attendance
- Exclusion of section 126 and 135 is illogical: Mismatch between police officers' view of mental health and health care professionals
- Street triage – police officers and nurse joint patrol
- Probation (CRCs new group / interface issue)
  ➔ Overlap with interface issue
- Gap in knowledge about care pathway post 136 discharge
- Held in custody (includes post-tariff)
- People in contact with CJS (not victims)

- Includes s. 136
- Street triage
- Not arrested
- Voluntary attendance
- Serving sentences (prison and community)

4.3.1 Key issues that will be covered

Organisation of care

- Transitions
- Resettlement
- Early part of care pathway is very messy and doesn't necessarily allow planning of time, etc.
- Interface with primary care, in-patient settings, social care, general health promotion
- Functional system – joint working between multiple agencies
- Need to include suicide and self-harm
- Need to include cognitive impairment (including dementia)

Case ID and Assessment

- Processes for case ID and assessment
- Personality disorder – link with dangerous and sever personality disorders units who are under CJS and not NHS and who manage programme (CUFF)
- CMHO need including
- 90% figure misleads that formal mental health treatment needed for all these people which is *not* true – need to be identified, but then what you do…
- Staff competence and training – mental health awareness – informed and skilled workforce
- Comorbidities statistic is about 70% in prisons
- How things are managed on first night / week - people with no history who do not know they have mental health problems
- Integrated health (physical and mental) assessment
    - not realistic to administer 20 assessment tools
    - but cannot be enormous, needs to be practical
    - multi-agency assessment and planning
    - drugs – need to include prescribed drugs addiction do not tend to ask about length of time on (for example Valium).

Interventions

- Supportive plans (CRC resettlement planning);
- Community rehabilitation companies (prior probation)
- Interventions to support wellbeing not just prevention
- Individual and system-wide interventions – mental health promotion
- Liaison with general health – diversion is an interventions, raid services
- Comorbidities between physical and mental health – psychotropics, unexplained symptoms, pain
- Peer support

Outcomes

- Pathways
- Social outcomes – relationships, employment, housing
- Recovery: social; mental health
- Rates of injury
    - violence and aggression might be better
    - financial penalties so not accurately reported

GDG members

- Pharmacist / pharmacologist
- Nurses
- Police officer
- Prison officer
- Detention centre: specialist advisor
- Occupational therapists
- Healthcare assistants
- Forensic mental health practitioner
- Mental health forensic practitioner
- Social services
- Substance use
- Private sector custodian care organisations
- Service users

Group 4

Facilitator: Clifford Middleton

Scribe: Rebecca Pye

Title

- 'Mental health' does not reflect learning disabilities
- Link to CBLD and MHLD – alerts stakeholders

General comments

Who within the prison:

- Officers
- Environment
- Healthcare sits aside (not under governor)
- Several healthcare commissioners: consider fragmentation of services
- Healthcare is non-health care staff?
- Custodial staff?
- Agree with CMS clarification of referral
- General versus specialist social care:
    - What triggers this?
    - Implications of Care Act
    - Those just under threshold but need extra care
- Parallel with public health guideline
- Current practice to reflect whole pathway (currently only within prison)
- Close supervision centres (i.e. most dangerous prisoners)
    - High secure hospitals
    - Issue: "segregation" ➔ *to be looked at specifically*
    - In-patient units ➔ *to be looked at specifically*
        - Legal definition – not hospital (usually part of primary care service within prison)
        - Confusion over care, inpatients versus outside care
- Issue with "offender" terminology:
    - People in contact with the CJS – concerns as this covers victims, witnesses etc.
    - Link to diversion
    - Specify / define offender for this guideline

Population

Include

- Prison transfer patients - add to care pathway (in and out of prison)
- Query re younger offenders – evidence to suggest early interventions help:
    - Agreed if remit is to include prevention then they should be considered
    - Large scope; is this practical
    - Suggested looking at transition
- Substance misuse - add
- Personality disorder – add
- People sent to psychiatric hospital

    - Define where they fit – “transferred prisoners”
- Define older adults – in terms of age or conditions?

Exclude

- “high secure” correct terminology
- Define young people as under 18
- Sexual offenders?? Fine line

Settings

- People
- Areas of hospital
- Include settings of people who have left prison: approved premises and rehabilitation (1 year supervision)
- Clarify “in & out” point currently within settings section
- Pre-release planning
    - Transfer of care (link to Care Act)

Issues

- Population interventions
- Screening – very important
    - Assessment ➔ link, liaison and div. (crucial!)
    - Reception and secondary screening (MH captured here)

Interventions

- Concern over “reactive” – prison officers do this not healthcare professionals
    - However, do not complete exclude: out of hours and rapid tranquillisation
    - Worth the conversation, right intervention for the context
- Psychological and psychosocial interventions to be considered

Organisation of care

- Capture pre-release planning, in addition to transfer when in prison – communication (mapping?)
- Currently fragmented, separate teams contribute to care
    - Need to integrate
    - Noting: mental health provision, different needs in different types of prison
- “in reach”
- Timeline transition to hospital to be captured

Training

- Domestic abuse, lack of training
- Prison officers not trained
    - Evidence that it is very successful when done (OHRN website)
- Shared training

Outcomes

- Inpatient needs clarification
- CPA
- Holding down a job – in prison?
- Reduce suicide and self-harm
- Better information from liaison / div.

GDG constituency

- Prison officer
- GP who works in prisons specifically
- Women's national services
- In-reach nurse with experience of secure hospitals and prisons