FOREWORD

This is a report on the work of the National Prisoner Healthcare Network (NPHN) Mental Health Working Group. The group reported to the NPHN Board on 30th April 2013 and a consultation strategy was launched. Feedback from the consultation is available on the Forensic Network website and has been incorporated into the final version and agreed by the group. Our aim is to create a mental health and learning disability service within prisons where the provision of care for prisoners is equivalent to the care received for people in the community but designed to meet the recognised increased mental health needs of prisoners. It is essential that the NPHN takes forward this report in an action plan to ensure that the report is enacted upon. With the management of prisoner mental healthcare moving from the Scottish Prison Service to the National Health Service, we have an opportunity, and indeed a responsibility, to make a difference.

Lindsay Thomson
Jim McGuiness

18th February, 2014
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EXECUTIVE SUMMARY

NATIONAL PRISONER HEALTHCARE NETWORK
MENTAL HEALTH SUB GROUP

Report

The responsibility to deliver primary and community healthcare to prisoners in Scotland transferred from the Scottish Prison Service (SPS) to NHS Scotland on 1 November 2011. The National Prisoner Healthcare Network (NPHN) was formed and established ten work streams to address issues around prisoner healthcare.

TERMS OF REFERENCE

The Mental Health working group was established to consider the mental health needs of the prison population

Inclusions

- all forms of mental disorder, including learning disabilities and personality disorder
- all prisons and prisoners in Scotland (including young offenders and private sector)

Exclusions

- mental health services provided outwith prisons in Scotland

MEMBERSHIP

The membership reflects the geographical, professional, managerial and service backgrounds of those working in prison mental health.

MEETINGS

The NPHN Mental Health Sub Group met monthly and had nine meetings in total.

The NPHN Mental Health Working Group reported directly to the NPHN. It provided monthly highlight reports to the NPHN team.

OBJECTIVES and COMMENT

The aim of the group is to create a mental health and learning disability service within prisons where the provision of care for prisoners is equivalent to the care received for people in the community.

The following specific objectives were set:

1. Needs Assessment

To review the current literature on the mental health needs assessment of prisoners in Scotland.

To develop a methodology for initial and on-going mental health needs assessment and care planning of prisoners.
The literature was reviewed and a table of prevalence studies in Scottish Prisons prepared. The last needs assessment of prisoner mental healthcare was carried out fourteen years ago and up to date information is required for the planning of services. The current database within prisons would allow the collation of only basic data for on going needs assessment to be gathered.

2. Service Mapping
To map the provision of mental health services currently provided within Scottish Prisons.

A service mapping exercise was carried out which found marked variation in the provision of nursing and psychiatric sessions for each establishment. These findings appeared to be based on largely historical factors rather than on any true assessment of need.

3. Model of Care and Service Provision
To develop a model of care that will improve mental health services to prisoners and make them equivalent to those found in the community.

To lead and co-ordinate the development of mental health services for prisoners that build on examples of good practice of multi-disciplinary and multi-agency working within Scotland, the UK and internationally.

At present the mental health teams in prison are not truly multidisciplinary, representative of mental health services found elsewhere in the NHS or designed to meet the level of need in the populations they serve.

The group identified a range of issues relating to the required services that should be considered when developing models of care from prisoners. These include:

- Acceptance of the principle of equivalence of provision of prison mental health services with those provided in the community
- Recognition that the prevalence of mental disorder and the experience of trauma in the prison population is in excess of that found in the community
- Acknowledgement of the need for partnership working.

Health and social care provision in prisons is the joint responsibility of both Justice and Health and therefore any mental health model of care must be constructed to include the governance arrangements that need to be in place to ensure both parties understand and operate within the boundaries of their responsibilities.

- Recognition of the range and complexity of mental disorders in the prison population and the need for services for prisoners with mental illness, learning disability, drug and alcohol problems, comorbidity and personality disorders / problem behaviours. Compounding the challenge of developing appropriate models of care is the wide ranging needs of the prisoner population which is dispersed across the 16 prison establishments in Scotland. This includes the young offender population and an ageing cohort.

There was acceptance of the principle that those with major mental disorder should be cared for in hospital rather than prison. An audit of transfer to hospital from prison found that sixteen of the twenty-two patients involved were transferred within 3 days of referral (Fraser, Thomson and Graham, BMJ 2007).
The need for in reach work by Community Mental Health Teams where geographically possible for existing patients or those likely to require ongoing care on release.

The need for throughcare arrangements that link prisoners to services in the community.

Recognition of the challenges of the prison environment to the effective care for those with mental disorders is essential. The physical environment and the prison rules are necessary to maintain order and safety of all concerned. However they can present challenges: examples of this may include access to patients, or conflict between the provision of mental health treatment and security, such as when prescribing psychotropic medication. For these reasons regular dialogue between healthcare and prison management will be necessary to enable appropriate planning and delivering of services.

The need to increase support for self-help approaches: through the chaplaincy service, listener scheme or access to tele-mental health packages.

Potential for the use of modern technology to provide telehealthcare.

Adoption of a health promoting and prevention approach – consistent with 2020 Vision.

The need for workforce planning to delineate the composition of an appropriate prison mental health team, allowing for prison population, mental disorder prevalence rates, environmental challenges, and the tiered care approach to mental disorder.

Recognition of lack of clinical psychology input in prisons but presence of forensic psychologists.

Consideration of the overlap between risk assessment, offending behaviour work and mental health interventions and respective roles of forensic psychologists, prisoner programmes staff and mental health teams.

Requirement to assess the educational needs of prison operational staff and provision of educational packages to meet these needs.

Having considered these issues, the following components were considered essential to a successful model of prisoner mental healthcare:

1) A prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services. Access to the appropriate level of service will depend on the tiered care model. Provision of services will be competency based.

2) Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.

3) The prison mental health team should have the following components: mental health, addictions and learning disability nursing staff, general practitioners, psychiatrists, allied health professionals such as occupation therapists, social workers and clinical psychologists. In addition, within a prison setting input from prison governors, operational staff, forensic psychologists, third sector providers and chaplaincy would be expected.

4) The team should be cohesive and the wider roles of team members found in the community should be fulfilled: for example, supervision, service development, leadership, education and advocacy.

5) Mental health nurses should be used for that role alone and not wider general physical health duties.

6) Psychological input should be provided on a tiered basis as set out in the Psychological Matrix. This is competency based.
7) Standards for prison mental healthcare should be developed and services inspected.

8) The working methods of a prison mental health team should include:
   - Screening
   - Referral system to prison mental health team
   - Standardised assessment, including diagnosis and formulation
   - Treatment planning
   - Use of condition specific integrated care pathways
   - Access to psychological therapies: using a matched step care approach and offering a range of modalities e.g. self-help, telemental health, individual therapy
   - Access to programmes that cover both clinical and criminogenic needs, such as substance misuse
   - Throughcare
   - Access to independent advocacy
   - Liaison with family and carers with regards to information sharing.
   - Liaison with relevant third sector organisations.

4. **Comorbidity**
   *To consider the needs of those with co-morbid mental health and substance misuse problems.*

Approximately 75% of prisoners have a drug misuse problem and a similar percentage a problem with alcohol misuse. There is a significant overlap between the population with a mental illness and learning disability, and those with substance misuse. At present mental health and substance misuse services in prisons are organised separately.

5. **Telemental Health**
   *To review the use of tele-mental health services in prisons for the delivery of psychological therapies, preparation of court reports, urgent assessments and peer support / training.*

The Scottish Centre for Telehealth and Telecare (SCTT) has successfully demonstrated the potential for use of video conferencing in prisons for clinical care, training and supervision; and the potential use of NHS 24 psychological based programmes on a telecare platform. This would help to address the problem of lack of psychological treatment within prison.

6. **Competencies**
   *To develop agreed core competencies for mental health staff working in prisons (linked to the generic competencies being developed for offender health).*

   *To develop first aid mental health training for officers and non-mental health NHS staff to raise awareness and build capacity in mental health competencies within prisons.*

Competencies have been developed for psychiatrists working in prison. The police custody health group is currently developing a competency framework for healthcare staff in police custody settings. In addition, a New to Forensic Programme on Managing Medical Conditions in Custody is being developed, and the New to Forensic: Essentials in Psychological Care will be published soon. This is a complementary programme to the New to Forensic Programme.
7. Placement of Prisoners
To consider the placement of prisoners, including the flow of information to, from and between prisons.
To examine the links between other NPHN workstreams such as throughcare.
To consider the transfer and transport (including care of prisoners during transport) of prisoners.

The SPS has a national process for all establishments to follow when transferring prisoners to another prison. The process ensures all significant and relevant information (including health care) is obtained, considered and recorded as part of the decision making process prior to transferring the prisoner. Issues of prisoner placement arose during the Group’s discussions, chiefly concerning the placement of prisoners, their movement within SPS and the flow of information with them as they move around the SPS estate. In addition, some concerns were raised about the suddenness of some transfer and the means of transportation of prisoners. The importance of throughcare was fully recognised.

Note
These issues have been identified but are not addressed within this report.

8. Safety of Visiting Staff
To consider the safety of visiting staff and to review the arrangements made for them.

The SPS national guidance agreed between National Partners sets out the principles that all SPS establishments should follow when utilising Non-Operational staff in an operational environment. The guidance provides a framework for Local Partners to work within and allows for such local flexibilities as may be required to meet service needs. NHS Greater Glasgow and Clyde has a working group which is considering the safety of visiting staff to prisons. A questionnaire has been circulated

Note
Given the ongoing work on these issues at this time, the Working Group has therefore not specifically addressed these.

9. National Guidance
To ensure that revised national guidance is provided by Scottish Government to support NHS Boards to follow a consistent process to access forensic health facilities for prisoners who have been resident in a prison within another health board area for more than 6 months. Responsible Commissioner guidance document NHS HDL (2004) 15.37.

Note
This guidance was issued on 05th March 2013.

Recommendations

1. Needs Assessment
   - An updated national assessment of the mental health needs of prisoners should be carried out.
   - ViSION should be utilised on a national basis to provide on-going data on prisoners’ mental healthcare needs.
2. **Service Mapping**

1) A comparison exercise should be carried out between standard resources for community mental health teams and mental health teams in prisons which takes account of the greater psychiatric morbidity found in prisons, the prison environment and the combined primary, community and specialist services roles of the prison mental health team. Equivalence of provision between community and prison mental health services is important as is the development of services within prisons that meet the level of assessed need.

- The Mental Welfare Commission Report on Prisons (2011) set out key messages for prisoner mental healthcare. See Appendix 7. These should be implemented.

3.1 **Models of Care and Service Provision**

- A model of a prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services should be adopted. Access to the appropriate level of service will depend on the tiered care model. Provision of services should be competency based.
- Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.
- Develop a standardised process for family and carers to liaise with a prisoner mental health team.
- Prison mental healthcare standards should be developed and audited.
- The prison mental health team should be multidisciplinary and planning should be carried out to provide guidance on the membership of a team. This workforce planning should delineate the composition of an appropriate prison mental health team allowing for prison population, mental disorder prevalence rates, any updated needs assessment, environment challenges, and the tiered care approach to mental disorder.
- There should be an overview of the tools required to assure fitness to practice including:
  - Competency Framework for healthcare staff
  - Education and Training Framework for health and operational staff.
- Joint Governance arrangements between NHS Scotland and the Scottish Prison Service for the management of mental health provision should be defined.
- A National Prison Mental Healthcare Steering Group should be established to oversee this model and standard building work.

**Recommendations**

- A model of a prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services should be adopted. Access to the appropriate level of service will depend on the tiered care model. Provision of services should be competency based.
- The prison NHS mental health and addictions provisions should be amalgamated to form one team.
- Develop a standardised process for family and carers to liaise with a prisoner mental health team.
3.2 Learning Disability

- There should be an awareness raising initiative concerning learning disability within Scottish prisons. This is the starting point for working to meet healthcare needs and provide people with learning disabilities and staff in prisons with the support that they require.

- “Learning Disability awareness” training should be provided to SPS staff, initially targeting new staff.

- Screening should be introduced into Scottish Prisons for adults with learning disability (AWLD). This will allow recognition of needs and identify individuals with “learning difficulties”. The use of the Learning Disability Screening Questionnaire should be considered.

- Formal liaison between health staff in prisons and community / forensic LD services should be established. There is also an important role for the Forensic Network and other organisations, e.g. Association of Real Change (ARC) in terms of promoting best practice and sharing resources / training, materials (especially with regard to modified therapeutic treatment programmes).

- A short-life working group should be established to take forward the above recommendations; to re-visit the comprehensive "No One Knows" recommendations; to work closely with colleagues from NHS Greater Glasgow and Clyde on their project to address prison healthcare for AWLD; and to develop links with Scottish Consortium for Learning Disabilities with regard to their impending research into People With Learning Disabilities in the Scottish criminal justice system.

3.3 Independent Advocacy

- All prisons should have an independent Advocacy Service for prisoners with mental disorders. Responsibility for this rests jointly with the local health board and local authority.

3.4 Problem Behaviours

- A problem behaviour service should be developed within Scottish Prisons in line with the Serious Offender Liaison Service in the Community.

- The mentalisation based service for female offenders should be evaluated and extended to male services if appropriate. It is recognized that this is one of a range of potential interventions for people with personality disorder.

4. Co-morbidity

- Services will require clear, cohesive, and consistent operational and clinical policies for the management of prisoners with dual diagnosis (mental disorder and substance misuse).

- There needs to be an agreed, evidence-based process for the prompt assessment, and recognition of co-occurring substance misuse and mental health problems within prisons.
To improve care for people with dual diagnosis within prison, it is imperative that improvements be made in the way that mental health and substance use services interface. Mental Health and Addiction Teams across services and agencies need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.

There is evidence that integrated care is best practice for people with dual diagnosis. This entails that workers should be skilled and competent in providing comprehensive care. It is also recognised that workers in mental health and substance use services often lack the skills and confidence to provide this care. This is also likely to be the case within the prison service. Therefore, staff must have an adequate working knowledge of the issues that are pertinent to dual diagnosis.

Given that staff need to be skilled and competent in both mental health and substance use assessment and interventions, there will be a need to raise the levels of competence of the workforce, facilitating joint working between substance use and mental health.

There should be consultation between the NPHN working groups on mental health and substance misuse to ensure that all recommendations are consistent.

5. Telemental Health

As outlined in the Review of Telemental health (2009) videoconferencing (VC) has been extensively used in mental health services across the world, notably in the USA, Canada and Australia. Clinical applications include the complete patient age range and a very broad range of clinical settings. These include emergency and mental health act assessments, standardised psychological testing and a variety of therapies and treatments.

Based on this evidence we would recommend the use of VC for the following:

- To improve access to a range of specialist MH and Learning Disability services
- To improve access to a range of specialist clinical services
- To improve access to staff training. For example, substance misuse and the new to forensic course
- To facilitate both supervision and mentoring

- Telephone services – by providing prisons with improved access to secure telephony a range of guided self-help and CBT services should be offered to increase access to the psychological therapies, such as those offered by NHS 24.

- Online MH Services – as more MH services are designed to be delivered via computerised technology these could be developed and tested specifically for the prison population. For example, NHS Tayside and Forth Valley currently hold licences for the computerised CBT (cCBT) system which is used in general psychology services in these regions. Forth Valley provides 50% of its CBT by computer and this is well received by patients and GPs

- Digital TV Platform – work is ongoing to develop an Alcohol Brief Intervention (ABI) and CBT for this platform. When ready, this should
be tested in the prison environment as many prisoners now have access to a digital television. Other health information such as smoking cessation, weight management and long term condition information should also be developed.

- Internet Broadcasting and Podcasts – digital media should be used to improve access to a range of training and education for staff and patients. We should work with a variety of stakeholders to ensure we exploit this technology to its full potential.

- It may be possible to deliver some specialist services to the SPS on a regional or national basis. This would provide economies of scale for example Out of Hours (OOH) service provision. This is the model used in Airedale NHS Trust where significant saving has been achieved.

- SCTT will develop an implementation plan for the above recommendations. This will address the financial implications of these recommendations and include an evaluation plan for the proposed interventions.

6 Competencies

- NPHN should adopt the competencies listed for psychiatrists working in prisons as a national standard for NHS Boards.

- NPHN should await the outcome of the NES Education and Training sub-group, to support those working in prisons and police offices, review of competencies for staff working with offenders.

- NPHN should develop competencies for all healthcare staff working with offenders. Training should be provided and practice standards agreed and monitored.

7 Placement of Prisoners

- NPHN should await the report from the throughcare working group and consider if any specific work on mental health issues is required on this, or the other issues listed above, at that time.

8 Safety of Visiting Staff

- NPHN should await the report from NHS Greater Glasgow and Clyde working group on the safety of visiting staff to prisons and consider if any further action is required. A questionnaire has been circulated as outlined in Appendix 12.

- Any safety concerns should be addressed immediately with the staff present and reported to the relevant prison Governor.

9 National Guidance

- Guidance was issued on 5th March 2013 and resolves the issue of NHS Board responsibility for transfer to psychiatric hospital depending on the location of prisons.
BACKGROUND TO NATIONAL PRISON HEALTHCARE NETWORK AND THE MENTAL HEALTH WORKING GROUP

The responsibility to deliver primary and community healthcare to prisoners in Scotland transferred from the Scottish Prison Service (SPS) to the NHS on 1 November 2011. This decision was taken in response to policies to reduce inequalities and re-offending in Scotland as well as being in line with European and international standards for the healthcare of prisoners intended to ensure equity in healthcare. Scottish Ministers approved the transfer in 2008 following a feasibility study in 2007. This was followed by the formation of a national programme board for prisoners’ healthcare in 2009 and the passing of the legislative amendments by Scottish Parliament in 2010.

The programme board was tasked with overseeing the planning and implementation of the work required to achieve the transfer, and to provide assurance to Scottish Ministers that the programme was achieving the agreed objectives. The programme board comprised of representatives from NHS boards, trade unions, SPS, third sector organisations and Scottish Government. To support the Programme board a programme team was established led by the Scottish Government Primary Care Division was formed. A suite of national workstreams was drawn up to ensure national outputs including guidance and frameworks were delivered so that Local Implementation Groups could begin to develop their local implementation plans. Each workstream was chaired by member of the Programme board.

Leading up to the transfer the Programme team, in collaboration with NHS boards and SPS colleagues, identified functions and issues that would either not be addressed prior to the transfer date, would need to continue post transfer, or additional functions. A representative group of NHS board leads and SPS healthcare colleagues agreed that post transfer a national forum would still be required to support NHS boards deliver healthcare to prisoners. The National Prisoner Healthcare Network (NPHN) was formed and is comprised of all 14 territorial NHS board leads, Scottish Prison Service, NHS Services Scotland Healthcare Improvement Scotland, NHS Education for Scotland, The State Hospitals Board for Scotland, The Forensic Mental Health Services Managed Care Network Scottish Government and Union and third sector representation.

The NPHN enables stakeholders to make collective decisions, address consistency issues and coordinate the national agenda across the prison estate. There is the need for a centrally co-ordinated resource (NHS Board Prison Healthcare Leads Network) to support the delivery of person centred, safe and effective healthcare to prisons across Scotland. Healthcare Improvement Scotland has been tasked to host and facilitate this Network in its statutory function to support the capacity and capability of NHS Boards to deliver quality healthcare services, including those related to prisoner healthcare.

The Mental Health working group has been established to consider the mental health needs of the prison population.

Other workstreams of the NPHN are:

- performance and outcome measurement (title may change)
- Throughcare
- Substance misuse
- Information governance
- Healthcare managers forum
- Communication
- National multi-disciplinary expert advisory group
• Prescribing module on ViSION
• Prison pharmacy group (Scotland)

**TERMS OF REFERENCE**

The Mental Health working group was established to consider the mental health needs of the prison population

**Inclusions**
- all forms of mental disorder, including learning disabilities and personality disorder
- all prisons and prisoners in Scotland (including young offenders and private sector)

**Exclusions**
- mental health services provided outwith prisons in Scotland

**MEMBERSHIP**

The membership reflects the geographical, professional, managerial and service backgrounds of those working in prison mental health (see appendix 1).

**MEETINGS**

The NPHN Mental Health Sub Group met monthly and had nine meetings.

The themes of the meeting were as follows:
- 11th September 2012 – Setting Objectives
- 12th October 2012 – Models of Care & Service Redesign
- 07th November 2012 – Telemental Health
- 04th December 2012 – Needs Assessment & Mapping Exercise
- 15th January 2013 – Co-morbidity
- 12th February 2013 – use of ViSION
- 12th March 2013 – Models of Care and draft report
- 19th April 2013 – Draft Report and Models of Care
- 17th September 2013 – Review of consultation responses

The NPHN Mental Health Working Group reports directly to the NPHN. It has provided monthly highlight reports to the NPHN team.

**OBJECTIVES**

The group established nine objectives at its first meeting on 11th September 2012 and set a timescale of six months to report on these. This was achieved although it was recognised to be ambitious and likely to require follow up work on specific initiatives.

The work of the NPHN mental health working group applies to all forms of mental disorder and learning disabilities.

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1 The clinical IT system used in prisons to create the electronic patient record. It is one of the two National GPIT systems. The proper title is INPS Vision. It is broadly used by GPs in the community, the other system being EMIS
The aim of the group is to create a mental health and learning disability service within prisons where the provision of care for prisoners is equivalent to the care received for people in the community.

It was recognised that the evidence suggests that patients with major mental illness within Scottish Prisons who require hospital care are dealt with swiftly and well. Mechanisms are required however, to improve the care of people with psychoses remaining in prison or with other forms of psychological morbidity such as depression, anxiety disorders, substance misuse and personality disorders / problem behaviours.

The following objectives were set:

1. **Needs Assessment**
   To review the current literature on the mental health needs assessment of prisoners in Scotland.
   To develop a methodology for initial and on-going mental health needs assessment and care planning of prisoners.

2. **Service Mapping**
   To map the provision of mental health services currently provided within Scottish Prisons.

3. **Model of Care and Service Provision**
   To develop a model of care that will improve mental health services to prisoners and make them equivalent to those found in the community.
   To lead and co-ordinate the development of mental health services for prisoners that build on examples of good practice of multi-disciplinary and multi-agency working within Scotland, the UK and internationally.

4. **Comorbidity**
   To consider the needs of those with co-morbid mental health and substance misuse problems.

5. **Telemental Health**
   To review the use of tele-mental health services in prisons for the delivery of psychological therapies, preparation of court reports, urgent assessments and peer support / training.

6. **Competencies**
   To develop agreed core competencies for mental health staff working in prisons (linked to the generic competencies being developed for offender health).
   To develop first aid mental health training for officers and non-mental health NHS staff to raise awareness and build capacity in mental health competencies within prisons.

7. **Placement of Prisoners**
   To consider the placement of prisoners, including the flow of information to, from and between prisons. To examine the links between other NPHN workstreams such as throughcare. To consider the transfer and transport (including care of prisoners during transport) of prisoners.
8. Safety of Visiting Staff
To consider the safety of visiting staff and to review the arrangements made for them.

NHS Greater Glasgow and Clyde (and possibly NHS Ayrshire and Arran) has a working group which is considering the safety of visiting staff to prisons. Therefore this recognised as a lower priority for this group and there is on-going work which they will link in with.

9. National Guidance
To ensure that revised national guidance is provided by Scottish Government to support NHS Boards to follow a consistent process to access forensic health facilities for prisoners who have been resident in a prison within another health board area for more than 6 months. Responsible Commissioner guidance document NHS HDL (2004) 15.37.

OBJECTIVE OUTCOMES AND RECOMMENDATIONS

1. Needs Assessment
To review the current literature on the mental health needs assessment of prisoners in Scotland.
To develop a methodology for a baseline and on-going mental health needs assessment and care planning of prisoners

The prevalence of mental disorder within the prison population is higher than the general community. Table 1 provides data on prevalence rates of mental illness, including drug and alcohol misuse, within the United Kingdom. As can be seen, the last needs assessment of prisoner mental healthcare was carried out fourteen years ago and up to date information is required for the planning of services. Data on the prevalence of learning disability and personality disorder are provided within the sections of the report on learning disability and problem behaviours.

Three needs assessments were specifically carried out in Scotland but all took place in the 1990s. Graham (2007) reported that from the G-PASS disease register that 14% of prisoners had a history of psychiatric disorder, with the highest prevalence of 36% in HM Prison Shotts. She concluded that the figures recorded were an underestimation based on community prevalence data and prison prescribing patterns, and that there was a “considerable burden of mental health problems, in particular depression and psychosis”. There were 45 transfers to psychiatric hospital and 9 suicides during that year. One in four prisoners in the Scottish Prison Survey reported feeling unhappy and not hopeful about the future. More recently HM Chief Inspector of Prisons in Scotland highlighted the issue of prisoner mental health in his report “Out of Sight: Severe and Enduring Mental Health Problems in Scotland’s Prisons” (2008). He identified at least 315 (4.5%) prisoners with severe and enduring mental health issues excluding Polmont Young Offenders Institution. These were individuals known to have contact with the prison healthcare system.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Study Cohort</th>
<th>Measures</th>
<th>Results</th>
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| Gunn et al (1991)  | 1769 male convicted prisoners                     | CIS      | 2% psychosis¹
|                    |                                                   |          | 6% neurotic disorder¹
|                    |                                                   |          | 23% drug/alcohol abuse²                                                 |
| Cooke (1994)       | 247 male remand & convicted prisoners             | SADS-L   | 7.3% major psychological disorders¹
|                    | Scotland                                          |          | 32% neurotic disorder¹
|                    |                                                   |          | 38% alcohol dependence²                                                  |
| Davidson et al     | 389 male remand prisoners                         | CIS      | 2.3% psychosis¹
| (1995)             | Scotland                                          |          | 24.8% neurotic disorder¹                                                |
|                    |                                                   |          | 22% alcohol abuse/dependence²                                           |
|                    |                                                   |          | 73% drug abuse/dependence²                                              |
| Brooke et al (1996)| 750 male remand prisoners                         | SADS-L   | 5% psychosis¹
|                    |                                                   |          | 26% neurotic disorder¹                                                  |
|                    |                                                   |          | 38% drug/alcohol misuse²                                                |
| Birmingham et al   | 548 male remand prisoners                         | SADS-L   | 4% psychosis¹
| (1996)             |                                                   |          | 22% minor psychological disorder¹
|                    |                                                   |          | 32% alcohol abuse/dependence²                                           |
|                    |                                                   |          | 33% drug misuse/dependence²                                             |
| Singleton et al    | 1250 male remand prisoners                        | CIS-R    | 10% psychosis¹
| (1998)             |                                                   | SCAN     | 59% neurotic disorder¹                                                 |
|                    |                                                   |          | 58% alcohol abuse³                                                        |
|                    |                                                   |          | 51% drug dependence³                                                     |
| Singleton et al    | 1121 male convicted prisoners                     | CIS-R    | 7% psychosis¹
| (1998)             |                                                   | SCAN     | 40% neurotic disorder¹                                                  |
|                    |                                                   |          | 63% alcohol abuse³                                                        |
|                    |                                                   |          | 43% drug dependence³                                                     |
| Bartlett et al     | 119 male receptions in one week to HMP Barlinnie  | CIS-R    | 5% psychosis
| (2000)             |                                                   | SCAN     | 30% depression / anxiety disorder                                        |
|                    | Scotland                                          |          | 79% drug abuse                                                           |
| Loucks et al       | 348 Young Offenders Scottish Prison Service       | YOAF     | 44.7% drug problem                                                       |
| (2000)             |                                                   |          | 28.9% alcohol problem                                                    |
|                    |                                                   |          | 28.4% contact with psychiatric services                                  |
| MacAskill et al    | 259 male prisoners (remand, sentenced and young   | AUDIT    | 73% alcohol use disorder                                                |
| (2011)             | offenders) in one Scottish Prison                 |          | Including 36% with possible dependence                                  |

Key: ¹ Point prevalence ² Lifetime diagnosis ³ Present in past year

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Mental Health Needs Assessment: Baseline and On-going

It is important to carry out a national needs assessment of prisoners’ mental health to find an accurate and up to date baseline. One of the co-chairs (LT) has previously been involved in 3 SPS large scale projects including the Scottish Remand Prisoner Study (Davidson et al, 1995). Its methodology could be adapted for the purpose of this needs assessment (see appendix 2). In addition, it is important to utilise systems to provide on-going data for needs assessment, service development, clinical and governance purposes. ViSION is currently used in all prisons, and all prisons have it installed. This system was demonstrated to the group and has clear potential to provide national and local data on a regular basis. It has limitations and it is recognised that some health boards use MiDAS or FACE which are more orientated towards mental health data. Appendix 3 provides an example of the recording system used in NHS Lanarkshire. This is currently out for comment regarding the use of coding. The Prisoner Survey (SPS, 2013) makes use of a mental wellbeing tool (appendix 4), also used within the Scottish Health Survey, known as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). WEMWBS asks respondents to read 14 separate statements describing feelings relating to mental wellbeing, and indicate how often they have felt this way over the last two weeks, using a 5 point scale (ranging from none of the time to all of the time). The overall score is calculated by totalling the scores for each item (minimum possible score is 14 and the maximum is 70); the higher a person’s score, the better their level of mental wellbeing.

Recommendations

1) An updated national assessment of the mental health needs of prisoners should be carried out.

2) ViSION should be utilised on a national basis to provide on-going data on prisoners’ mental healthcare needs.

2. Service Mapping

To map the provision of mental health services currently provided within Scottish Prisons.

MAPPING EXERCISE

Data was collected in December 2012 using a structured questionnaire (see Appendix 5) from each of the prisons in Scotland. The full results are presented in Appendix 6. Table 2 presents details of the prison size and number of mental health or learning disability nurses, and weekly psychiatric input.
Table 2 Psychiatric and Nursing Provision in Scottish Prisons 2012

<table>
<thead>
<tr>
<th>Prison</th>
<th>Establishment Size</th>
<th>MH Registered Nurses</th>
<th>Prisoners per Nurse*</th>
<th>Psychiatric Sessions per week</th>
<th>Prisoners per Psychiatric Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen</td>
<td>170</td>
<td>2</td>
<td>85</td>
<td>0.5</td>
<td>340</td>
</tr>
<tr>
<td>Addiewell</td>
<td>700</td>
<td>4</td>
<td>175</td>
<td>1</td>
<td>700</td>
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<tr>
<td>Barlinnie</td>
<td>1250</td>
<td>7</td>
<td>179</td>
<td>3</td>
<td>417</td>
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<tr>
<td>Cornton Vale</td>
<td>309</td>
<td>9.5</td>
<td>33</td>
<td>4</td>
<td>77</td>
</tr>
<tr>
<td>Dumfries</td>
<td>195</td>
<td>1</td>
<td>195</td>
<td>1</td>
<td>195</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>860-920**</td>
<td>4.5</td>
<td>198</td>
<td>2</td>
<td>430-460</td>
</tr>
<tr>
<td>Glenochil</td>
<td>750</td>
<td>3</td>
<td>250</td>
<td>3</td>
<td>250</td>
</tr>
<tr>
<td>Greenock</td>
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<td>4</td>
<td>64</td>
<td>1</td>
<td>255</td>
</tr>
<tr>
<td>Inverness</td>
<td>130</td>
<td>3</td>
<td>43</td>
<td>1</td>
<td>130</td>
</tr>
<tr>
<td>Kilmarnock</td>
<td>649</td>
<td>7</td>
<td>93</td>
<td>1</td>
<td>649</td>
</tr>
<tr>
<td>Low Moss</td>
<td>720</td>
<td>5</td>
<td>144</td>
<td>3</td>
<td>240</td>
</tr>
<tr>
<td>Perth &amp; Castle Huntly</td>
<td>528 capacity, Castle Huntly – 285</td>
<td>5.5</td>
<td>148</td>
<td>5</td>
<td>161</td>
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<tr>
<td>Peterhead</td>
<td>142</td>
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<td>N/A</td>
<td>0.5</td>
<td>284</td>
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<tr>
<td>Polmont</td>
<td>763</td>
<td>6</td>
<td>127</td>
<td>3</td>
<td>254</td>
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<tr>
<td>Shotts</td>
<td>540</td>
<td>3</td>
<td>180</td>
<td>2</td>
<td>270</td>
</tr>
</tbody>
</table>

* Mental Health Registered Nurses and Learning Disability Nurses Combined  
** Average population of 890 used

The number of prisoners per mental health and learning disability nurse, and per psychiatric session varies markedly between prisons. Each prison is unique and mental health needs will vary depending on proportion of remand or sentenced prisoners, long or short term sentences, males and females, and young offenders. Discussion within the group suggested however, that these figures arose largely from historical factors and did not arise from any formal needs assessment. In the absence of a formal needs assessment and a comparison with community mental health teams no comments can be made on the adequacy of these ratios. No establishments had any provision from clinical psychologists and only two had occupational therapists. Lack of mental health staff and fully functioning multi-disciplinary teams were highlighted in the Mental Welfare Commission Report into Prison Mental Health Services in Scotland (2011).

**Recommendations**

1. A comparison exercise should be carried out between standard resources for community mental health teams and mental health teams in prisons which takes account of the greater psychiatric morbidity found in prisons, the prison environment and the combined primary, community and specialist services roles of the prison mental health team. Equivalence of provision between community and prison mental health services is important as is the development of services within prisons that meet the level of assessed need.

3. Model of Care and Service Provision

To develop a model of care that will improve mental health services to prisoners and make them equivalent to those found in the community.

To lead and co-ordinate the development of mental health services for prisoners that build on examples of good practice of multi-disciplinary and multi-agency working within Scotland, the UK and internationally.

3.1 Model of Care

The historical context of mental health provision in prisons prior to the transfer of responsibility in 2011 and the strategic and political context to mental healthcare in Scotland are important in determining appropriate models of care.

Prior to transfer of services to the NHS a multi agency multi professional approach was in place in each of the prison establishments. The key stakeholders included NHS Boards, Local Authorities and other agencies as well as the SPS. This supported a model of care which was predominantly nurse led albeit supported by a number of professional groups who interacted closely with the healthcare teams employed by the SPS.

Mental health nurses were employed within each prison to provide specialist care and treatment to those with mental health disorders. This was part of a three strand model with specialist nurses also employed in the areas of primary care and addiction services.

Currently across SPS and private establishments services exist in a variety of forms. There is a health centre with general practitioner and psychiatric input. There is a primary care nursing team, an addictions nursing team and a mental health nursing team. Across different prisons there is variation in how integrated these teams are and what models they use for practice. Some addiction services run a medical model organising substitute medications for additions to substances with third sector organisations providing support services. In some prisons those roles are carried out within the team.

Psychiatry operates an in-reach service across establishments in Scotland. A mixture of forensic psychiatrists and general adult psychiatrists visit Scottish prisons to conduct clinics and visit prisoners in the prison halls. The extent of the involvement of psychiatrists in extended roles varies across Scotland with some psychiatrists attending multi-disciplinary meetings, risk management meetings, nursing handover, integrated case management meetings, complex case reviews and CPA meetings; and providing educational input. In most institutions the psychiatrist does not have a management role or that of a clinical lead.

Mental health teams are established in all Scottish prisons. They usually consist of mental health nurses. In some institutions there are nursing staff who are trained to deliver psychological interventions. In Shotts this consists of SPIRIT and EMDR. In HMP Cornton Vale and HMP Glencochil a nurse therapist delivers CBT. In HMP Edinburgh and HMP Addiewell a visiting nurse therapist delivers CBT, EMDR and DBT informed group work.

Accepting the above, as yet, many mental health teams have no access to clinical psychology, and limited access to psychological interventions. In some
establishments. Forensic Psychologists may provide some therapeutic interventions. The Forensic Psychologists are employed by the prison service to run offence related group work, provide risk assessments and input to prison process (parole board hearings, Integrated Case Management and Risk Management Team meetings etc). Whilst some Forensic Psychologists may have some clinical background this experience is neither mandatory nor widespread. Their background and training are different to clinical psychologists. The Scottish Government advocates a matched stepped care model for the delivery of psychological interventions (Forensic Mental Health Matrix, 2012). Currently (as described above) access to psychological interventions in prisons is patchy. Some services have access to nurse therapists working in Cognitive Behavioural Therapy, Eye Movement Desensitisation Reprocessing, and Dialectical Behavioural Therapy and using psychosocial interventions. These would represent “high intensity” interventions as defined by The Matrix. It is the opinion of the working group that these current arrangements should be strengthened and the capacity of those services increased, so that prisoners have access to psychological interventions across the full range of intensity levels. Access to “low intensity” interventions should be provided to prisoners and this is currently being developed across the estate. A good example of such interventions are “beating the blues” computerised CBT. Consideration is currently being given to developing a health channel through prisoners digital TV’s to access self-help materials for depression and anxiety in NHS Lothian. Access to specialist and highly specialist psychological therapies continues to be an issue for many institutions. Whilst in-reach arrangements exist for some prison health care services this is not widespread. Consideration to rectifying this across the estate should be given. Clinical psychologists exist as a key component to most CMHT’s and form an integral part of the patients care team. In addition to delivering psychological interventions to the more complex cases, they play a key role in supervising and training other mental health staff in the delivery of lower intensity therapies. The lack of direct access to these services is a key area of deficiency in the health service delivered to prisoners and should not be allowed to continue indefinitely. Whilst we understand that developments we require service redesign and will have resource issues on this key area of equivalence health boards should be required to deliver access to these services in a timely manner. How access to these services is delivered will vary across health boards and the challenges faced by individual boards will vary. NHS Forth Valley with 3 national prisons (HMP Glenochil and Cornton Vale and HMYOI Polmont) will face particular issues of demand and capacity. HMP Inverness will face different challenges.

Within the prison establishments there is well established practice of multidisciplinary working. There is the practice of having a multidisciplinary meeting which brings together professionals from social work, forensic psychology, chaplaincy, hall staff and the mental health team. It is usually chaired by senior prison management such as the deputy governor and is used as a forum to share information and to discuss mental health issues of prisoners.

Although this model worked well in some of the establishments with significant inroads made to the care and treatment of prisoners with a range of mental health conditions it worked less well in others. A particular challenge of this model was that not all mental health nurses were able to fully dedicate their time to their mental health role.

The Scottish Government has recently commissioned a governmental task force, chaired by Michael Matheson, into health inequalities. The Scottish Health Inequalities agenda promulgates that the delivery of mental health services to those in prison should mirror that which is available to the wider population of Scotland.
This task force reflects the premise within the NHS Healthcare Quality Strategy (Scottish Government May 2010) and the NHS 2020 vision (Scottish Government 2011) that the population of Scotland should receive equivalent care regardless of their circumstances. However these strategic documents recognise that there are significantly different health outcomes at present for those from disadvantaged and deprived areas of the country. It is well documented that the prisoner population is largely drawn from these more deprived areas of the country and that their health, both physical and mental, is generally poorer.

The Mental Health Strategy for Scotland 2012-2015 (Scottish Government September 2011) sets out the way in which mental health provision should be delivered across the country including faster access to psychological services, improved identification of treatment for those with alcohol related mental health issues, improved throughcare and better self help. Notably mental health in offenders is mentioned specifically within this strategy under key change area 4 although this is largely focused on female offenders.

It is wholly appropriate that this strategy should be followed however it is important to acknowledge the need to tailor this within the context of the prison environment.

The group is aware that several Scottish Government HEAT targets have been developed, for example around the mental health of older people and access to psychological services. At present however, the question remains as to whether these will apply in prison establishments and consequently these may therefore be for future consideration.

An overall aim of the group is to reflect the intention of the NHS Healthcare Quality Strategy and create mental health care provision that is person centred, safe and effective; and equitable to that found in the community. By doing so, in addition to meeting the objectives of national health strategy, the group aims to improve the mental health of prisoners and to contribute to a reduction in recidivism.

'Better Health, Better Lives for Prisoners’ is a framework for improving the health of Scotland’s prisoners (Brutus et al, 2012). It is designed to assist with the planning, commissioning and delivery of health improvement services in Scotland’s prisons. It seeks to support the development of the ‘healthy prison’, and is built around 11 health promotion pillars relating to tobacco, alcohol, illicit drugs, mental wellbeing, healthy eating/ obesity, oral health, sex and relationships, blood borne viruses, physical activity, parenting and long-term conditions.

**Key Issues in Developing a Model of Care**

The group identified a range of issues relating to the required services that should be considered when developing models of care from prisoners. These include:

- Acceptance of the principle of equivalence of provision of prison mental health services with those provided in the community and based on prisoners’ mental health needs.
- Recognitions that the prevalence of mental disorder in the prison population is in excess of that found in the community
- Acknowledgement of the need for partnership working
Health and social care provision in prisons is the joint responsibility of both Justice and Health and therefore any mental health model of care must be constructed to include the governance arrangements that need to be in place to ensure both parties understand and operate within the boundaries of their responsibilities.

The SPS has created a range of approaches to support prisoners with mental health issues. Examples include the listener scheme, mental health first aid training for officers, the chaplaincy service and the highly developed suicide risk management system. These work well due to the close involvement of prison officers. This role must be recognised and integrated into any future healthcare model; as must the work of the third sector agencies and the prisoners themselves, for example as listeners.

- Recognition of the range and complexity of mental health disorders in the prison population and the need for services for prisoners with mental illness, learning disability, drug and alcohol problems, comorbidity and personality disorders / problem behaviours. Compounding the challenge of developing appropriate models of care is the wide ranging needs of the prisoner population which is dispersed across the 16 prison establishments in Scotland. This includes the young offender population and an ageing cohort.

There was acceptance of the principle that those with major mental disorder should be cared for in hospital rather than prison. An audit of transfer to hospital from prison found that sixteen of the twenty-two patients involved were transferred within 3 days of referral (Fraser, Thomson and Graham, BMJ 2007).

- The need for in reach work by Community Mental Health Teams where geographically possible for existing patients or those likely to require ongoing care on release

- The need for throughcare arrangements that link prisoners to services in the community.

- Recognition of the challenges of the prison environment to the effective care for those with mental health conditions is essential. The physical environment and the prison rules are necessary to maintain order and safety of all concerned. However they can present challenges: examples of this may include access to patients, or conflict between the provision of mental health treatment and security, such as when prescribing psychotropic medication. For these reasons regular dialogue between healthcare and prison management will be necessary to enable appropriate planning and delivering of services.

- The need to increase support for self help approaches: through the chaplaincy service, listener scheme or access to tele-mental health packages.

- Potential for the use of modern technology to provide telehealthcare

- Adoption of a health promoting and prevention approach – consistent with 2020 Vision

- The need for workforce planning to delineate the composition of an appropriate prison mental health team, allowing for prison population, mental disorder prevalence rates, environmental challenges, and the tiered care approach to mental disorder. The tiered care model matches the urgency, magnitude and complexity of a clinical problem to the urgency, magnitude and complexity of the treatment. See appendix 8a which provides guidance on integrating conditions and the level of care required.

- Recognition of lack of clinical psychology input in prisons but presence of forensic psychologists.
• Consideration of the overlap between risk assessment, offending behaviour work and mental health interventions and respective roles of forensic psychologists, prisoner programmes staff and mental health teams.
• Requirement to assess the educational needs of prison operational staff and provision of educational packages to meet these needs

Model of Delivery of Prisoner Mental Healthcare

Having considered the principles and issues set out above, the following components were considered essential to a successful model of prisoner mental healthcare:

• A prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services. Access to the appropriate level of service will depend on the tiered care model. Provision of services will be competency based.
• Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.
• The prison mental health team should have the following components: mental health, addictions and learning disability nursing staff, general practitioners, psychiatrists, allied health professionals such occupation therapists, social workers and clinical psychologists. In addition, within a prison setting input from prison governors, operational staff, forensic psychologists, third sector providers and chaplaincy would be expected.
• The team should be cohesive and the wider roles of team members found in the community should be fulfilled: for example, supervision, service development, leadership, education and advocacy.
• Mental health nurses should be used for that role alone and not wider general physical health duties.
• Psychological input should be provided on a tiered basis as set out in the Psychological Matrix. This is competency based.
• Standards for prison mental healthcare should be developed and services inspected.
• The working methods of a prison mental health team should include:
  - Screening
  - Referral system to prison mental health team
  - Standardised assessment, including diagnosis and formulation
  - Treatment planning
  - Use of condition specific integrated care pathways
  - Access to psychological therapies: via self-help, telemental health, individual therapy
  - Access to programmes that cover both clinical and criminogenic needs, such as substance misuse
  - Throughcare
  - Access to Independent Advocacy
  - Liaison with family and carers with regards to information sharing.
  - Liaison with relevant third sector organisations.
Recommendations

1) A model of a prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services should be adopted. Access to the appropriate level of service will depend on the tiered care model. Provision of services should be competency based.

2) The prison NHS mental health and addictions provisions should be amalgamated to form one team.

3) Develop a standardised process for family and carers to liaise with a prisoner mental health team.

4) Prison mental healthcare standards should be developed and audited.

5) The prison mental health team should be multidisciplinary and planning should be carried out to provide guidance on the membership of a team. This workforce planning should delineate the composition of an appropriate prison mental health team allowing for prison population, mental disorder prevalence rates, any updated needs assessment, environment challenges, and the tiered care approach to mental disorder.

6) There should be an overview of the tools required to assure fitness to practice including:
   - Competency Framework for healthcare staff
   - Education and Training Framework for health and operational staff.

7) Joint Governance arrangements between NHS Scotland and the Scottish Prison Service for the management of mental health provision should be defined.

8) A National Prison Mental Healthcare Steering Group should be established to oversee this model and standard building work.

3.2 Prison Healthcare for People with Learning Disability

The keys to life – improving quality of life for people with learning disabilities (Scottish Government, 2013) is the new learning disability strategy in Scotland and it advocates that an individual with learning disability should access mainstream health services as soon possible.

The number of people with learning disability (PWLD) in prison is unknown and the prevalence rates from UK studies (see Appendix 8b) provide more questions than answers. This is in part due to diagnostic issues, the conflation of the terms “learning disability” and “learning difficulties” being particularly problematic.

The British Psychological Society (2000) cites three core criteria for learning disabilities, namely significant impairment of intellectual functioning (IQ of less than 70); significant impairment of adaptive/social functioning; and age of onset before adulthood. The population prevalence for mild learning disability (the individuals likely to have contact with Criminal Justice Services) is 2%. The prison population for Scotland currently sits at approximately 8000 inmates. There is no convincing evidence that people with learning disabilities are more or less likely to offend, thus it is reasonable to assume that at least 2% of the Scottish Prison population of 8000 have a learning disability. This equates to approximately 160 individuals. We would suggest, based on previous experience in Scotland, that the majority of these individuals (approximately 75%) are probably not recognised within the prisons as having learning disabilities.
People with learning disabilities are known to have greatly increased health and social care needs. They suffer from considerably higher rates of physical health co-morbidities and as a consequence annual health checks for people with learning disabilities are an integral part of the GP contract. The Royal College of General Practitioners document “Annual health checks for people with learning disabilities” (2010) helpfully summarises physical health co-morbidities in this group and also describes the primary care interventions that are important to undertake. The point prevalence of mental health problems in PWLD is also significantly higher than that of the general population (Smillie, 2005) together with co-morbid neurodevelopmental disorders, particularly Autism (up to 30% of the LD population) and ADHD. Mental Health presentations are often atypical in nature and often attributed to the learning disability itself (“diagnostic overshadowing”), rather than the mental illness. A familiarity with atypical mental health presentations in PWLD is important within prison settings, if individuals are to receive the appropriate treatment (rather than presentations being attributed to being “behavioural”).

What is clear from the literature is that people with learning disabilities are not routinely identified prior to arriving in prison and as a result once in prison they face a great number of difficulties; prisoners with learning disability are 5 times more likely to be subjected to control and restraint procedures and 3 times as likely to be placed in a segregation unit as other mainstream prisoners; most prisoners with LD also report being bullied or exploited within prison.

We know that this failure of “information flow” is a significant systemic issue within SPS, resulting in a range of valuable reports/assessments from the community not being accessible to prison staff. The failure to recognise LD at the outset means that staff often overlook or do not have awareness of health and social care needs. Perhaps most importantly, this will then include a lack of awareness of the communication deficits that are associated with learning disability, both in terms of expressive and receptive language, but also with regard to probable impaired literacy ability (meaning that “helpful” information leaflets cannot be understood).

**Approaches to supporting PWLD in Scottish prisons:**

In 2007 the Prison Reform Trust completed an important report, “No One Knows – Prisoners with Learning Difficulties and Learning Disabilities, Scotland”. It is worth emphasising that one of the big drivers behind this report was concern about breaches of disability discrimination legislation (now the Equality Act, 2010), with regard to the treatment of prisoners with LD; this issue was initially raised in England and Wales following lobbying by Mencap. Mencap later supported a successful legal challenge against the Ministry of Justice in England: Claimant vs Secretary of State for Justice (case number CO/10088/2009), relating to a failure to provide a learning disabled man with an appropriately modified offender treatment programme.

The “No One Knows” Report provided 17 recommendations; these are listed as Appendix 8c. Disappointingly, this report has largely not been enacted since publication, despite the then Director of Health and Care for the Scottish Prison Service being an integral part of the working group responsible for the report. There has not been a strategy devised to address the 17 recommendations. “No One Knows” needs to be re-visited.

There have been two recent encouraging developments:
Firstly, a new project in Greater Glasgow and Clyde to address prison healthcare for PWLD has commenced. Funded by the Scottish Government, a Clinical Nurse Specialist (Andy Graham) has been appointed to undertake a 2 year project, the post having 6 key objectives:

1. Gather the necessary data on the prevalence / needs / numbers of People with LD
2. Use this information to develop a detailed Project Plan
3. Develop / Implement straightforward screening methods, care planning and clinical interventions
4. Provide practical support, advice and education to staff to raise awareness and to assist in the care of people with learning disabilities
5. Enable all healthcare staff to confidently meet the healthcare needs of people with LD
6. Review / evaluate the success of interventions

Andrew Graham will work in the 3 prisons within the NHS Greater Glasgow and Clyde catchment area. Whilst primarily focusing on PWLD receiving good healthcare in the prison environment, their journey through the criminal justice system (from Police Custody to Liberation and beyond) will also be looked at to better understand the roles of local NHS community learning disability teams / forensic services and Local Authority / 3rd sector staff. The aim is to develop Care Pathways which address the range of healthcare needs people may have; this work is to be joined up with a new wider LD strategy within NHS Greater Glasgow and Clyde.

Recent discussion between Andrew Graham and the Forensic Network Lead on Learning Disability has discussion focused mainly on the need for screening; both parties had previously used the HASI (Hayes Ability Screening Index) and agreed it took too long in practice for it to be rolled out more widely. The LDSQ (LD Screening Questionnaire) is now being used by Criminal Justice Services in England and Wales; it takes a maximum of 5 minutes to be completed and helpfully draws attention to literacy issues—so also raises awareness of “learning difficulties”. It is planned to trial the use of this screening tool within one of the 3 Greater Glasgow and Clyde prisons.

Secondly, the Scottish Government has funded the Scottish Consortium for Learning Disabilities (SCLD) to carry out a piece of research into how people with a learning disability are dealt with in the Scottish criminal justice system as a whole (from investigation of crime through to sentencing and follow-up). This will include consideration of people with a learning disability in prison.

**Recommendations:**

1. There should be an awareness raising initiative concerning learning disability within Scottish prisons. This is the starting point for working to meet healthcare needs and provide people with learning disabilities and staff in prisons with the support that they require.

2. “Learning Disability awareness” training should be provided to SPS staff, initially targeting new staff.

3. Screening should be introduced into Scottish Prisons for adults with learning disability (AWLD). This will allow recognition of needs and identify
individuals with “learning difficulties”. The use of the Learning Disability Screening Questionnaire should be considered.

4. Formal liaison between health staff in prisons and community /forensic LD services should be established. There is also an important role for the Forensic Network and other organisations, e.g. Association of Real Change (ARC) in terms of promoting best practice and sharing resources / training, materials (especially with regard to modified therapeutic treatment programmes).

5. A short-life working group should be established to take forward the above recommendations; to re-visit the comprehensive “No One Knows” recommendations; to work closely with colleagues from NHS Greater Glasgow and Clyde on their project to address prison healthcare for AWLD; and to develop links with Scottish Consortium for Learning Disabilities with regard to their impending research into People With Learning Disabilities in the Scottish criminal justice system.

3.3 Independent Advocacy

Independent advocacy helps people to make their voices stronger and to have as much control as possible over their lives. It is called independent because advocates and advocacy workers are separately employed and managed from the services in which they function. They do not work for hospitals, social work or other services. While many people bring their existing difficulties with them into prison, it is also an inescapable fact that imprisonment has deleterious effects on people’s mental health. Many lose personal control over most of the practical aspects of their lives. Despite the high walls and bars, prisoners are still individuals and citizens with valid rights and choices.

The law and Independent Advocacy
The Mental Health (Care and Treatment) (Scotland) Act 2003 applies to people who have a mental disorder, learning disability or personality disorder however caused or manifested. Under the Mental Health (Care and Treatment) (Scotland) Act, people with learning disabilities and people with a mental illness have a right to independent advocacy. It is stipulated that patients do not have to be in hospital or under any mental health act order for this to apply. The Patient Rights (Scotland) Act 2011 and in particular the Charter of Patient Rights and Responsibilities sets out a summary of the rights and responsibilities that patients have when using NHS services. The Charter raises awareness of support services (such as advocacy), that should be available to NHS patients. This legal right to access advocacy therefore applies as much to those in prison as those who are not.

Access to Independent Advocacy in Scotland’s prisons
The Publication of HMIP Thematic Report – ‘Out of Sight’ - Severe and Enduring Mental Health Problems in Scotland’s Prisons’ (2008) made 20 recommendations one of which stated: Prisoners with severe and enduring mental health problems should be made aware that they have the right to access advocacy services which should be available and understood. The Scottish Prison Service Health Standard 3.2.1 (2011) states that: arrangements will be in place in prisons for the provision of Mental Health Independent advocacy services.

Despite these stated intentions the Mental Welfare Commission (MWC) report Mental Health of Prisoners: Themed Visit Report into Prison Mental Health Services in Scotland (2011) highlighted that across the prison estate in 2011, only seven of the fifteen prisons reported having access to advocacy services. In
these cases a referral would be made to a local community advocacy service. There seemed to be no specific funding for these agencies or arrangements in place to provide robust and consistent advocacy services to prisons. It is of note that only 12 prisoners interviewed by the MWC had even heard of advocacy.

This MWC report recommended that they would raise access to advocacy with NHS Boards and local authorities for their area and ensure that advocacy services are promoted for prisoners with mental health problems or learning disability. The MWC report states “We would expect that the care prisoners with mental health problems receive whilst in custody would be the same as, or equivalent to, the care they would receive in the community”. Access to Independent Advocacy services forms part of this principle of equity of access to services for prisoners.

Targeted access
Mental Health (Care and Treatment) (Scotland) Act 2003 states that it is the duty of Health Boards and Local authorities to collaborate not only to secure the availability of advocacy services but also to take appropriate steps to ensure that those persons have the opportunity of making use of those services. Furthermore, that “advocacy services” are services of support and representation made available for the purpose of enabling the person for whom they are available to have as much control of, or capacity to influence, that person’s care and welfare as is, in the circumstance appropriate.

Prisoners with a mental disorder therefore should have access to independent advocacy facilitated by appropriately supported pathways.

In the context of prisoners, access should apply particularly to those:

- Who regularly use the prison mental health services;
- Who had been subject to a Transfer for Treatment Direction (TTD) and those who have subsequently been returned to prison.
- Who have a learning disability

Service Development and Specification
Since the responsibility for providing prisoner health care transferred to the NHS in November 2011 some NHS Boards and partners have made access more available although provision on the whole remains patchy. NHS boards and local authorities will need to jointly agree independent advocacy service specifications which identify the aims, principles, policies and procedures, which will operate between the Commissioner(s) and the Provider to deliver the service. These specifications will need to ensure that the arrangements are compliant with the relevant legislation and that implementation plans are developed in partnership with the full range of partners including SPS. Access for prisoners to independent advocacy should be viewed as one of the pillars on which models of prison mental health care services are based.

Recommendations
1) All prisons should have an independent Advocacy Service for prisoners with mental disorders. Responsibility for this rests jointly with the local health board and local authority. A copy of the Scottish Independent Advocacy Alliance guidelines are included for information (appendix 9).
3.4 Problem Behaviours

To consider service development for individuals with problem behaviours such as sex offending, serious violence, stalking or self harming; and/or for those with personality disorders; and to improve joint working between mental health and criminal justice services to address these needs.

Many people in prison present with problem behaviours and are likely to have a personality disorder. The term challenging behaviour may also be used in this context but is more typically applied to people with learning disability.

A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

The Forensic Network Report on Services for People with Personality Disorder in Scotland (2005) outlined the development of services for people with personality disorder. This included recommendations for people in prison. See Appendix 10A.

This report supported the focus of the Scottish Prison Service during the initial sentence management process on identifying problems and needs rather than diagnosis. The report recognised that the issue of personality disorder is central to many problem behaviours found in prisons, to failure to engage with therapeutic programmes and to an excessive drain on health service resources within prison by continual demands for assessment and medication. The group therefore recommended that in these contexts assessment of individuals for the presence of personality disorder would assist in their subsequent management. The report identified a need for visiting mental health professionals to engage more widely with the therapeutic work of the prison service, including offender based programmes and recommended that one or more pilot prison and mental health team should be identified to carry out detailed assessments of problematic prisoners, and to develop management plans in conjunction with the prison’s Risk Management Group.

At the present time within the Forensic Mental Health Services Managed Care Network, services are being developed to provide clinical support to multi-agency partners. See Appendix 10B. The Serious Offender Liaison Service (SOLS) was established in October 2012 to provide clinical consultation, assessment and management advice to help criminal justice agencies manage complex and/or high risk violent and sexual offenders in the community. This service developed from its predecessor, the NHS Lothian Sex Offender Liaison Service, which was established in 2007 when Multi-Agency Public Protection Arrangements (MAPPA) were introduced. A similar service is required within prisons to provide clinical input for violent and sex offenders who have personality disorders and/or sexual deviations; and those who present with problem behaviours such as stalking, threatening, fire setting, violent offending and sexual offending. The service will provide consultation, assessment and management advice. It will not provide psychological treatment or case management. The aim is to reduce risk and improve risk management through helping frontline staff to implement psychologically informed interventions and management strategies. This would be a significant new area of work for the NHS within prisons. The structure and funding of such a service will require to be considered.

A problem behaviour / personality disorder service for women based on mentalisation is currently being established in HMP Cornton Vale and HMP Edinburgh. See Appendix 10C.
**Recommendations**

1. A problem behaviour service should be developed within Scottish Prisons in line with the Serious Offender Liaison Service in the Community. It should work jointly with the forensic psychology service in prisons.

2. The mentalisation based service for female offenders should be evaluated and extended to male services if appropriate. It is recognized that this is one of a range of potential interventions for people with personality disorder.

**4 Co-morbidity**

*To consider the needs of those with co-morbid mental health and substance misuse problems.*

**Background**

People with have co-occurring substance misuse and mental health problems are among the most vulnerable in our communities. In comparison to those who have only mental health problems, those who have a dual diagnosis are significantly more likely to have:

- Increased suicide risk
- More severe mental health problems
- Homelessness/unstable housing
- Increased risk of being violent
- Increased risk of victimisation
- Poorer general health
- More contact with criminal justice system
- Family and relationship problems
- History of childhood abuse (physical and sexual)
- More likely to fall through the net of care
- Less likely to be compliant with medication and other treatment

**Definitions**

The term ‘dual diagnosis’ covers a wide range of problems that have both mental health and substance misuse in common. Dual diagnosis is typically characterised in four main ways (DoH, 2009):

- A primary mental health problem that leads to substance use (e.g. someone with schizophrenia who uses cannabis to reduce symptoms.)

- Substance misuse or withdrawal that leads to mental health symptoms (e.g. developing anxiety or depression post-detoxification treatment)

- Thirdly, a mental health problem that is made worse by substance misuse (e.g. someone with panic disorder who uses cannabis to relax, but finds it increases paranoia, leading to increased alienation.)

- Finally, substance misuse and mental health problems that do not appear to be related, such as someone with an ongoing anxiety
disorder that is made neither better or worse by their drug or alcohol use.

At its broadest, a dual diagnosis is any combination of mental health problem and substance misuse disorder.

**Prevalence**

In the UK, it is estimated that one-third of people with serious mental health problems also have a substance misuse problem. Cantwell (1999) reported that up to 21% of individuals with schizophrenia had co-occurring problematic substance use. In a large scale study in the USA, Regier (1990) found that 37% of those with an alcohol disorder had another mental health condition. Within the United Kingdom, around 50% of clients attending Drug and Alcohol Services typically have some form of co-occurring mental health problem. Indeed, the National Census of UK alcohol treatment agencies found that the main presenting problem at alcohol services was clients’ worry about psychological wellbeing. There is also evidence of increasing prevalence of dual diagnosis (e.g., Casher and Bess, 2010).

Within the prison population, the prevalence of co-morbid mental health and substance misuse problems is significantly greater than in the general population. See Table 1. Many prisoners have mental health problems. In an Office of National Statistics prison survey, Singleton et al., (1998) found that over three-quarters of prisoners were dependent on drugs, and a similar percentage of those assessed as ‘hazardous drinkers’ also had two or more additional mental disorders. Alcohol was said by prisoners to be a factor in 50% of violent crimes (Parkes et al, 2010).

In a systematic review of 13 studies of 7600 prisoners, Fazel et al, (2006) reported prevalence rates for drug dependence of 10-48% in male prisoners and 30-60% in female prisoners. Almost two-thirds of sentenced males (63%) and two-fifths of females admitted hazardous alcohol use. Of these, about half had a severe alcohol dependency. In his 2010 report, the Chief Inspector of Prisons for England and Wales reported that 75% of all prisoners had mild to severe mental disorders and other forms of substance use problems. The Safer Prisons report stated that 44% of prisoners with alcohol problems also reported mental health problems, and 32% of people who committed suicide whilst in prison had two co-morbid diagnoses.

The Scottish Prison Service Needs Assessment (Graham, 2007) reported that prisoners were generally more than twice as likely to receive medication in relation to mental health problems than the general population. Some medications, for depression and psychosis, were prescribed at ten times the rate found in the general population. In summary, there is little doubt that there exists overwhelming evidence of significant comorbid substance misuse and mental health problems within the prison population.

**Management of Co-morbidity in Prisons**

Given the extent of the problem, there is a need to have effective, consistent, and cohesive management of mental health and substance misuse service provision in prisons. This may prove to be a significant challenge. Within some prisons, it is evident that mental health, and substance misuse, services are provided within professional silos, with little communication or cooperation between the two. If services are provided and managed by different agencies or teams this can lead to a fragmented service, lack of coordination of policies,
procedures, and protocols. In consequence, there may exist inconsistencies of care, ineffective working practices and failure to effectively engage and retain people in the treatment process. Such difficulties are compounded when, on the one hand, mental health staff may have little or no training in substance misuse, whilst the addiction team may have little mental health background. The Scottish Government recognizes the importance of this issue and has provided guidance on alcohol and offenders (2012).

Whilst there is a movement towards mental health services taking primary responsibility for those with serious mental health problems and substance use; and Substance Misuse services taking primary responsibility for those with primary substance problems, and common mental health problems (Closing the Gaps, 2007), it remains crucial for mental health and substance use services should work together and support each other in the assessment and treatment of people with dual diagnoses.

**Recommendations**

A number of key recommendations can be made:

1. Services will require clear, cohesive, and consistent operational and clinical policies for the management of prisoners with dual diagnosis.

2. There needs to be an agreed, evidence-based process for the prompt assessment, and recognition of co-occurring substance misuse and mental health problems within prisons.

3. To improve care for people with dual diagnosis within prison, it is imperative that improvements be made in the way that mental health and substance use services interface. Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.

4. There is evidence that integrated care is best practice for people with dual diagnosis. This entails that workers should be skilled and competent in providing comprehensive care. It is also recognised that workers in mental health and substance use services often lack the skills and confidence to provide this care. This is also likely to be the case within the prison service. Therefore, staff must have an adequate working knowledge of the issues that are pertinent to dual diagnosis.

5. Given that staff need to be skilled and competent in both mental health and substance use assessment and interventions, there will be a need to raise the levels of competence of the workforce, facilitating joint working between substance use and mental health.

6. There should be consultation between the NPHN working groups on mental health and substance misuse to ensure that all recommendations are consistent.

5. **Telemental Health**

To review the use of tele-mental health services in prisons for the delivery of psychological therapies, preparation of court reports, urgent assessments and peer support / training.
**Background**

In 2009 the Scottish Centre for Telehealth & Telecare (SCTT) commissioned a Review of Telemental health in Scotland. [http://www.sctt.scot.nhs.uk/?page_id=514](http://www.sctt.scot.nhs.uk/?page_id=514)

Based on this evidence a mental health team was formed in 2010 under the governance of NHS 24. SCTT along with its territorial board partners was tasked to embed mental health improvement into all its activities, particularly in respect of those who are at risk of developing mental health problems as a result of substance misuse or other lifestyle issues.

The SCTT has recently published A National Telehealth and Telecare Delivery Plan for Scotland to 2015. This aims to build on the good progress to date and to continue to innovate and expand ‘technology-enabled’ service redesign at scale. The plan outlines Scotland’s ongoing commitment and investment in this area. [http://www.sctt.scot.nhs.uk/?page_id=27](http://www.sctt.scot.nhs.uk/?page_id=27)

**Introduction to Telemental health, Telehealth & Telecare,**

“**Telemental health**” Telemental health is the use of communications technology to provide mental health services from a distance.

The three main areas of activity are clinical, educational and administrative.

“**Telehealth**” is the provision of health services at a distance using a range of digital and mobile technologies. This includes the capture and relay of physiological measurements from the home/community for clinical review and early intervention, often in support of self management; and “teleconsultations” where technology such as email, telephone, telemetry, video conferencing, digital imaging, web and digital television are used to support consultations between professional to professional, clinicians and patients, or between groups of clinicians.

“**Telecare**” is the provision of care services at a distance using a range of analogue, digital and mobile technologies. These range from simple personal alarms, devices and sensors in the home, through to more complex technologies such as those which monitor daily activity patterns, home care activity, enable ‘safer walking’ in the community for people with cognitive impairments/physical frailties, detect falls and epilepsy seizures, facilitate medication prompting, and provide enhanced environmental safety.

“**Telehealthcare**” is used as an overarching term to describe both telehealth and telecare together.

**Uses in Prison**

Currently, videoconferencing (VC) is used across many of Scotland’s prisons for clinical, educational and administrative purposes. The SCTT has been working with 2 of Scotland’s prisons to establish the feasibility of using VC to improve access to forensic psychiatry services and staff training. In 2011 **HMP Edinburgh** became the first prison to use the technology to deliver direct patient care and facilitate regular multi-disciplinary MH team meetings. Recent discussions with **HMP Addiewell** and the Scottish Training on Drugs and Alcohol (STRADA) which is the leading national workforce development organisation supporting those working with and affected by drug and alcohol have been very positive. Working in collaboration with other organisations we hope to establish the
feasibility of using a range of communication technologies (podcasts and VC) to support the delivery of substance misuse training for prison healthcare staff and other stakeholders.

In England videoconferencing technology is currently being used to support the delivery of many clinical services to improve prison healthcare. In 2006 Airedale NHS Trust completed a project to assess the potential of telemedicine in prison healthcare. They have now launched a Digital Healthcare Centre. This means that the service is now available 24/7 and provided across 21 specialties, although not psychiatry, for over 23 prisons across the UK, from the South Coast to Durham. Rheumatology

The benefits of the service include -

- High Quality equitable and prompt clinical care
- Reduced transfers out/ lock downs (impact on security and cost)
- 75% of elective patients treated without transfer out of prison
- 50% of acute patients treated without transfer out of prison
- Reduced litigation risk (more access to second opinions)
- Staff feel supported
- Local secondary care less disruption/Risk
- Reduced carbon footprint

http://www.airedaledigitalhealthcarecentre.nhs.uk/Prisons/

Mental Health Services provided by NHS 24
There are several areas where new service models of care are being used to improve access to a range of MH services.

- Telephone Guided Self Help (GSH)
- Telephone Cognitive Behavioural Therapy (CBT)
- Breathing Space – free phone confidential listening service

Several new services are currently being developed by NHS 24 for the Digital TV platform. These include;

- Alcohol Brief Interventions (ABIs)
- Cognitive Behavioural Therapy (CBT)
- NHS Scotland services on Freesat & Sky: Go to Channel 539 (Community Channel) and Press RED NHS Scotland services on Virgin: Interactive Channel. Also available to download as an app on android and i-phones by texting postcode or 'NHS24' to 61061

Other MH services that have been developed in partnership with some of the territorial boards include;

- Forensic psychiatry services via videoconferencing (for prisons)
- Dementia Services via videoconferencing
- Substance Misuse Services via videoconferencing
- Neuropsychology services via videoconferencing

These services are delivered in real-time and improve access to a range of specialist MH services for patients, carers and staff.

Training
The use of technology to facilitate staff training & continued professional development (CPD) is described below. Where possible, real examples of courses or webcasts that are currently available are used;
Videoconferencing (VC) - is an excellent medium to deliver staff training/CPD. This has been delivered over several years by many organisations. The British Association for Immediate Care (BASICS) has recently developed a series of courses using real-time videoconferencing.
http://www.basics-scotland.org.uk/courses.php

Internet Broadcasting (IB) - The Scottish Centre for Telehealth & Telecare have developed a Telehealth & Telecare Learning Network using IB which is hosted on the Telehealthcareportal

The Scottish Centre for Telehealth & Telecare is committed to supporting knowledge transfer and facilitating shared learning from the telehealth and telecare programmes in Scotland. The Learning Network will deliver a programme of themed webcasts-webinars and networking events throughout 2013. The webcasts/webinars will cover new developments in SCTT programmes as well as highlighting good practice in telehealth and telecare service delivery from across Scotland, the UK and beyond. To view the webcasts recorded in 2012 please click on the following link.http://video3uk.com/default.aspx

Clinical Podcasts – A series of clinical skills podcasts have been developed by the students and staff of the School of Medicine at the University of Glasgow, with funding from the Clinical Skills Managed Educational Network, NHS Education for Scotland and support from the University of Glasgow Media Production Unit. https://itunes.apple.com/itunes-u/clinical-skills/id528255713?mt=10

Podcasts on Mental Health – The University of Aberdeen has developed two podcasts on Schizophrenia covering the diagnosis, causes and pathological changes of the disease and a guide to treatment and side effects of the medications. https://www.abdn.ac.uk/mymbchb/rc/podcasts/index.php

The Clinical Psychiatry Digital Network in America. Excellent example of how digital media can be used to provide up to date information on a range of mental health conditions http://www.clinicalpsychiatrynews.com/home.html

**Recommendations**

1. As outlined in the Review of Telemental health (2009) videoconferencing (VC) has been extensively used in mental health services across the world, notably in the USA, Canada and Australia. Clinical applications include the complete patient age range and a very broad range of clinical settings. These include emergency and mental health act assessments, standardised psychological testing and a variety of therapies and treatments. Based on this evidence we would recommend the use of VC for the following
   - To improve access to a range of specialist MH and Learning Disability services
   - To improve access to a range of specialist clinical services
   - To improve access to staff training. For example, **substance misuse** and the **new to forensic course**
   - To facilitate both supervision and mentoring

2. Telephone services – by providing prisons with improved access to secure telephony a range of **guided self-help and CBT services** should be offered to increase access to the psychological therapies, such as those offered by NHS 24.
3. Online MH Services – as more MH services are designed to be delivered via computerised technology these could be developed and tested specifically for the prison population. For example, NHS Tayside and Forth Valley currently hold licences for the computerised CBT (cCBT) system which is used in general psychology services in these regions. Forth Valley provides 50% of its CBT by computer and this is well received by patients and GPs.

4. Digital TV Platform – work is ongoing to develop an Alcohol Brief Intervention (ABI) and CBT for this platform. When ready, this should be tested in the prison environment as many prisoners now have access to a digital television. Other health information such as smoking cessation, weight management and long term condition information should also be developed.

5. Internet Broadcasting and Podcasts – digital media should be used to improve access to a range of training and education for staff and patients. We should work with a variety of stakeholders to ensure we exploit this technology to its full potential.

6. It may be possible to deliver some specialist services to the SPS on a regional or national basis. This would provide economies of scale for example Out of Hours (OOH) service provision. This is the model used in Airedale NHS Trust where significant saving has been achieved.

7. SCTT will develop an implementation plan for the above recommendations. This will address the financial implications of these recommendations and include an evaluation plan for the proposed interventions.

6. Competencies
To develop agreed core competencies for mental health staff working in prisons (linked to the generic competencies being developed for offender health).

Competencies have been developed for psychiatrists working in prison (see appendix 11) A complementary programme to the existing New to Forensic Programme has been developed entitled New to Forensic - Managing Medical Conditions in Custody. A competency framework for healthcare staff in police custody settings is also being developed specifically for nurses and possibly AHPs but not for medical staff.

Recommendations

1. NPHN should adopt the competencies listed for psychiatrists working in prisons as a national standard for NHS Boards.

2. NPHN should await the outcome of the NES Education and Training sub group to support those working in prisons and police offices.

3. NPHN should develop competencies for all healthcare staff working with offenders. Training should be provided and practice standards agreed and monitored.

7 Placement of Prisoners
To consider the placement of prisoners, including the flow of information to, from and between prisons.
To examine the links between other NPHN workstreams such as throughcare.
To consider the transfer and transport (including care of prisoners during transport) of prisoners.
The SPS has a national process for all establishments to follow when transferring prisoners to another prison. The process ensures all significant and relevant information (including health care) is obtained, considered and recorded as part of the decision making process prior to transferring the prisoner.

Issues of prisoner placement arose during the Group’s discussions, chiefly concerning the placement of prisoners, their movement within SPS and the flow of information with them as they move around the SPS estate. In addition, some concerns were raised about the suddenness of some transfer and the means of transportation of prisoners. The importance of throughcare was fully recognised.

**Note**
These issues have been identified but are not addressed within this report.

**Recommendation**

1. NPHN should await the report from the throughcare working group and consider if any specific work on mental health issues is required on this, or the other issues listed above, at that time.

8 **Safety of Visiting Staff**

*To consider the safety of visiting staff and to review the arrangements made for them.*

The SPS national guidance agreed between National Partners sets out the principles that all SPS establishments should follow when utilising Non-Operational staff in an operational environment. The guidance provides a framework for Local Partners to work within and allows for such local flexibilities as may be required to meet service needs.

NHS Greater Glasgow and Clyde (and possibly NHS Ayrshire and Arran) has a working group which is considering the safety of visiting staff to prisons. A questionnaire has been circulated (see appendix 12). The Group has therefore not specifically addressed this issue.

**Recommendation**

1. NPHN should await the report from NHS Greater Glasgow and Clyde working group on the safety of visiting staff to prisons and consider if any further action is required. A questionnaire has been circulated as outlined in Appendix 12.

2. Any safety concerns should be addressed immediately with the staff present and reported to the relevant prison Governor.

9 **National Guidance**

*To ensure that revised national guidance is provided by Scottish Government to support NHS Boards to follow a consistent process to access forensic mental health inpatient facilities for prisoners who have been resident in a prison within another health board area for more than 6 months. Responsible Commissioner Guidance document NHS HDL (2004) 15.37.*

Guidance was issued on 5th March 2013 and resolves the issue of NHS Board responsibility for transfer to psychiatric hospital depending on the location of prisons.

– sections 29-70 with specific reference to sections 62, 65 and 70; and
The National Health Service (Responsible Health Board) (Scotland) Directions 2013 Part 7.

Note: issue resolved.

Recommendations

1. Needs Assessment
   - An updated national assessment of the mental health needs of prisoners should be carried out.
   - ViSION should be utilised on a national basis to provide on-going data on prisoners’ mental healthcare needs.

2. Service Mapping
   - A comparison exercise should be carried out between standard resources for community mental health teams and mental health teams in prisons which takes account of the greater psychiatric morbidity found in prisons, the prison environment and the combined primary, community and specialist services roles of the prison mental health team. Equivalence of provision between community and prison mental health services is important as is the development of services within prisons that meet the level of assessed need.
   - The Mental Welfare Commission Report on Prisons (2011) set out key messages for prisoner mental healthcare. See Appendix 7. These should be implemented.

3.1 Models of Care and Service Provision
   - A model of a prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services should be adopted. Access to the appropriate level of service will depend on the tiered care model. Provision of services should be competency based.
   - Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.
   - Develop a standardised process for family and carers to liaise with a prisoner mental health team.
   - Prison mental healthcare standards should be developed and audited.
   - The prison mental health team should be multidisciplinary and planning should be carried out to provide guidance on the membership of a team. This workforce planning should delineate the composition of an appropriate prison mental health team allowing for prison population, mental disorder prevalence rates, any updated needs assessment, environment challenges, and the tiered care approach to mental disorder.
   - There should be an overview of the tools required to assure fitness to practice including:
     - Competency Framework for healthcare staff
     - Education and Training Framework for health and operational staff.
- Joint Governance arrangements between NHS Scotland and the Scottish Prison Service for the management of mental health provision should be defined.
- A National Prison Mental Healthcare Steering Group should be established to oversee this model and standard building work.

**Recommendations**

- A model of a prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services should be adopted. Access to the appropriate level of service will depend on the tiered care model. Provision of services should be competency based.
- The prison NHS mental health and addictions provisions should be amalgamated to form one team.
- Develop a standardised process for family and carers to liaise with a prisoner mental health team.

3.5 **Learning Disability**

- There should be an awareness raising initiative concerning learning disability within Scottish prisons. This is the starting point for working to meet healthcare needs and provide people with learning disabilities and staff in prisons with the support that they require.
- “Learning Disability awareness” training should be provided to SPS staff, initially targeting new staff.
- Screening should be introduced into Scottish Prisons for adults with learning disability (AWLD). This will allow recognition of needs and identify individuals with "learning difficulties". The use of the Learning Disability Screening Questionnaire should be considered.
- Formal liaison between health staff in prisons and community /forensic LD services should be established. There is also an important role for the Forensic Network and other organisations, e.g. Association of Real Change (ARC) in terms of promoting best practice and sharing resources / training, materials (especially with regard to modified therapeutic treatment programmes).
- A short-life working group should be established to take forward the above recommendations; to re-visit the comprehensive "No One Knows" recommendations; to work closely with colleagues from NHS Greater Glasgow and Clyde on their project to address prison healthcare for AWLD; and to develop links with Scottish Consortium for Learning Disabilities with regard to their impending research into People With Learning Disabilities in the Scottish criminal justice system.

3.6 **Independent Advocacy**

- All prisons should have an independent Advocacy Service for prisoners with mental disorders. Responsibility for this rests jointly with the local health board and local authority.
3.7 **Problem Behaviours**

- A problem behaviour service should be developed within Scottish Prisons in line with the Serious Offender Liaison Service in the Community.

- The mentalisation based service for female offenders should be evaluated and extended to male services if appropriate. It is recognized that this is one of a range of potential interventions for people with personality disorder.

4. **Co-morbidity**

- Services will require clear, cohesive, and consistent operational and clinical policies for the management of prisoners with dual diagnosis (mental disorder and substance misuse).

- There needs to be an agreed, evidence-based process for the prompt assessment, and recognition of co-occurring substance misuse and mental health problems within prisons.

- To improve care for people with dual diagnosis within prison, it is imperative that improvements be made in the way that mental health and substance use services interface. Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.

- There is evidence that integrated care is best practice for people with dual diagnosis. This entails that workers should be skilled and competent in providing comprehensive care. It is also recognised that workers in mental health and substance use services often lack the skills and confidence to provide this care. This is also likely to be the case within the prison service. Therefore, staff must have an adequate working knowledge of the issues that are pertinent to dual diagnosis.

- Given that staff need to be skilled and competent in both mental health and substance use assessment and interventions, there will be a need to raise the levels of competence of the workforce, facilitating joint working between substance use and mental health.

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- NPHN should await the report from NHS Greater Glasgow and Clyde working group on the safety of visiting staff to prisons and consider if any further action is required. A questionnaire has been circulated as outlined in Appendix 12.
- Any safety concerns should be addressed immediately with the staff present and reported to the relevant prison Governor.

9 National Guidance

- Guidance was issued on 5th March 2013 and resolves the issue of NHS Board responsibility for transfer to psychiatric hospital depending on the location of prisons.
REFERENCES/BACKGROUND INFORMATION

Background Papers

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- Commission on Women Offenders: Final Report 2012
- HM Chief Inspector of Prisons for Scotland, Out of Sight: Severe and Enduring Mental Health Problems in Scotland’s Prisons
- Mental Health and Scots Law in Practice (Chapter 5)
  Act 2 Care: Suicide Risk Management Strategy (Revised 2005)
- Working with Personality Disordered Offenders: A practitioners guide (Ministry of Justice)
- Report of the Working Group on Services for People with Personality Disorder (Forensic Network)
  http://www.forensicnetwork.scot.nhs.uk/documents/reports/Personality%20disorder.pdf
- Mental Health of Prisoners (Mental Welfare Commission)
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- No One Knows: Report and Final Recommendations
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- Good Practice in Women’s Prisons: A literature review (2011)
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NEEDS ASSESSMENT

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LEARNING DISABILITY REFERENCES

- The Royal College of General Practitioners (2010) “Annual health checks for people with learning disabilities”
- Claimant vs Secretary of State for Justice (case number CO/10088/2009)
- Learning Disability Screening Questionnaire (2006). Karen Mckenzie and Donna Paxton (Published by GCM Records)

ADVOCACY

- Mental Health of Prisoners: Themed Visit Report into Prison Mental Health Services in Scotland (2011)

CO MORBIDITY


The Scottish Government (2012) Alcohol and Offenders Guidance Statement

http://www.scotland.gov.uk/Topics/Health/Services/Alcohol/treatment/offenders-guidance


TELEMENTAL HEALTH


Mental Health Pathway, Efficiency and Productivity Report

I’m only at the end of a video link

Breathing Space Presentation

Mental Health Review

NHS24 Living Life Pilot Service

Prison Network Report

Prison Network Report Appendix 1

Video Conferencing Facilities to Support Forensic Services
## APPENDIX 1

### MEMBERSHIP TABLE
National Prisoner Healthcare Network

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chairs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jim McGuinness</td>
<td>Prisoner Healthcare Service Manager</td>
<td>HM Prison Perth, NHS Tayside</td>
</tr>
<tr>
<td>Professor Lindsay Thomson</td>
<td>Medical Director</td>
<td>The State Hospital &amp; Forensic Network</td>
</tr>
<tr>
<td><strong>Members</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Susan Anderson</td>
<td>Legislation Manager (Clinical Services)</td>
<td>NHS Fife</td>
</tr>
<tr>
<td>Dr Melanie Baker</td>
<td>Consultant Forensic Psychiatrist</td>
<td>HM Prison Barlinnie (NHS GG&amp;C)</td>
</tr>
<tr>
<td>Natalie Beal</td>
<td>Deputy Governor</td>
<td>HM Prison Glenochil</td>
</tr>
<tr>
<td>Dr Keith Bowden</td>
<td>Consultant Clinical Psychologist</td>
<td>NHS Forth Valley</td>
</tr>
<tr>
<td>Penny Curtis</td>
<td>Mental Health Division</td>
<td>Scottish Government</td>
</tr>
<tr>
<td>Cathy Dorrian</td>
<td>Service Development Manager-National MH Programme</td>
<td>NHS24</td>
</tr>
<tr>
<td>Dr Fergus Douds</td>
<td>Consultant Learning Disability Psychiatrist</td>
<td>The State Hospital</td>
</tr>
<tr>
<td>Rosemary Duffy</td>
<td>Clinical Manager, Mental Health and Addictions</td>
<td>NHS Forth Valley</td>
</tr>
<tr>
<td>Celia Flanagan</td>
<td>Clinical Manager</td>
<td>HM Prison Glenochil</td>
</tr>
<tr>
<td>Sarah Grant</td>
<td>Learning Disability Strategy</td>
<td>Scottish Government</td>
</tr>
<tr>
<td>Gillian Henderson</td>
<td>Clinical Manager</td>
<td>HM Prison Shotts</td>
</tr>
<tr>
<td>Linda Irvine</td>
<td>Strategic Programme Mgr, Mental Health &amp; Wellbeing</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Nancy Loucks</td>
<td>Chief Executive</td>
<td>Families Outside</td>
</tr>
<tr>
<td>Lesley McDowall</td>
<td>Clinical Advisor</td>
<td>Scottish Prison Service</td>
</tr>
<tr>
<td>Annie McGeeney</td>
<td>Mental Health Manager</td>
<td>South Lanarkshire Council/The State</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Hospital</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Jayne Miller</td>
<td>NPH Network Co-ordinator</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>John Porter</td>
<td>Nursing Services Manager</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Dr Pradeep Pasupuleti</td>
<td>Consultant Forensic Psychiatrist</td>
<td>NHS Greater Glasgow &amp; Clyde</td>
</tr>
<tr>
<td>Dr Alex Quinn</td>
<td>Consultant Forensic Psychiatrist</td>
<td>HM Prisons Edinburgh and Addiewell</td>
</tr>
<tr>
<td>Mark Richards</td>
<td>Head of Mental Health &amp; Partnerships</td>
<td>East Dunbartonshire CHP</td>
</tr>
<tr>
<td>Dr Ruth Stocks</td>
<td>Professional Lead for Psychology in Forensic Mental Health</td>
<td>NHS Greater Glasgow &amp; Clyde</td>
</tr>
<tr>
<td>Craig Stewart</td>
<td></td>
<td>NHS Ayrshire &amp; Arran</td>
</tr>
<tr>
<td>Dr Gary Tanner</td>
<td>Head of Psychological Services</td>
<td>NHS Lanarkshire</td>
</tr>
<tr>
<td>David Thomson</td>
<td>Mental Health Project Manager; ICP Co-ordinator</td>
<td>Healthcare Improvement Scotland</td>
</tr>
</tbody>
</table>
Appendix 2 Mental Health Needs Assessment Methodology

Prevalence of psychiatric morbidity among remand prisoners in Scotland
(Davidson et al, 1995)

"Methodology
In September 1993 nine institutions in Scotland housed prisoners awaiting trial: seven prisons for adult males, one women's prison and another exclusively for males aged between 16 and 21. At each establishment 50% random sample of all untried prisoners was selected from lists of hall residents. Printed information was distributed to potential subjects 48 h before the researcher's visit, and selected inmates were approached on the day of the study and the nature and purpose of the project explained to them. Emphasis was placed on voluntary participation and confidentiality. Written consent was obtained from participants. Prison medical records of non-participants were examined where available.

Interviews were conducted by 12 psychiatrists (teams of four in larger institutions and two in the five smaller jails). They each lasted 20-30min, but were extended where necessary. Practice sessions had been used to establish consistent technique and scoring. Sociodemographic and historical data were collected using a specifically designed schedule which included information about the current charge, personal and family background, past medical, psychiatric and forensic history and use of alcohol (Mayfield et al, 1974) and drugs. Subjects were examined using the Clinical Interview Schedule (Goldberg et al, 1970), and two tests of cognitive function, the Quick Test (Ammons & Ammons, 1962), and the Word Recognition Subtest of the British Abilities Scales (Elliot et al, 1983). Clinical diagnoses were based on ICD-10 criteria. No measure of personality was included."
Appendix 3 Use of ViSION for on-going needs assessment

NHS Lanarkshire

Guideline Creation Request

Please complete all sections as fully as possible, where possible providing the desired Read code. Please copy/paste sections as necessary to cover your requirements.

**Guideline Name/Title:** Mental Health – Medical Assessment  
**Heading:** Patient Details  
**Information to show from patient record:** Patient Name, CHI, location

<table>
<thead>
<tr>
<th>Data to record</th>
<th>Read code</th>
<th>Description</th>
<th>Button label / additional instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Language</td>
<td>131%</td>
<td>Main spoken language</td>
<td></td>
</tr>
<tr>
<td>Interpreter Required</td>
<td>9NU%</td>
<td>Interpreter required</td>
<td></td>
</tr>
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</table>

**Heading:** General Appearance  
**Information to show from patient record:** As recorded

<table>
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<tr>
<th>Data to record</th>
<th>Read code</th>
<th>Description</th>
<th>Button label / additional instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition</td>
<td>R037</td>
<td>Insufficient intake of food and water due to self neglect</td>
<td>Poor nutrition</td>
</tr>
<tr>
<td>Bruising</td>
<td>SE%</td>
<td>Bruising</td>
<td></td>
</tr>
<tr>
<td>Rash</td>
<td>R021</td>
<td>Rash and other nonspecific skin eruption</td>
<td>Rash</td>
</tr>
<tr>
<td>Jaundice</td>
<td>R024</td>
<td>Jaundice</td>
<td></td>
</tr>
<tr>
<td>Pallor</td>
<td>R0260</td>
<td>Pallor</td>
<td>Pale</td>
</tr>
<tr>
<td>Hygiene</td>
<td>Ry10.</td>
<td>Very low level of personal hygiene</td>
<td>Poor hygiene</td>
</tr>
<tr>
<td>General appearance</td>
<td>Ry1...</td>
<td>Symptoms and signs involving appearance</td>
<td>General Appearance</td>
</tr>
</tbody>
</table>

**Heading:** Social / Lifestyle  
**Information to show from patient record:**

<table>
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<th>Read code</th>
<th>Description</th>
<th>Button label / additional instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marital Status</td>
<td>133%</td>
<td>Marital Status</td>
<td>Single, Married, Separated, Divorced, Widowed, Cohabiting</td>
</tr>
<tr>
<td>Living arrangements &amp; Accommodation</td>
<td>13FJ.</td>
<td>Independent housing, lives alone.</td>
<td>Lives alone</td>
</tr>
<tr>
<td></td>
<td>13FH.</td>
<td>Lives with relatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13D..</td>
<td>Housing Lack</td>
<td></td>
</tr>
<tr>
<td>Personal History</td>
<td>Housing NOS</td>
<td>Other housing</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>--------------</td>
<td></td>
</tr>
<tr>
<td>13FZ.</td>
<td>Schooling</td>
<td>Family details</td>
<td></td>
</tr>
<tr>
<td>13Z4.</td>
<td>Job Details</td>
<td>Problems related to lifestyle</td>
<td></td>
</tr>
<tr>
<td>13JU.</td>
<td>Family milestone NOS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13IZ.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZV4K.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spiritual/Religion</th>
<th>135% Religion</th>
<th>Issues with key relationships (e.g. patient and main carer)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13HP</td>
<td>Relationship problems</td>
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</table>

<table>
<thead>
<tr>
<th>Diet &amp; Nutrition</th>
<th>687C. Malnutrition universal screening tool score</th>
<th>MUST score</th>
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<tbody>
<tr>
<td>1F7..</td>
<td>Restricted diet pattern</td>
<td>Special dietary requirements</td>
</tr>
<tr>
<td>1FA..</td>
<td>Diet good</td>
<td></td>
</tr>
<tr>
<td>1FB..</td>
<td>Diet bad</td>
<td></td>
</tr>
<tr>
<td>1FC..</td>
<td>Diet average</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug and Alcohol Use</th>
<th>136% Alcohol Consumption</th>
<th>H/O Alcoholism</th>
</tr>
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<tbody>
<tr>
<td>1462.</td>
<td>Drug User</td>
<td></td>
</tr>
<tr>
<td>13c%</td>
<td>Previously injecting drug user</td>
<td></td>
</tr>
<tr>
<td>13cJ.</td>
<td>Never injecting drug user</td>
<td></td>
</tr>
<tr>
<td>13c2.</td>
<td>Injecting drug user</td>
<td></td>
</tr>
<tr>
<td>13c0.</td>
<td>O/E Injection Site Normal</td>
<td></td>
</tr>
<tr>
<td>2F18.</td>
<td>O/E Injection Site Abnormal</td>
<td></td>
</tr>
<tr>
<td>2F16.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Smoking</th>
<th>137% Tobacco consumption</th>
<th>Current smoker</th>
</tr>
</thead>
<tbody>
<tr>
<td>137R.</td>
<td>Ex-smoker</td>
<td></td>
</tr>
<tr>
<td>137S.</td>
<td>Never smoked</td>
<td></td>
</tr>
<tr>
<td>137I.</td>
<td></td>
<td></td>
</tr>
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**Heading**: Physical Examination

**Information to show from patient record**:

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<th>Description</th>
<th>Button label / additional text instructions</th>
</tr>
</thead>
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<tr>
<td>Height</td>
<td>229..</td>
<td>O/E: Height</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>22A..</td>
<td>O/E: Weight</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td></td>
<td></td>
<td>Note: no code, calculated automatically</td>
</tr>
<tr>
<td>BP</td>
<td>246..</td>
<td>O/e - blood pressure reading</td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td>242%</td>
<td>O/E - pulse rate</td>
<td></td>
</tr>
<tr>
<td>Heart Sounds</td>
<td>24B%</td>
<td>O/E – heart sounds</td>
<td></td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>235%</td>
<td>O/E – respiratory rate</td>
<td></td>
</tr>
<tr>
<td>Breath Sounds</td>
<td>23B%</td>
<td>O/E – breath sounds</td>
<td></td>
</tr>
<tr>
<td>Gait</td>
<td>299%</td>
<td>O/E - gait</td>
<td></td>
</tr>
<tr>
<td>Involuntary Movements</td>
<td>297%</td>
<td>O/E – involuntary movements</td>
<td></td>
</tr>
<tr>
<td>Pupils (PERLA)</td>
<td>22E..</td>
<td>General eye examination</td>
<td>Pupils examined</td>
</tr>
<tr>
<td>Reflexes</td>
<td>2A1..</td>
<td>O/e - general reflex exam</td>
<td></td>
</tr>
<tr>
<td>Tongue</td>
<td>256%</td>
<td>O/E Tongue Examined</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>258%</td>
<td>O/E - Abdominal Wall</td>
<td></td>
</tr>
<tr>
<td></td>
<td>259%</td>
<td>Skin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25A%</td>
<td>O/E – Abdominal wall movement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25B%</td>
<td>O/E – Abdominal wall contour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25C%</td>
<td>O/E – Intra-abdominal movement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25D%</td>
<td>O/E – guarding on palpitation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25E%</td>
<td>O/E – rebound tenderness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25F%</td>
<td>O/E – abdominal rigidity</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abdominal Wall</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>O/E - Abdominal Wall Skin</td>
<td></td>
</tr>
<tr>
<td>O/E – Abdominal wall movement</td>
<td></td>
</tr>
<tr>
<td>O/E – Abdominal wall contour</td>
<td></td>
</tr>
<tr>
<td>O/E – Intra-abdominal movement</td>
<td></td>
</tr>
<tr>
<td>O/E – guarding on palpitation</td>
<td></td>
</tr>
<tr>
<td>O/E – rebound tenderness</td>
<td></td>
</tr>
<tr>
<td>O/E – abdominal rigidity</td>
<td></td>
</tr>
</tbody>
</table>

| Liver | 25G.. | O/E – Liver palpated |
|       | 25G1. | O/E – Liver not palpable |
|       | 25G2. | O/E – liver edge palpable |
|       | 25G3. | O/E – liver moderately enlarged |
|       | 25G4. | O/E – liver grossly enlarged |
|       | 25G5. | O/E – liver palpated NOS |

<table>
<thead>
<tr>
<th>Liver</th>
<th>O/E – Liver palpated</th>
</tr>
</thead>
<tbody>
<tr>
<td>O/E – Liver not palpable</td>
<td></td>
</tr>
<tr>
<td>O/E – liver edge palpable</td>
<td></td>
</tr>
<tr>
<td>O/E – liver moderately enlarged</td>
<td></td>
</tr>
<tr>
<td>O/E – liver grossly enlarged</td>
<td></td>
</tr>
<tr>
<td>O/E – liver palpated NOS</td>
<td></td>
</tr>
</tbody>
</table>

**Heading**: Mental Examination

**Information to show from patient record**:

<table>
<thead>
<tr>
<th>Data to record</th>
<th>Read code</th>
<th>Description</th>
<th>Button label / additional text instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past psychiatric history – deliberate self-harm, previous treatment, etc</td>
<td>146.. ZV4J2 ZV69. 146B. 146A. 1BT..</td>
<td>H/O: Psychiatric disorder [V]Seek+accept eahav+psychol intervntns known hazard+harmful [V]Psychiatric patient admission details</td>
<td>H/O Psychological Intervention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>H/O: Deliberate Self-Harm</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>H/O: Attempted Suicide</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Depressed Mood</td>
<td></td>
</tr>
<tr>
<td>Family History</td>
<td>128% 1282. 1283. 1284. 1285. 1289.</td>
<td>FH: Mental disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FH: Alcoholism</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FH: Drug dependency</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FH: Schizophrenia</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FH: Depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FH: Suicide</td>
<td></td>
</tr>
<tr>
<td>Sleep, appetite, etc.</td>
<td>1B1B. 1B1Q. R0000</td>
<td>Cannot sleep - insomnia</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor sleep pattern</td>
<td></td>
</tr>
<tr>
<td>R001.</td>
<td>R0020</td>
<td>1611.</td>
<td>1615.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Suicide Risk</td>
<td>1BD9.</td>
<td>No thoughts of deliberate self harm.</td>
<td>1BDA.</td>
</tr>
<tr>
<td></td>
<td>1BDE.</td>
<td>Suicide risk increased from previous level</td>
<td>1BDF.</td>
</tr>
<tr>
<td>Cognitive function (attention/concentration / alertness / memory)</td>
<td>1BW..</td>
<td>Poor concentration</td>
<td>1B1A.</td>
</tr>
<tr>
<td>Capacity to consent</td>
<td>9Nd2.</td>
<td>Gillick competent for consent</td>
<td>9X2..</td>
</tr>
<tr>
<td>Named Person /</td>
<td>9d4..</td>
<td>Other person in</td>
<td>Named Person</td>
</tr>
<tr>
<td>Guardian</td>
<td>918S.</td>
<td>contact Legal Guardian details</td>
<td>Guardian</td>
</tr>
<tr>
<td>----------</td>
<td>-------</td>
<td>---------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Mental Health Plan</td>
<td>6A60.</td>
<td>Mental Health review follow-up</td>
<td>MH Plan</td>
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</tbody>
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**Heading:**

**Information to show from patient record:**

<table>
<thead>
<tr>
<th>Data to record</th>
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<th>Description</th>
<th>Button label / additional instructions</th>
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<tbody>
<tr>
<td>Referral History</td>
<td>9N6J. 9N5Z. 8H7..</td>
<td>Referred by GP Patient initiated enc NOS Other Referral</td>
<td>Self-Referral</td>
</tr>
</tbody>
</table>
### Prisoner Survey 2013

**Your Chance To Tell Us**

**THIS IS YOUR CHANCE TO GIVE US YOUR VIEWS ON ASPECTS OF PRISON LIFE THAT AFFECT YOU, SUCH AS FOOD, VISITS AND CLEANLINESS. PLEASE READ THE QUESTIONS AND PLACE A CROSS √ IN THE BOX THAT BEST DESCRIBES YOUR VIEWS OF THIS PRISON.**

**How would you rate the atmosphere in your cell?**
- Very
calm
- Fairly
calm
- Neither
calm nor
unrelaxed
- Fairly
unrelaxed
- Very
unrelaxed

**How well would you say you get on with each of the following groups?**
- Prisoners in your cell
- Officers in your cell
- Staff in the VEHICLE that carried you to COURT
- Staff in the COURT

**How are you spoken to by STAFF in THIS PRISON?**
- Very
civilised
- Fairly
civilised
- Neither
civilised nor
polite
- Fairly
polite
- Very
polite

**During your time in THIS prison, on THIS sentence which of the following have you attended?**
- Medical
- Mental Health
- Dentist
- Other

**For your most recent appointment in THIS PRISON please indicate the length of time you waited/have been waiting to see the following health care staff:**
- Same
day
- 1-3 days
- 3-6 days
- 6-10 days
- Over 10 days
- Not
evaluated

---

### Before entering prison were you ever assessed or diagnosed as having any of the following?

- Attention
  - Disordered
  - Disorders
- Attention
  - Disordered
- Personality
  - Disorder
- Other
  - PTSD (Post Traumatic Stress Disorder)

**Sex?**
- Male
- Female

**Age?**
- Yes
- No

**How old are you?**

- Never
- 1-5 times
- 6-10 times
- Over 10 times

**How many times have you been on remand before?**
- Never
- 1-5 times
- 6-10 times
- Over 10 times

**If you are CONVICTED, how long is your current sentence?**
- Up to 90 days
- Over 1 year up to 4 years
- Over 4 years

**Have you ever served a sentence in the community?**
- Yes
- No

**Have you ever received a custodial sentence as a result of breaching a community sentence?**
- Yes
- No

**What is your ethnic background?**
- Black
  - Caribbean or Black
  - African or Caribbean
  - Other or Mixed

**What is your NATIONALITY?**

- Arab
  - Arab or Other
  - Other

---

### Additional Information:

**Other or Mixed ethnic group (please specify).**

**Other or Mixed ethnic group (please specify).**

---

56
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Possibly</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever undertaken work in prison?</td>
<td></td>
<td></td>
<td></td>
<td>YES  NO</td>
</tr>
<tr>
<td>If YES, please answer the following:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prison work has helped me learn to work regular hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prison work has helped me learn to work with other people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prison work has helped me take more responsibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have found prison work interesting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you attended a Learning Centre in this prison?</td>
<td></td>
<td></td>
<td></td>
<td>YES  NO</td>
</tr>
<tr>
<td>If YES, which subjects have you attended?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Art, Literacy, Numeracy, IT, ESOL, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any problems with your reading?</td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Would you like help with your reading?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any problems in writing?</td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Would you like help with your writing?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any problems using numbers?</td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Would you like help with your numbers?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you ever assessed or diagnosed as having disabilities?</td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Were you ever assessed or diagnosed as having mental health problems?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where were you living before coming into prison?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owner-occupier</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Council tenant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing Association</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you lose your tenancy or accommodation when you came to prison?</td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Where will you be living when you leave prison?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owner-occupier</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Council tenant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing Association</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where were you living at the age of 16?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were you ever in care as a child?</td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>Were you in care at the age of 18?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever served in the Armed Forces?</td>
<td></td>
<td></td>
<td></td>
<td>YES  NO</td>
</tr>
<tr>
<td>If YES, which service?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Army</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Navy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reservist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What was your method of discharge?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Still serving</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### If YES, which ILLEGAL drugs have you used in the LAST MONTH?

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzodiazepines (e.g. Valium, Alprazolam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecstasy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Are you being prescribed methadone?**

- Yes
- No

If YES, is the prescription:
- A detoxing dose
- A maintenance dose
- A stabilizing dose

**Have you taken another prisoner's prescribed medication?**

- Yes
- No

### If YES, have you used illegal drugs in the 12 months before coming into prison?

**Did you use any illegal drugs in the 12 months before coming into prison?**

- Yes
- No

**If YES, please indicate the drugs used:**

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Prior to coming into prison have you ever used any other drugs known as legal highs?

- Yes
- No

**If YES, what did you use before coming into prison?**

- Stimulant
- Synthetic Cannabis
- Hallucinogen
- Dowser

**During your time in prison have you ever used any other drugs known as legal highs?**

- Yes
- No

**If YES, what did you use in prison?**

- Stimulant
- Synthetic Cannabis
- Hallucinogen
- Dowser
<table>
<thead>
<tr>
<th>If YES, which ILLEGAL drugs have you used in the LAST MONTH?</th>
<th>YES ☐ NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis ☐</td>
<td>Other opium (e.g., morphine, DF316) ☐</td>
</tr>
<tr>
<td>Benzo diazepanes (e.g., Valium, Ativan) ☐</td>
<td>Tran zep am ☐</td>
</tr>
<tr>
<td>Amphetamine s ☐</td>
<td>Heroin ☐</td>
</tr>
<tr>
<td>Barbiturates ☐</td>
<td>Methadone (not on prescription) ☐</td>
</tr>
<tr>
<td>Ecstasy ☐</td>
<td>Other ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are you in regular methadone therapy?</th>
<th>YES ☐ NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During your time at prison have you ever taken another prisoner's prescribed medication?</th>
<th>YES ☐ NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If YES, which ILLEGAL drugs did you inject in the LAST MONTH?</th>
<th>YES ☐ NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin ☐</td>
<td>Cocaine ☐</td>
</tr>
<tr>
<td>Other opiates (e.g., opium, DF316) ☐</td>
<td>Other ☐</td>
</tr>
<tr>
<td>Benzo diazepanes (e.g., Valium, Ativan) ☐</td>
<td>Methadone ☐</td>
</tr>
<tr>
<td>Amphetamine s ☐</td>
<td>Other ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you use illegal drugs in the 12 months before coming into prison?</th>
<th>YES ☐ NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IYES, please indicate the drugs used.</th>
<th>YES ☐ NO ☐</th>
</tr>
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<tr>
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<td>Other opiates (e.g., opium, DF316) ☐</td>
</tr>
<tr>
<td>Benzo diazepanes (e.g., Valium, Ativan) ☐</td>
<td>Other ☐</td>
</tr>
<tr>
<td>Amphetamine s ☐</td>
<td>Other ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you been prescribed methadone?</th>
<th>YES ☐ NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During your time at prison have you ever taken another prisoner's prescribed medication?</th>
<th>YES ☐ NO ☐</th>
</tr>
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<td>NO ☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If YES, which ILLEGAL drugs have you used in the LAST MONTH?</th>
<th>YES ☐ NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis ☐</td>
<td>Other opium (e.g., morphine, DF316) ☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>During your time at prison have you ever taken another prisoner's prescribed medication?</th>
<th>YES ☐ NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES ☐</td>
<td>NO ☐</td>
</tr>
<tr>
<td>Would you wish to access interventions/support services which would help you overcome or learn to live with issues of violence in the past?</td>
<td>YES</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Have you ever carried a knife?</td>
<td>YES</td>
</tr>
<tr>
<td>Have you carried a knife in the 12 months before coming into prison?</td>
<td>YES</td>
</tr>
<tr>
<td>Have you ever used a knife to injure someone?</td>
<td>YES</td>
</tr>
<tr>
<td>Have you ever been cautioned by the police for carrying a knife?</td>
<td>YES</td>
</tr>
<tr>
<td>Have you been convicted of a knife crime?</td>
<td>YES</td>
</tr>
<tr>
<td>If you were cautioned for carrying a knife would this stop you?</td>
<td>YES</td>
</tr>
<tr>
<td>Are you a gang member?</td>
<td>YES</td>
</tr>
<tr>
<td>What is your main reason for carrying a knife?</td>
<td>Self defence</td>
</tr>
<tr>
<td>Don't feel safe where I live</td>
<td>Gang member</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information on the following issues have been communicated to me in a manner that I understand (e.g. native language, breath, large print, signing, etc.)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception/Admission procedures</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Induction</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Mediation</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>The Visit process/Family contact</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Human Rights/Equality and Diversity</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Prison Rules/Complaints</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Healthcare</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Freedom of Information</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Violence/Anti-Bullying</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Education/Learning</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Programmes</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Service providers/Community contact</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During the sentence in prison I have personally experienced discrimination in respect to the following:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your age</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Disability</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Gender assignment (sex/gender)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Race</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Below are a number of statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks.</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I've been feeling optimistic about the future</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling anxious</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling relaxed</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling lonely</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling interested in other people</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've had energy to spare</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been dealing with problems well</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been thinking clearly</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling good about myself</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling close to other people</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling confident</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been able to make up my own mind about things</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling loved</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling involved in new things</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>I've been feeling cheerful</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
How would you describe the cleanliness of the following in the prison:

- The cleanliness of your cell
- The cleanliness of the toilet area
- The cleanliness of the showers
- The cleanliness of the communal area
- The cleanliness of your cell when you first moved in

How often do you get access to clean bed linen?
- Every week
- Every 2 weeks
- Once a month
- Never

How would you describe the following regarding food in the prison:

- The choice of meals
- The size of portions
- The condition of the food when you get it
- The time at which meals are served
- The meals provided in this prison meet your cultural/religious needs

How would you describe the following regarding the canteen system (bag & tag) in the prison:

- The accuracy of your order
- The selection of goods
- The price of goods
- Overall, how would you describe the canteen system
- Do you have difficulty understanding/completing the canteen order forms?

Are you in regular contact with anyone outside the prison? (You may choose more than one)
- No
- Yes, by letter
- Yes, by telephone
- Yes, by visits
- Yes, by home leaves

How often do you get visits from family and friends?
- Never
- Daily
- Weekly
- Termightly
- Monthly
- Other

Have you ever been involved in violence towards your spouse or partner?
- Yes
- No

Have you ever been convicted of an offense involving violence to your spouse or partner?
- Yes
- No

As a child, did you ever witness any violence between your parents/carer?
- Yes
- No

How often do you have six or more drinks on one occasion?
- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

How often during the last year have you found that you were unable to stop drinking once you had started?
- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

How often during the last year have you failed to do what was normally expected from you because of drinking?
- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

How often during the last year have you had a short drink in the morning to get yourself going after a heavy drinking session?
- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

How often during the last year have you had a feeling of guilt or remorse after drinking?
- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

Are you a SMOKER?
- Yes
- No

If YES do you want to give up smoking?
- Yes
- No

Do you SHARER your cell with a SMOKE/RICKER?
- Yes
- No

Have you tried to give up smoking in the last 12 months?
- Yes
- No

Have you received advice on smoking & its related health risks since coming into prison?
- Yes
- No

Have you ever used nicotine patch, gum or inhaler before coming into prison?
- Yes
- No

Have you ever used nicotine patch, gum or inhaler in prison?
- Yes
- No

Have you ever heard about e-egs (electronic cigarettes)?
- Yes
- No

If e-egs were available in prison would you use them?
- Yes
- No

What programme/intervention have you ever attended:
- Violence prevention
- Anger Management
- Smoking Cessation
- None
- Other

Did you complete the programme?
- Yes
- No

If YES did it help to address issues relating to your offending?
- Yes
- No

Have staff in the IPS been helpful in supporting you to address your offending behaviour?
- Yes
- No

Have you ever been involved in violence towards your spouse or partner?
- Yes
- No

Have you ever been convicted of an offence involving violence to your spouse or partner?
- Yes
- No

As a child did you ever witness any violence between your parents/carer?
- Yes
- No
National Prisoner Healthcare Network
Mental Health Workstream

The National Prisoner Healthcare Network Mental Health Workstream is trying to ascertain the number of mental health professionals working in prisons in Scotland. In order to support us in doing this we would be grateful if you could please complete this short form as accurately as possible.

THE ESTABLISHMENT

<table>
<thead>
<tr>
<th>Prison Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Board</td>
<td></td>
</tr>
<tr>
<td>Category of Prison</td>
<td></td>
</tr>
<tr>
<td>Establishment size / number of prisoners</td>
<td></td>
</tr>
</tbody>
</table>

MENTAL HEALTH PROFESSIONALS IN YOUR ESTABLISHMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>Your response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please detail the number of registered mental health nurses in your establishment</td>
<td>Number:</td>
</tr>
<tr>
<td>Are the nurses counted above <em>exclusively</em> working in mental health or do they practice physical health too?</td>
<td>Exclusively mental health Mental health and physical health</td>
</tr>
<tr>
<td>Does the establishment have any visiting psychiatry sessions?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>If yes, how many sessions a week?</td>
<td>Number per week</td>
</tr>
<tr>
<td>Does the establishment have access to clinical psychology?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>If yes, how many sessions a week?</td>
<td>Number per week</td>
</tr>
<tr>
<td>Does the establishment have any occupational therapists or other allied health professionals that work in mental health services that</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Details:</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Your response</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>visit?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>Does the establishment have any third sector colleagues that work in</td>
<td></td>
</tr>
<tr>
<td>mental health services that visit?</td>
<td>Details:</td>
</tr>
<tr>
<td>Does the establishment have any social work colleagues that work in</td>
<td></td>
</tr>
<tr>
<td>mental health services that visit?</td>
<td>Details:</td>
</tr>
<tr>
<td>Does the establishment have a mental health multi-disciplinary team that</td>
<td></td>
</tr>
<tr>
<td>meets regularly?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>If yes to the above question:</td>
<td>Details:</td>
</tr>
<tr>
<td>• do social work / criminal justice social work colleagues contribute</td>
<td></td>
</tr>
<tr>
<td>to these meetings?</td>
<td>Yes / No</td>
</tr>
<tr>
<td>• what input do forensic psychologists have to these meetings?</td>
<td>Details:</td>
</tr>
<tr>
<td>What other interventions do you provide, for example day care,</td>
<td>Details</td>
</tr>
<tr>
<td>acupuncture, hobbies workshop etc?</td>
<td></td>
</tr>
<tr>
<td>Do you have video conferencing facilities available which could be used</td>
<td>Details</td>
</tr>
<tr>
<td>for tele-mental health?</td>
<td></td>
</tr>
<tr>
<td>Are you able to provide statistics from the electronic systems that you</td>
<td>Details</td>
</tr>
<tr>
<td>use?</td>
<td></td>
</tr>
<tr>
<td>Is there anything else you would like to share with us in relation to</td>
<td>Details</td>
</tr>
<tr>
<td>the mental health services that you provide?</td>
<td></td>
</tr>
</tbody>
</table>

Thank you for taking the time to provide us with this information which will be used in a positive way to establish the current resource providing mental health services in prisons across Scotland.
**APPENDIX 6**
**RESULTS OF MAPPING EXERCISE**

<table>
<thead>
<tr>
<th>PRISON NAME</th>
<th>NHS BOARD</th>
<th>CATEGORY OF PRISON</th>
<th>ESTABLISHMENT SIZE</th>
<th>PLEASE DETAIL NO OF REGISTERED MENTAL HEALTH NURSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMP Aberdeen</td>
<td>Grampian</td>
<td>Local remand</td>
<td>170 approx</td>
<td>2</td>
</tr>
<tr>
<td>HMP Addiewell</td>
<td>Lothian</td>
<td>Learning</td>
<td>700</td>
<td>4</td>
</tr>
<tr>
<td>HMP Barlinnie</td>
<td>Greater Glasgow &amp; Clyde</td>
<td>Receiving Prison</td>
<td>1250</td>
<td>6 + 1 LD nurse</td>
</tr>
<tr>
<td>HMP Dumfries</td>
<td>Dumfries &amp; Galloway</td>
<td>Local remand/short term convicted</td>
<td>195</td>
<td>1</td>
</tr>
<tr>
<td>HMP Edinburgh</td>
<td>Lothian</td>
<td>Remand and convicted</td>
<td>860-920</td>
<td>4 full time and one part time</td>
</tr>
<tr>
<td>HMP Glenochil</td>
<td>Forth Valley</td>
<td>Long term</td>
<td>670 capacity 750</td>
<td>2.8 FTE &amp; 0.4 CBT nurse</td>
</tr>
<tr>
<td>HMP Greenock</td>
<td>Greater Glasgow &amp; Clyde</td>
<td>Local/receiving</td>
<td>255</td>
<td>4</td>
</tr>
<tr>
<td>HMP Inverness</td>
<td>Highland</td>
<td>Short Term</td>
<td>130 average population</td>
<td>3 (1 x Clinical Manager, 1 x Addictions Nurse, 1 x Mental Health Nurse)</td>
</tr>
<tr>
<td>HMP Kilmarnock</td>
<td>Ayrshire &amp; Arran</td>
<td>High Security</td>
<td>500 (recently 649)</td>
<td>7</td>
</tr>
<tr>
<td>HMP Low</td>
<td>Greater</td>
<td>Local/Receiving</td>
<td>720</td>
<td>5</td>
</tr>
<tr>
<td>Establishment</td>
<td>Region</td>
<td>Type</td>
<td>Population</td>
<td>Response Details</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>-------------------------------</td>
<td>------------</td>
<td>------------------</td>
</tr>
<tr>
<td>HMP Perth/Castle Huntly*</td>
<td>Tayside</td>
<td>High Secure</td>
<td>528 Castle 285</td>
<td>Complement 1xwte band 6, 1x30hrs band 6, 1xwte band 5, 1x30hrs band 5 and Clinical Manager (mental health) wte band 7. Actual - 1xband 7, 1x30hr band 6 and 1xwte band 5.</td>
</tr>
<tr>
<td>HMP Peterhead</td>
<td>Grampian</td>
<td>Local/receiving</td>
<td>142</td>
<td>0 - currently looking into resolving this issue with recruitment.</td>
</tr>
<tr>
<td>HMP Shotts</td>
<td>Lanarkshire</td>
<td>Maximum secure</td>
<td>540</td>
<td>3</td>
</tr>
<tr>
<td>HMP/YOI Cornton Vale</td>
<td>Forth Valley</td>
<td>Female Offenders</td>
<td>309</td>
<td>4.5 RMN and 3 RNLD in the mental health team and addictions team. Have RMN and 1 RNLD</td>
</tr>
<tr>
<td>HMYOI Polmont</td>
<td>Forth Valley</td>
<td>Young Offenders</td>
<td>769 max</td>
<td>6</td>
</tr>
</tbody>
</table>

**MENTAL HEALTH PROFESSIONALS IN YOUR ESTABLISHMENT – COLLATED FOR 15 RETURNS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Your response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the establishment have any visiting psychiatry sessions?</td>
<td>Yes - 15</td>
</tr>
<tr>
<td>If yes, how many sessions a week?</td>
<td>14 weekly</td>
</tr>
<tr>
<td></td>
<td>1 fortnightly</td>
</tr>
<tr>
<td>Does the establishment have access to clinical psychology?</td>
<td>All 15 responded no</td>
</tr>
<tr>
<td>If yes, how many sessions a week?</td>
<td>0</td>
</tr>
<tr>
<td>Does the establishment have any occupational therapists or other allied health professionals that work in mental health services that visit?</td>
<td>No – 13</td>
</tr>
<tr>
<td></td>
<td>Yes - 2</td>
</tr>
<tr>
<td>Does the establishment have any third sector colleagues that work in mental health services that visit?</td>
<td>No – 6</td>
</tr>
<tr>
<td></td>
<td>Yes – 9</td>
</tr>
</tbody>
</table>

* response includes figures for Castle Huntly as it is the same team who cover HMP Perth and Castle Huntly, albeit a Band 6 member of team works predominantly in Castle
<table>
<thead>
<tr>
<th>Question</th>
<th>Your response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the establishment have any social work colleagues that work</td>
<td>No – 12</td>
</tr>
<tr>
<td>in mental health services that visit?</td>
<td>Yes – 3</td>
</tr>
<tr>
<td>Does the establishment have a mental health multi-disciplinary team</td>
<td>All 15 responded yes</td>
</tr>
<tr>
<td>that meets regularly?</td>
<td></td>
</tr>
<tr>
<td>If yes to the above question:</td>
<td></td>
</tr>
<tr>
<td>• do social work / criminal justice social work colleagues contribute</td>
<td></td>
</tr>
<tr>
<td>to these meetings</td>
<td></td>
</tr>
<tr>
<td>Do you have video conferencing facilities available which could be</td>
<td>Yes - 9</td>
</tr>
<tr>
<td>used for tele-mental health?</td>
<td>No – 6</td>
</tr>
<tr>
<td>Are you able to provide statistics from the electronic systems that</td>
<td>Yes - 11</td>
</tr>
<tr>
<td>you use?</td>
<td>No - 4</td>
</tr>
</tbody>
</table>

**WHAT INPUT DO FORENSIC PSYCHOLOGISTS HAVE TO MDT**
- Invited but don’t attend regularly, Will provide input if they are working with any clients that are too be discussed at meeting.
- Forensic Psychologist contribute on prisoners care plan and treatment.
- Asked to attend
- Nil this services comes from Peterhead so not available at our meetings.
- Forensic psychologists will attend to discuss only if there is concern about anyone in offence focussed work programmes, or those who fall under the auspices of RMT/OLR.
- Attend meeting but minimal input or provision of service.
- Prison based social workers attend and input regularly. Forensic psychology will update on any contact they have with the prisoners being discussed.
- The Senior Forensic Psychologist attends and makes valuable contributions and has assisted with specific assessments of individuals.
- Attend meeting to discuss cases involved in programmes etc. Some availability to offer EMDR and CBT if urgently required.

**WHAT OTHER INTERVENTIONS ARE PROVIDED**
- Relaxation Groups
Day care services, relaxation 1:1 support, motivational interviewing, medication monitoring, group work.
Hobbies workshop-daily. Nurse therapist visits twice a week and has case load.
Auricular acupuncture, mindfulness, group work in future, MH drop in clinic, CBT, EMDR in future,
AT group, Alternative Therapy, Gym Group
Group work e.g. sleep promotion and anxiety management
Not as yet work in progress
1:1 work is all that is currently delivered with the MH nurse. No staffing to deliver group work at present. Various self directed help is available and offered.
RMN/RNLD provision available 9am to 5pm, Monday to Friday in Ross House, the area identified for vulnerable prisoners/ those with mental/physical health issues those identified as a risk of suicide or significant self harm. Groups are available in this area Relaxation/ sleep hygiene/media group. SPS provide access to recreational activity, Gym and support Health care staff
Psychotropic monitoring. ADHD medication monitoring. Anxiety and depression management. Sleep clinic.

IS THERE ANYTHING YOU WISH TO SHARE IN RELATION TO MENTAL HEALTH SERVICE YOU PROVIDE

Good feedback from NWC Advocacy Service; work in progress.
Understaffed
No learning disability service in Edinburgh or clinical psychology support.
Look at developing our interventions more in line with NICE guidance in the future.
We have no cover/or limited service if staff are on annual leave, rest days or off sick.
There is great challenge at present in protecting mental health nurse time due to RGN staff shortages.
We are in the process of a full services review, with Mental Health being addressed into the New Year Jan /Feb. This is something that is warmly received to assist us in ensuring that we have the correct resources and our needs met to deliver a robust service to prisoners with mental health needs. We have noticed within our team a steady increase in the need to attend prison based meetings in relation to sentence/prisoner management- Integrated case management( ICM) Order of life long restriction(OLR) Risk Management meetings(RMT) for progression etc. Often this work involves input with offenders with complex mental health needs/behaviours in a background of Personality Disorder. We will also as of 26/11/12 start taking the South Fife courts back to HMP Perth. This will have an impact on Mental health resources, due to previous times when we have had them, our numbers for mental health transfers out to hospital increased dramatically.
Current service meets the MH needs of most clients however, would benefit from Clinical Psychology service. It would also be useful to have suggestions/contributions that may better the current service provision.
NHSL has invested considerably in the service providing training and support for staff. There have been strong links made with the
clinical lead for Mental Health within NHSL. Prison Staff attend clinical governance and clinical leadership meetings externally. Links are also being made with other Mental Health teams to provide clinical supervision for HMP Shotts staff and the opportunity to shadow. HMP Shotts has undertaken the SRI2 audit and has devised an action plan supported by NHSL practice development team. We are currently exploring telemental health.

- We have a CBT nurse therapist 3 days per week (included in above complement as 0.5), Speech and Language therapist x1 day per week, Art Psychotherapist (previously temp whilst training, however funding agreed for 1 day per wk) Clinical Aroma-therapist Re-commencing (funding agreed for 1 day per week). All Mental health team have had MBT Skills training, 4 have CAT skills training.

- The nursing team demonstrate leadership skills and accountability in a nurse-led service, managing their own caseloads in multidisciplinary custodial settings. They are responsible for providing comprehensive assessments, consultations, the planning, implementation and evaluation of evidence based programmes of care and through care needs of the patient with complex health needs. Achieving this by utilising risk assessments, In addition, the nursing staff provide an advice service to a range of referrers.
Appendix 7 Mental Welfare Commission Mental Health of Prisoners: Themed Visit Report into Prison Mental Health Services in Scotland (2011)

Key Messages

Key message 1
Prisons should have staff and facilities in place that are able to support prisoners with a wide range of mental health difficulties. To address this, SPS and NHS Boards should:

- Ensure that prisons have a sufficient complement of registered mental health nursing staff available to meet the needs of their prisoner population. Prisoners need to be able to access help for their mental health problems from trained health staff with the appropriate understanding of mental illness in the same way as treatment would be provided in cases of physical illness.
- Audit and review the operation of Multi-Disciplinary Mental Health Teams (MDMHTs) and provide clear operational guidance on their role, process and function. SPS needs to review its health centre facilities to consider the needs of prisoners with mental health problems. There requires to be sufficient interview rooms to allow prisoners to talk about their issues and appropriate space to deliver therapeutic activities.

Key message 2
Prisoners are particularly vulnerable in the early days of their time in a prison. Skilled staff with knowledge of mental health issues need to be involved from the start. To address this, SPS and NHS Boards should:

- Improve targeting of registered mental health nurse (RMN) cover at times prisoners are being received into prison.
- Establish at reception interviews whether the new prisoner was receiving care for mental health difficulties from their GP or mental health services prior to custody.
- Ensure protocols are in place to address issues regarding changes in treatment and delays in receiving medication.

Key message 3
Support for people with mental health difficulties needs to be about more than just medication alone. There needs to be a fuller range of supports available and facilities for them. To address this, SPS and NHS Boards should:

- Audit the availability and use of ‘therapeutic activity’ for prisoners with mental health problems. A sustainable strategy needs to be developed for such an important aspect of intervention.
- Ensure improved and consistent access to psychological interventions for prisoners with mental health needs. Access to psychological interventions has become an important part of mental health care in the community and should be more available in prison.

Key message 4
There needs to be a more direct involvement from disciplines beyond the prison health centre in supporting prisoners’ mental health issues – we saw little evidence of multidisciplinary working. To address this, SPS and NHS Boards should:

- Ensure that supporting prisoners’ mental health is the responsibility of all disciplines within the prison. There are many professionals working in prisons who could contribute to better mental health care for prisoners. Current contracts appear to be very constricting in terms of addressing wider mental wellbeing for prisoners.
- Address the issue of lack of specialist help identified by many prisoners.
• Ensure there is a clear training strategy in relation to mental health knowledge and awareness required for front line staff in the prison. This then needs to be implemented and monitored.

**Key message 5**
Prison is not the place for seriously and acutely mentally ill prisoners. To address this, SPS and NHS Boards should:
• Ensure that there are protocols and policies in place to make sure that seriously and acutely mentally unwell prisoners are moved quickly to be treated in a hospital setting.
• Review the appropriateness of any facilities used to accommodate prisoners with mental health problems as to suitability and purpose.

**Key messages 6**
People with learning disabilities are very vulnerable in prison. They are likely to have difficulty understanding and adjusting to the complex rules and regimes of prison and will require extra support. There need to be systems in place to identify prisoners with a learning disability, help for prison staff in relation to communicating with prisoners with a learning disability and an understanding of the support needs of such prisoners.
• Establish a stepped care approach to mental health care in prisons encompassing mental health promotion, self help options, therapeutic activities, psychological interventions and use of medication.
• Challenge stigma and discrimination in relation to prisoners with mental health problems at all levels.
• Raise access to advocacy with NHS Boards and local authorities for their area and ensure that advocacy services are promoted for prisoners with mental health problems or learning disability.
• Address the issues raised by prisoners in relation to the prison ‘Listener Services’ and review the operation of these services.

**Key message 7**
Where mental health difficulties are identified, a specific care plan detailing support should be in place. To address this, SPS and NHS Boards should:
• Ensure clear guidance and documentation are available to prison managers and health centre staff with regard to the care planning and case management of prisoners receiving mental health care in prison.
• Ensure that interventions in prisons should be focused on improving ‘choice, control, and participation’ for prisoners with learning disability as emphasised by the Disability Rights Commission (2005)3. This requires the ability of trained staff to identify these prisoners’ needs and support to address them.
• Ensure that the new guide ’People with Learning Disabilities and the Criminal Justice System’ (Scottish Government 2011)4 is available to front line prison staff.
• Ensure clear guidance is available for staff in relation to keeping MDMHT records and that records of individual discussions with regard to each prisoner are included in the personal health records for that prisoner. This is likely to be a part of the audit and review of the operation of MDMHTs which is an action recommended to SPS and NHS Boards under key message 1.

**Key message 8**
Most prisoners return to their communities on release from prison. Proactive contact with community services can help maintain mental wellbeing and reduce
the risk of reoffending. To address this SPS, NHS Boards and Local Authorities should:

- Ensure they have protocols in place for the exchange of information on patients and prisoners to enable good communication and liaison between prison and community services in their areas. 3


4 People with Learning Disabilities and the Scottish Criminal Justice System
## Appendix 8A
### Guidance on integrating conditions and the required level of care
- Courtesy of NHS Greater Glasgow and Clyde

<table>
<thead>
<tr>
<th>Care level</th>
<th>① public (community mental health &amp; wellbeing)</th>
<th>② open access (self-care and peer support for vulnerable groups)</th>
<th>③ ERBI: early response, brief intervention</th>
<th>④ longer-term, multi-disciplinary care</th>
<th>⑤ intensive treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is the service for?</td>
<td>A public health and health improvement approach to the general population, but especially those who may be at risk of developing a condition</td>
<td>Anyone concerned about their own or other peoples’ health.</td>
<td>A prompt response for people who develop symptoms/problems associated with a condition</td>
<td>longer-term and more intensive care when when multidisciplinary or multi-agency input is required, or when brief interventions proved to be inappropriate or ineffective</td>
<td>Home care or inpatient care, typically requiring &gt;3 contacts per week, especially to minimise risk of harm to self or others</td>
</tr>
<tr>
<td>Type of Interventions</td>
<td>information, screening, self-help</td>
<td>education, self-help, peer support, group classes</td>
<td>“low intensity” work: brief interventions, psychological therapies, guided self-help</td>
<td>longer-term psychological therapies; community rehabilitation; risk management, physical health care</td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>everyone</td>
<td>open, self-referral</td>
<td>self-referral and GP referral</td>
<td>GP or secondary care referral</td>
<td>GP or secondary care referral</td>
</tr>
<tr>
<td>Step up to more intense care when...</td>
<td>service user chooses</td>
<td>service user chooses, GP referral</td>
<td>non-response or ERBI approach unlikely to be useful - by referral only</td>
<td>non-response, risk - by referral only</td>
<td></td>
</tr>
<tr>
<td>Example interventions</td>
<td>1 public</td>
<td>2 open access</td>
<td>3 ERBI</td>
<td>4 longer-term, multi-disciplinary care</td>
<td>5 intensive treatment</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------</td>
<td>--------------</td>
<td>-------</td>
<td>---------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>depression &amp; anxiety</strong></td>
<td>antistigma self-assessment</td>
<td>open access CBT-education classes</td>
<td>brief IPT or CBT, guided self-help</td>
<td>longer-term psychological therapies</td>
<td>treatment resistance, ECT, suicide risk</td>
</tr>
<tr>
<td><strong>schizophrenia</strong></td>
<td>information about early signs psychosis</td>
<td>education, information, peer support to self-selecting participants</td>
<td>prompt assessment of psychotic/prodromal symptoms</td>
<td>holistic clinical and social support; risk &amp; case management; relapse plans; recovery-oriented working; multi-agency involvement</td>
<td>crises, clozapine, acute risk management</td>
</tr>
<tr>
<td><strong>dementia</strong></td>
<td>health promotion message on dementia prevention</td>
<td>education, information, peer support to self-selecting participants</td>
<td>memory assessment and diagnosis</td>
<td>multidisciplinary older people’s services</td>
<td>care homes</td>
</tr>
<tr>
<td><strong>borderline PD</strong></td>
<td>destigmatisation of DSH</td>
<td>education, information, peer support, advice</td>
<td>liaison team responding to DSH in acute hospitals</td>
<td>integrated programme of 1:1 therapy, group work, education, social support</td>
<td>acute crises, risk management</td>
</tr>
<tr>
<td><strong>alcohol and drug misuse</strong></td>
<td>alcohol pricing; licensing law; public information about risks</td>
<td>education, information, peer support to self-selecting participants; opportunistic screening</td>
<td></td>
<td>group work; AA</td>
<td>inpatient detox</td>
</tr>
<tr>
<td><strong>individual care planning</strong></td>
<td></td>
<td></td>
<td></td>
<td>MDT</td>
<td></td>
</tr>
</tbody>
</table>
Estimates of prevalence of learning disability (LD) amongst offenders in the United Kingdom

Department of Health (1998) general population 2% IQ <70
17% IQ <85
Rack (2005) prisoners 60% IQ <85
Coid (1998) remand prisoners 34 of 10,000 ‘subnormal’
Gunn et al. (1991) sentenced prisoners 7 of 1,769 had ‘mental retardation’
Myers (Scotland; 2004) secure settings 19 prisoners across 16 prisons known with LD or ASD
Herrington et al. 2003 review; male young offenders 0-36% LD
Lyall et al. (1995) London police stations 5% LD
Gudjonsson et al. (1993) police stations (excluding adolescent males) 9% LD
McNulty et al. (1995) 5% LD
Mason (1998) subject tp probation orders 6% LD
Singleton et al. (1998) male remand prisoners 11% LD
male sentenced prisoners 5% LD; 17% IQ 70-75
female sentenced prisoners 20% IQ 70-75
male and female remands 21% IQ 70-75
Lader, Singleton & Meltzer (2000) young offenders average IQ <80
Harrington & Bailey (2005) young offenders in custody approx 25% IQ <70
approx 33% IQ 70-80
Mottram & Lancaster (2006) prisoners 6.7% LD; 25.4% IQ 70-79
male young offenders in custody 27% LD or borderline
1971) review 30-76% LD for prisoners

APPENDIX 8C
No One Knows Recommendations, Scotland, 2007:

1) A review of the information that accompanies prisoners into prison and on release should be conducted. The review should include the quality and content of the information as well as the effectiveness of the ‘flow’ of information to and from various locations.

2) User-friendly tools for screening defendants for learning difficulties and learning disabilities should be developed and agreed for use across the criminal justice system.

3) Screening and, where appropriate, diagnostic assessment of people for learning difficulties and learning disabilities should be undertaken routinely and systematically prior to their arrival in prison.

4) Referrals from staff of prisoners they are concerned about should be recognised and encouraged, with clear routes for such referrals established at every prison.

5) Multi-disciplinary approaches to supporting the needs of prisoners with learning difficulties or learning disabilities should continue, though some route for this other than through Integrated Case Management or Act to Care (such as mental health review meetings) should be explored.

6) Clear protocols for information-sharing, and for confidentiality in information-sharing, should be disseminated and practiced throughout the prison estate.

7) Prison regimes should be fully accessible to the entire prison population. In particular every prisoner should have full access to information, to offending behaviour programmes, and to opportunities for education, training and employment.

8) A matrix of support for prisoners with learning difficulties or learning disabilities, including access to community-based support services, should be available in every prison. The matrix should specify referral routes and areas of staff and departmental responsibility.
9) National standards should be agreed for levels of care and support for offenders with learning difficulties or learning disabilities while in custody and upon release.

10) All prison staff should undertake specific disability awareness training on learning difficulties and learning disabilities and how these issues may manifest themselves in the prison environment.

11) Staff responsible for specific areas of work, such as education and health care, should receive specific training on learning difficulties and learning disabilities.

12) Information about learning disabilities and learning difficulties, as well as referral routes and community-based supports, should be advertised and easily accessible on the Scottish Prison Service’s staff intranet.

13) Details of work that prison staff are most proud of and examples of good practice should be identified, built upon, and disseminated routinely across the prison estate.

14) The Scottish Prison Service’s Disability Equality Scheme should draw more attention to the specific needs of prisoners with learning difficulties and learning disabilities and reflect this more thoroughly in its Action Plans.

15) The Inspectorate of Prisons for Scotland and Social Work Inspection Agency and/or HM Inspectorate of Education for Scotland should conduct a joint thematic review on the care and treatment of prisoners with learning difficulties and learning disabilities.


17) A cross-departmental working group should be convened to address the needs of offenders with learning difficulties and learning disabilities throughout the criminal justice system in Scotland. The group should include, among others, the Community Justice Authorities, representatives of the Scottish Executive, and relevant representatives from criminal justice social work, education, employment, and social exclusion.
APPENDIX 9

Guidelines for advocates working in prisons
A companion to the Code of Practice for Independent Advocacy

Section 1
Introduction
Background
The Scottish Independent Advocacy Alliance (SIAA) believes that everyone who needs independent advocacy should have access to it. However we recognise that access does vary from area to area and will be dependent on local Contracts or Service Level Agreements. Priority is given, in all areas, to those with a statutory right of access as detailed in the Mental Health (Care & Treatment) (Scotland) Act 2003. The right of access is for anyone with a mental disorder (mental health problem, learning disability, dementia, acquired brain injury) and includes access to both one-to-one and to collective advocacy.

The 2008 HM Chief Inspector for Prisons in Scotland report ‘Out of Sight – Severe and Enduring Mental Health Problems in Scottish Prisons’ detailed findings suggesting that over four in every hundred prisoners has a severe and enduring mental health problem and that, in addition, a very large proportion of prisoners, possibly as many as 70%, have some form of mental health problem.

The SIAA has been aware of and has reported on very limited access to independent advocacy within many Scottish prisons. The transfer of responsibility for healthcare from the Scottish Prison Service in 2011 has led to some NHS Boards looking at this gap in relation to their local advocacy planning and advocacy organisations increasingly have to consider how they can provide advocacy within a prison setting.

Purpose of the document
Good practice in independent advocacy is detailed in the SIAA Principles and Standards for Independent Advocacy and the associated Code of Practice. The Guidelines work alongside these documents. They have been written to apply to all models of advocacy. Throughout Scotland advocacy organisations share the same core Principles although they might do things in a slightly different way.

In thinking about independent advocacy provision in Scottish prisons it is important to remember that although there may be a difference in the setting there should not be any difference in practice. Independent advocacy workers should adhere to good practice as detailed in the Code of Practice while also keeping in mind issues around security. Advocacy organisations should ensure that all work is undertaken within the frameworks of the Principles and Standards for Independent Advocacy and any Working Protocol agreed between the advocacy organisation and the Prison management.

This guidance will also be relevant to independent advocacy for prisoners in private prisons as well as those within the Scottish Prison Service.
The guidance will provide information for Prison staff and management about the role of an independent advocacy worker and for what will be expected from the advocacy organisation.

It is now usual in an NHS or Community care setting, particularly when planning for hospital discharge or care planning, where an individual has advocacy support, for the independent advocacy worker to have involvement with the multi-disciplinary team. This can help ensure that the person concerned is as fully involved as possible in any planning and decision making.

In certain situations for people in prison, particularly around points of transition, access to independent advocacy may be particularly valuable and referrals should be made if the person concerned is not already in contact with the advocacy organisation. To help ensure effective advocacy in such circumstances it may be helpful, e.g. in planning prior to release, for similar involvement in multi-disciplinary team meetings.

**Terminology**

The term advocacy partner is in general use in many advocacy organisations to refer to a person in receipt of advocacy, other organisations use terms such as client or service user. The term advocacy partner is used throughout this document to refer to prisoners in receipt of advocacy.

The title for staff in many advocacy organisations is advocate; some use the term advocacy worker. The term advocacy worker has been used in this document to avoid any potential for confusion with a legal advocate.

**Commissioning Guidance**

The most recently updated advocacy Guide for Commissioners includes the four Principles detailed in the Principles and Standards for Independent Advocacy and the associated Code of Practice. The standards relating to Principle 3, Advocacy should be as free as possible from conflicts of interest, vary from those included in the Principles and Standards for Independent Advocacy. The standards included in the Guide for Commissioners should be considered in commissioning advocacy for people in prisons.

**Different models of advocacy**

One to one or individual advocacy

This includes professional or issue based advocacy. It can be provided by both paid and unpaid advocates. An advocate supports an individual to represent their own interests or represents the views of an individual if the person is unable to do this themselves. They provide support on specific issues and provide information but not advice. This support can be short or long term.

Another model of one to one advocacy is citizen advocacy. Citizen advocacy happens when ordinary citizens are encouraged to become involved with a person who might need support in their communities. The citizen advocate is not paid and not motivated by personal gain. The relationship between the citizen advocate and their advocacy partner is on a one-to-one, long term basis. It is based on trust between the partner and the advocate and is supported but not influenced by the advocacy organisation. The advocate supports their partner using their natural skills and talents rather than being trained in the role.

Peer advocacy is also individual advocacy. Peer advocates share significant life experiences with the advocacy partner. The peer advocate and their advocacy partner may share age, gender, ethnicity, diagnosis or issues. Peer advocates use their own experiences to understand and have empathy with their advocacy partner. Peer advocacy works to increase self-awareness, confidence and assertiveness so that the individual can speak out for themselves, lessening the imbalance of power between the advocate and their advocacy partner.

Group or Collective advocacy

Collective Advocacy enables a peer group of people, as well as a wider community with shared interests, to represent their views, preferences and experiences. A
collective voice can help reduce an individual's sense of isolation when raising a difficult issue. A collective voice can be stronger than that of individuals when campaigning and can help policy makers, strategic planners and service providers know what is working well, where gaps are and how best to target resources. Being part of a collective advocacy group can help to reduce an individual's sense of isolation when raising a difficult issue. Groups can benefit with the support of resources and skilled help from an independent advocacy organisation. The aim of all models of advocacy is to help individuals gain increased confidence and assertiveness so that, where possible, they will feel able to self-advocate when the need arises.

How to use this guide
The first section gives details of what needs to be agreed and put into place by the advocacy organisation and the prison. It includes considerations for inclusion in a Service Level Agreement, specific policies and procedures that will be required and gives some information about training and security requirements. The following four sections are divided into the four main Principles of independent advocacy.
Principle 1: Independent advocacy puts the people who use it first
Principle 2: Independent advocacy is accountable
Principle 3: Independent advocacy is as free as it can be from conflicts of interest
Principle 4: Independent advocacy is accessible
Principles are the core beliefs about independent advocacy. These are the ideas that guide everything that advocates and advocacy organisations do.
The indicators are the evidence of how advocates meet each Principle.
The sections for each Principle give a set of indicators for advocates and for organisations. These indicators relate to the specific requirements within the prison setting and build on the indicators from the Code of Practice for Independent Advocacy which should also be considered.

Section 2
Special considerations for providing advocacy to people in prison
(i) Before setting up a service in a prison

A robust Service Level Agreement should be agreed, between the advocacy organisation, the SPS and the prison and the funder, to include agreed procedures for the following considerations:
- Security
- PVG Scheme membership for independent advocacy workers
- Access to prisoners
- Risk assessment – possible safety issues for independent advocacy workers
- Getting around the prison
- Protection of mail to and from the advocacy service
- Telephone access to the advocacy service
- Storage of advocacy records/documents
- Confidentiality
- Prison security in relation to Advocacy Agreements
- Information provided within the advocacy relationship

The SLA should also include a clear definition of what advocacy is and what will be expected within an advocacy role.
(ii) SPS Third Sector Partnership Pack

The Scottish Prison Service has developed a Partnership Framework Agreement designed to bring together service providers within the criminal justice community to ensure a shared understanding of service needs, resources and access to ensure that all parties agree the shape of service delivery for delivery in prisons or in the community. The Third Sector Partnership Pack provides guidance to assist third sector organisations to work in partnership with public organisations providing Criminal Justice services. The pack can be found at www.sps.gov.uk/AboutUs/PartnershipWorking.aspx

(iii) Policies and Procedures

The organisation should develop clear relevant policies, in addition to existing policies and procedures, specifically for this area of work. These may not need to vary from existing policies and procedures but these should be considered in light of the special circumstances of the environment. These may include policies on:

- Confidentiality – very clear guidance to be in place around any need for sharing of information, possible breaching of the advocacy partner’s confidentiality and how this should be approached
- Boundaries – clear guidance on the maintenance of boundaries between independent advocacy workers and advocacy partners needed in this specific situation

A working protocol should be developed and agreed between the advocacy organisation and the prison. The protocol should include referral pathways and tracking of referrals. This may also include regular meetings between the advocacy organisation and designated prison staff for discussion and resolution of problems, issues etc. This would also allow for feedback of any emerging themes or issues. The protocol could also detail mechanisms for communication between independent advocacy workers, prison staff and other relevant professionals where needed.

Clear Complaints Procedures for prisoners or the Prison about the advocacy organisation and for the advocacy organisation about the prison should be developed and agreed.

(iv) Monitoring

The organisation should agree and implement a sound monitoring system for this area. This can be useful for the Prison Service if it allows for identification of common issues which may need to be addressed. The advocacy organisation should provide a report to the prison management on a regular basis.

(v) Awareness raising

To help in establishing advocacy within the prison setting the advocacy organisation should work to raise awareness about independent advocacy, including the difference it can and has made to individuals,

- for prisoners
- for prison staff
- for others e.g. relevant voluntary organisations, lawyers

Awareness raising should be conducted on an ongoing basis to ensure that recently admitted prisoners, new prison staff and relevant others are kept aware of the existence of independent advocacy, what it can do and what to expect from
the advocacy organisation. Consideration should be given to developing literature which informs the prisoners of what they can expect from advocacy workers and organisations within the prison.

(vi) Training for independent advocacy workers

The Scottish Prison Service had a programme of mandatory training that must be completed by all third sector staff working in a prison. This includes personal protection training, security brief, health and safety and conditioning and manipulation.

The advocacy organisation is responsible for ensuring that all independent advocacy workers working within the prison are available for all relevant training. Independent advocacy workers should be clear about their role and that they are there only to provide independent advocacy. The advocacy organisation should ensure that all concerned have clarity about boundaries as they would apply in this situation.

(vii) Relationships

To ensure that all who have a right to and who need it have access to independent advocacy the organisation should work to raise awareness of independent advocacy amongst prisoners. This should include building relationships and ensuring a clear understanding of what independent advocacy is and what can be expected from the organisation and from the independent advocacy workers.

The organisation should build relationships and trust with prisoners while bearing in mind boundaries and security arrangements within the prison situation.

The organisation should build relationships with the senior management of the prison. They should also work at building appropriate relationships with staff within the prison bearing in mind issues around possible conflicts of interest and around the perception prisoners may have of the relationships between the prison staff and the organisation and independent advocacy workers.

The prison should designate a senior manager and an operational manager who are responsible for ensuring the delivery of independent advocacy services within the establishment. This provides a link person for the advocacy organisation for communications, reports and complaints.

The advocacy organisation should build relationships with other voluntary sector organisations that operate within or have links with the prison. These may include Samaritans, SACRO, Families Outside, PASS etc. The advocacy organisation should also ensure effective working relationships with other advocacy organisations where a prisoner may be required to be referred to another organisation if they are being liberated to different area of Scotland from where the prison is situated.

Section 3
Principles and Standards and Code of Practice

The Principles and Standards for Independent Advocacy are the same while working within prisons as for any other advocacy situation. The Indicators as detailed in the Code of Practice for Independent Advocacy apply in this area of work. Full information on these Principles and Standards and Code of Practice can be found in the SIAA website at www.siaa.org.uk.

There are some additional factors to take into consideration. These are outlined here. It should be borne in mind that, as this is designed as a companion to the Code, the indicators included here are in addition to or expand upon those detailed in the Code.
(i) Principle 1 Independent advocacy puts the people who use it first

Independent advocacy workers must:

a) Act on the issues agreed by their advocacy partner, with reference to the Working Protocol, and at the pace appropriate to the advocacy partner’s needs whilst acknowledging the pace restrictions due to security arrangements of the environment.

b) Follow the agenda agreed with their advocacy partner, where possible and while bearing in mind the restrictions applying within the prison situation, and not be influenced by others.

c) Not let their personal opinions, choices and values interfere with their advocacy partner’s choices. Independent advocacy workers should be aware of their own prejudices.

d) Help their advocacy partner to access accurate information from appropriate sources, while recognising the restrictions to prisoners to access online information, as agreed in discussion with the prison service.

e) Be clear that any information is not shared with a third party unless by agreement with the advocacy partner, except in cases where the advocacy partner intends to harm themselves or others or where possible security issues arise — according to relevant laws. The sharing of information should be clearly laid out in the Service Level Agreement to ensure the advocacy worker and the advocacy partner are fully aware of what information must be shared with the prison.

f) Participate in training on the different laws that apply to what they do.

g) Be aware of the rights of people in prison.

h) Not do anything their partner does not want them to do, except in certain circumstances laid out in the law and the organisation’s policies with specific reference to the security requirements of the environment.

Organisations must:

i) Have and implement policies, procedures and guidelines for working with people within prisons.

j) Ensure training for independent advocacy workers on Equality and Diversity also including reflection on attitudes to offenders.

k) Ensure independent advocacy workers receive regular support and supervision or guidance to make sure they are clear about their role and about issues specific to security and the working environment.

l) Ensure independent advocacy workers receive training in their role, including issues specific to security and the working environment, how to review the relationship with their advocacy partner or group and how to record information.

m) Ensure regular monitoring meeting that may also include operational issues between the advocacy organisation manager and the designated First Line Manager within the prison and also arrange an annual meeting between the Advocacy organisation senior management and the prison senior management to assess the effectiveness of the current service and agree any changes or development to the service.

n) Have agreed procedures for storage and security of advocacy records.
o) Ensure that independent advocacy workers undertake training or preparation on laws and policies and procedures relevant to the Scottish Prison Service.

p) Ensure that all independent advocacy workers are kept up to date with changes in legislation and policies and procedures relevant to the Scottish Prison Service.

q) Ensure that independent advocacy workers undertake preparation and ongoing training as required by the advocacy organisation’s policies and procedures and the Service Level Agreement.

r) Ensure that independent advocacy workers undertake specific training relevant to the environment to include topics such as legal requirements, security, personal safety and prison protocols. Such training will be delivered by the Scottish Prison Service.

(ii) Principle 2 - Independent advocacy is accountable

Independent advocacy workers must:

a) Act on the issues agreed by their advocacy partner, with reference to the Working Protocol, and at the pace appropriate to the advocacy partner’s needs whilst acknowledging the pace restrictions due to security arrangements of the environment.

b) Be aware of and act within the law, the prison rules and within the security requirements of the Prison Service at all times.

c) Be aware that they might have to break their advocacy partner’s confidentiality, if the law or the organisation’s policies say so, if their advocacy partner intends to breach prison security or harm themselves or others, or if the advocate has information that the person’s health and safety is in danger from the actions of others.

d) Know what the organisation’s policies and procedures are if they are aware of their advocacy partner being in danger of harm or intending to breach prison security or break the law.

e) Act within the Principles and Standards for Independent Advocacy and Code of Practice and the policies and procedures of the organisation, in particular those policies relevant to the working environment.

Organisations must:

f) Have a rigorous recruitment or selection policy which will include the need for references and membership of the PVG Scheme in order to protect the safety of the people who use advocacy and the security of the environment.

g) Have policies and procedures for the line management or support of independent advocacy workers, including support and supervision or guidance, training and personal development.

h) Provide appropriate training on all relevant policies and procedures

i) Ensure a risk assessment is undertaken to ensure safety of independent advocacy workers, prisoners and the prison environment. The prison will be responsible for ensuring the environment that the advocacy organisation is working in is safe and has been risk assessed. Where the prison assess a prisoner as a high risk it may require prison staff to be
present during a consultation with the advocacy worker or may require special measure being put in place to ensure the worker’s safety.

j) Have a policy and procedures for keeping files and records of the advocacy partnerships which comply with relevant legislation, including who the information belongs to and what happens to files and records when the advocacy partnerships end. This should include details of where and how records are stored. It should also include details of what and how much should be recorded in any notes.

k) Ensure that any advocacy agreement complies with the law, the security requirements of the Prison Service and the Principles and Standards for Independent Advocacy and Code of Practice.

(iii) Principle 3 Independent advocacy is as free as it can be from conflicts of interest

Independent advocacy workers must:

a) Be clear about their role as an advocate and where their responsibilities lie, including the boundaries of relationships with people other than their advocacy partner.

b) Only act within the boundaries of their role descriptions and those of the organisation.

c) Be aware of the boundaries set by the organisation and the specific requirements of the working environment and what will happen if these boundaries are not upheld. The Prison Service will maintain the right to exclude any worker from the prison where there has been or there is a potential for a breach of security or agreed working practices as set out in the Service Level Agreement.

Organisations must:

d) Ensure that any Service Level Agreement is made in accordance with the Guide for Commissioners while also bearing in mind the Principles and Standards for Independent Advocacy and Code of Practice.

e) Have clear policies and procedures in place about the things that independent advocacy workers do and what to do in situations where service providers may try to direct the work of the independent advocacy workers.

f) Make sure that service providers are aware of what advocacy is and what the professional boundaries are.

g) Ensure that all members of the organisation have clear job or role descriptions.

h) Provide training, guidance and information to all its staff and volunteers about conflicts of interest and what they mean regarding the independence of the organisation in the context of Guide for Commissioners, the Principles and Standards for Independent Advocacy and Code of Practice and in the context of the prison environment.
(iv) Principle 4 Independent advocacy is accessible

Independent advocacy workers must:
  a) Promote the organisation and independent advocacy in the course of their work.

Organisations must:
  b) Provide training for all relevant staff and agencies within the Prison Service to promote referral to independent advocacy.
  c) Have joint working protocols or relationships with other organisations that work within the prison environment and, where necessary, provide training and awareness-raising for staff.
  d) Engage with Prison Service management to consider what are the needs of prisoners in relation to accessing advocacy, what, if any, are the barriers to accessing advocacy and how to promote full access.
  e) Ensure that information about independent advocacy is made available to all prisoners.
  f) Develop referral pathways for prisoners being held in national facilities to ensure that on their release they are still able to access independent advocacy from organisations located in other parts of Scotland.

Appendix 1
Advocacy is, Advocacy is not

Advocacy is...
• about standing alongside people who are in danger of being pushed to the margins of society
• about standing up for and sticking with a person or group and taking their side
• a process of working towards natural justice
• listening to someone and trying to understand their point of view.
• finding out what makes them feel good and valued
• understanding their situation and what may be stopping them from getting what they want
• offering the person support to tell other people what they want or introducing them to others who may be able to help
• helping someone to know what choices they have and what the consequences of these choices might be
• enabling a person to have control over their life but taking up issues on their behalf if they want you to

Advocacy is not...
• making decisions for someone
• mediation
• counselling
• befriending
• care and support work
• consultation
• telling or advising someone what you think they should do
• solving all someone’s problems for them
• speaking for people when they are able to express a view
• filling all the gaps in someone’s life
• acting in a way which benefits other people more than the person you are advocating for
• agreeing with everything a person says and doing anything a person asks you to do.

Appendix 2
Glossary of Terms

Advocate
An advocate helps people express their views and make informed decisions. An advocate helps people to find out information, explore options and decide for themselves what they want. Advocates can be a voice for the person and encourage them to speak out for themselves.

There are different kinds of advocacy, though they all share things in common. Advocates will never tell people what to do, or allow their own opinions to affect the support they provide. All advocacy tries to increase confidence and assertiveness so that people can start speaking out for themselves.

Independent Advocates are as free from conflicts of interest as possible.

Advocacy
The process of standing alongside another, speaking on behalf of another and encouraging the person to speak up for themselves. Advocacy can help address the imbalance of power in society and stand up to injustice.

Advocacy agreement
An Advocacy Agreement explains, for example, what the person can expect from their advocate, what issues they want the advocate to support them with, the contact details of the advocate, what happens at the end of the Advocacy Partnership and the advocacy organisation’s complaints process.

Advocacy Partner
The person who uses advocacy. Some advocacy organisations use the term ‘client’ or ‘service user’.

Commissioner
Usually representatives from the Local Authority or Health Board who fund advocacy.

Conflict of interest
Anything that could get in the way of an advocate being completely loyal to their Advocacy Partner. For example, it would not be appropriate for an advocate volunteering for a mental health advocacy organisation to also work in the local psychiatric hospital, because this would affect their ability to be on the side of the Advocacy Partner. It would also affect their relationships with hospital staff. Other conflicts of interest could include relationships as well as financial investments.

Independent Advocacy organisation
Advocacy organisation that is structurally, financially and psychologically separate from service providers and other services.

Structurally — an Independent Advocacy organisation is a separate organisation in its own right. For example, they are registered as a charity or company and have their own Management Committee or Board of Directors. Everyone involved in the organisation recognises that they are separate and different from other organisations and services.
Financially — an Independent Advocacy organisation has its own source of funding that does not cause any conflicts of interest and that does not compromise the work it does. (See conflict of interest)

Psychologically — Everyone involved in the organisation knows that they are only limited in what they do by the principles of Independent Advocacy, resources and the law. It is important to recognise that although there may be conflicts of interest present, psychological independence is vital.

**Named Person**
A person chosen by a service user to be involved in decisions about their mental health care and treatment.

**Non-instructed advocacy**
Non-instructed advocacy happens when a person who needs an Independent Advocate cannot tell the advocate what they want. This may be because the person has complex communication needs or has a long term illness or disability that prevents them from forming or clearly stating their wishes/desires. This usually takes place with people who have dementia or profound and/or severe learning difficulties.

**Safeguard**
Ensuring that people’s rights are protected.

**Service provider**
A person or organisation involved in giving support or care services to an individual.

**Service User**
The person who uses advocacy. Some advocacy organisations use the term ‘client’ or ‘Advocacy Partner’.

**Appendix 3**
**Principles of the Mental Health (Care & Treatment) (Scotland) Act 2003**

The Principles require that any person, other than those who are exempt (which includes those providing independent advocacy services under section 259 of the 2003 Act), in considering a decision or course of action in relation to the Act, takes into account the following matters:-

- the present and past wishes and feelings of the patient, where they are relevant to the exercise of the function and in so far as they can be ascertained by any means of communication appropriate to the patient. Where the decision relates to medical treatment and the patient has an Advance Statement then this should be given due consideration.
- the views of the patient’s named person, carer, and any guardian or welfare attorney so far as it is practical and reasonable to do so.
- the importance of the patient participating as fully as possible in any decisions being made and the importance of providing information to help that participation (in the form that is most likely to be understood by the patient). Where the patient needs help to communicate (for example, translation services or signing) then these should be considered. Any unmet need should be recorded.
- the range of options available in the patient’s case.
- the importance of providing the maximum benefit to the patient.
• the need to ensure that the patient is not treated any less favourably than the way in which a person who is not a patient would be treated in a comparable situation, unless that treatment can be shown to be justified by the circumstances.

• the patient's abilities, background and characteristics, including, without prejudice to that generality, the patient's age, sex, sexual orientation, religious persuasion, racial origin, cultural and linguistic background, and membership of any ethnic group.
EXECUTIVE SUMMARY
This report was commissioned by the Forensic Mental Health Services Managed Care Network.

Terms of reference
• To consider the assessment and management of individuals with personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system;
• To describe services currently available in Scotland for this group;
• To describe treatment strategies currently used in Scotland with this group; and
• To make recommendations regarding the development of services and strategies, including staff training, for this group.

Terminology
Forensic personality disorder is the term used throughout the report to refer to individuals with personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system. It is essential to note that this term is used as an abbreviated description and is not a diagnosis.

Working methods
The group used recently published literature reviews, and presentations on or visits to relevant services as background information. A questionnaire was developed to gather information about existing services and treatment strategies for people who fall within the remit in Scotland.

Background Summary
• A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.
• The assessment and management of people with personality disorder is an issue for mental health and social services as a whole, and is the subject of a recent discussion paper – Personality Disorder in Scotland: Demanding patients or deserving people? (Centre for Change and Innovation, 2005).
• Within the Mental Health (Care and Treatment) (Scotland) Act 2003 a mental disorder is defined as any mental illness, personality disorder or learning disability however caused or manifested. There are five criteria to be considered in the use of the civil provisions of the Act for detention and/or treatment:
  - Does the patient have a mental disorder?
  - Does the patient have significantly impaired ability to make decisions about treatment?
  - Does the patient present a significant risk to his/her health, safety or welfare; or the safety of others?
  - Are treatments available that are likely to prevent the patient’s mental disorder from worsening or alleviate its symptoms or effects?
  - Is any order necessary?
Whilst the term personality disorder is specifically included in the 2003 Act most patients with this diagnosis will not come within its remit because they will not have significantly impaired ability to make decisions about treatment. This criterion is excluded under the provisions for mentally disordered offenders although the other four criteria remain in place. Issues of treatability will therefore be prominent in any decision to use the 2003 Act for mentally disordered offenders with a primary diagnosis of personality disorder.

- Personality disorders are common:
  - 6-15% of the general population
  - 60-80% of male prisoners (50% female prisoners).
  - 5% of the State Hospital population - primary diagnosis of antisocial personality disorder
  - 27-42% of the State Hospital population - secondary diagnosis of antisocial personality disorder

- There is evidence to suggest that services fail to record or diagnose personality disorder in the inpatient population. Only 5.1% of discharges from psychiatric hospital in Scotland in 2000 were given a primary or secondary diagnosis of personality disorder even though over one-third of patients in psychiatric hospital would be expected to have a diagnosis of personality disorder.

- At the present time it is routine psychiatric practice in Scotland not to admit individuals with a primary diagnosis of personality disorder to forensic psychiatric units.

- Community forensic mental health service provision in many parts of Scotland is rudimentary. Most forensic psychiatrists do have a small cohort of outpatients with a primary diagnosis of personality disorder.

- The majority of individuals with a primary diagnosis of personality disorder who offend in a manner that merits a custodial disposal will be sent to prison or to a young offenders’ institution.

- The Scottish Prison Service strategy for the management of prisoners is based on the identification of problem behaviours and needs. It does not focus its management of prisoners on the concept of personality disorder, nor is the majority of its staff qualified to assess and diagnose this condition.

- There are three principal structures that allow for the identification and management of prisoners with behavioural problems and needs: Sentence Management, Risk Management groups and Mental Health teams. The focus of the latter is mainly on people suffering major mental illness rather than personality disorder.

- A variety of cognitive behavioural therapy based interventions with a focus on violent behaviour and sexual offending behaviour are delivered by prison staff, including officers, psychologists and social workers.

- The report on Serious, Violent and Sexual Offenders (Scottish Executive, 2001) recommended the creation of the Risk Management Authority, the Risk Assessment Order and the Order for Lifelong Restriction as methods of controlling future risk. These orders commence in early 2006. The emphasis of the report is on offence and
There has been considerable development of services for the assessment and treatment of people with personality disorder in recent years in England and Wales, and in the creation of a structure to encourage this. These include:

- Rejection of personality disorder as a diagnosis of exclusion
- The creation of the Multiagency Public Protection Arrangements which require police, probation and prison officers to work together to manage the risks posed by dangerous offenders in the community, including a statutory duty for health, housing, social services, education, social security and employment services, youth offending teams and electronic monitoring providers to cooperate with area Multiagency Public Protection Panels (MAPPPs). MAPPPs have four core functions:
  i. Identification of MAPPA offenders
  ii. Sharing of relevant information
  iii. Assessment of risk of serious harm
  iv. Management of risk of serious harm

- Investment by the Department of Health and the Home Office in establishing pilot services for people with personality disorder in general psychiatric and forensic services including pilot community forensic personality disorder services and five inpatient forensic personality disorder units.

- The development of the concept of Dangerous and Severe Personality Disorder (DSPD) and the creation of four DSPD units: 2 in prison and 2 in high security hospitals.

- The continued role of HMP Grendon, and other units, as therapeutic communities for prisoners with challenging behaviours.

Survey of Services for People with Forensic Personality Disorder in Scotland

A survey of current services available, and treatment strategies in use, in Scotland for individuals with a forensic personality disorder was carried out. The questionnaire was sent to the lead psychiatrist for each of the forensic services in Scotland (10/11 received). In addition, the survey was sent to members of the Scottish Forensic Clinical Psychologists’ Interest Group (5/15 received) and to directors of social work and chief social work officers throughout Scotland (11/46 received). The main findings of the ten forensic psychiatric services that responded were:

- Implicitly exclude people with a primary diagnosis of personality disorder from admission.
- Assess people with a primary diagnosis of personality disorder.
- Use multidisciplinary and 10 comprehensive methods of assessment but only use structured clinical tools for the assessment of personality disorder.
- Services did not accept people with a primary diagnosis of personality disorder for specific intervention, treatment or management, and services did not accept people with a secondary diagnosis.
- No reliable figures on the assessment or management of people with a primary or secondary diagnosis of personality disorder could be supplied. Those that were supplied suggest major unmet need when compared to known prevalence figures.
• Access to services appropriate to people with personality disorder was variable:
  Drug and alcohol services 10
  Cognitive behavioural therapy 9
  Individual psychotherapy 6
  Dialectical behaviour therapy 2
  Specialist interventions 4
  (such as relapse prevention, sex offending, problem-solving)
• Training requirements were identified in particular for developing case formulations and employing evidence based interventions.

**Recommendations**

**General**

1. Personality Disorder should not be a diagnosis of exclusion from forensic mental health services in Scotland. Forensic Mental Health Services should develop a philosophy of care or stated service principles for people with forensic personality disorder.
2. Services for people with personality disorders are required given the frequency with which they are found in the criminal justice and mental health systems in Scotland.
3. The Forensic Network should track any proposals arising from the work of the Centre for Change and Innovation and the Scottish Executive in the assessment and management of people with personality disorder in other fields of mental health throughout Scotland.
4. Data collection systems should be improved to provide accurate information on forensic personality disorder for service planning.

**Assessment of People with Personality Disorder**

The following practice is recommended for the assessment of people with a suspected personality disorder. It is recognized that the ideal standard will not be attainable at all consultations and will require modification accordingly. It should be attainable in all forensic mental health inpatient settings.

5. A diagnosis of personality disorder (primary or secondary) should be considered during all forensic mental health consultations.
6. The assessment of personality disorder should ideally be multidisciplinary and include:
   - An emphasis on third party information
   - Assessment for the presence of axis I disorders
   - Use of standardized measures of personality disorder
   - Assessment of risk of harm to others using standardized measures
   - Formulation of symptoms and behaviours associated with the personality disorder
7. Suggested assessment measures include:
   - Personality Disorder - Clinical assessment based on ICD-10 or DSM-IV criteria
   - International Personality Disorder Examination
   - Psychopathy Checklist-Revised or Screening Version
   - Mental Illness - Clinical ICD-10
   - Risk of Violence - Historical Clinical Risk 20
   - Risk of Sexual Offending - Risk of Sexual Violence Protocol; Risk Matrix 2000
Management of People Personality Disorder

8. The evidence base for the treatment of personality disorder is not strong. There is some evidence of the efficacy of structured coherent psychological approaches for people with personality disorder but the use of these and of medication for the treatment of specific symptoms is under researched. In addition, such approaches require further assessment of their effectiveness in people with a forensic personality disorder.

9. Any interventions should be developed in line with the evidence based ten Home Office accreditation criteria for offending behaviour programmes and should:
   - have a clear model of change (i.e. a theoretical underpinning to the programme, based on a model of personality development and disorder)
   - have clear criteria for patient selection
   - target relevant dynamic risk factors
   - use effective methods
   - teach skills that will assist patients to avoid offending and pursue legitimate pursuits
   - have a clear description of the sequencing, intensity and duration of the different components of the programme
   - maximise engagement and motivation
   - ensure continuity with other programmes/services
   - monitor its performance
   - undertake a long term-evaluation

10. Services developed for people with personality disorders should adopt a problem behaviour focus arising from a case formulation and address a range of interventions that target the factors that underlie risk related behaviour.

11. These services require to be developed within a range of environments including the community, hospital and prison.

Community

12. The Risk Management Authority should be given the powers to develop arrangements similar to those provided by Multi Agency Public Protection Panels in England and Wales to encourage the involvement of health and social services staff in the assessment and management of individuals with forensic personality disorder in the community by the development of a system of information sharing, responsibility sharing, risk assessment and risk management. To successfully engage staff in working with people with forensic personality disorder, and thereby increase the likelihood of improved public safety, it is essential that a culture of information exchange and shared responsibility is developed, and that a blame culture is avoided.

13. A formal system for criminal justice social workers to request forensic mental health assessments should be established. This should be offered as a pilot service in one or more area to assess workload and resource requirements. These pilots should develop clear referral criteria and an assessment battery. Such criteria are likely to focus on problem behaviours rather than a specific diagnosis. Additional resources will be required for the pilots. Any pilot must be evaluated. The pilots should offer an assessment service with treatment as usual, and any specific collective treatment and / or training needs should be identified during the pilot for further service planning.
14. The Forensic Network should monitor the outcome of the pilot community services currently being established in England and Wales.

**Inpatient Services**

15. Patients with a primary diagnosis of personality disorder who present a significant risk of physical and psychological harm to others and who come into contact with, or are likely to come into contact with, the criminal justice system, are not normally admitted on a compulsory basis to psychiatric hospital. At present no change is recommended to current clinical practice in Scotland.

16. The Forensic Network should monitor the outcome of the pilot inpatient services for people with a personality disorder and DSPD units currently being established in England and Wales before considering any change to current clinical practice. Any future developments of inpatient units for people with primary diagnosis of personality disorder in Scotland must include clearly defined routes to lower security and to the community.

17. Recognition should be given to the problem of personality disorder as a comorbid diagnosis, and assessment and management protocols made available in all forensic mental health settings accordingly.

18. It is recognised that there is a small cohort of patients in special security psychiatric care in Scotland that have a primary diagnosis of personality disorder. Whilst some of these cases are historical there is evidence to suggest that there may be a small number of patients added to this cohort because of a change in diagnosis. The following are therefore advised to avoid further cases:
   - A recommendation of an interim hospital order or interim compulsion order to court as standard practice to prolong the period of assessment.
   - A recommendation of a hospital direction to court in cases where personality disorder may be the prominent issue in future risk to public safety and the link between the major mental illness / learning disability and the offending behaviour is not clear.
   - An automatic review of all patients detained under a transfer direction or transfer for treatment direction in forensic mental health inpatient units before being considered for ongoing civil detention after the expiry of their prison sentence. Local arrangements should be put in place for such reviews.
   - The development of similar options for the courts in Northern Ireland.

19. A service should continue to be developed for the small group of patients with a primary diagnosis of personality disorder currently in the State Hospital whose discharge is prevented under the provisions of the Mental Health (Public Safety and Appeals) (Scotland) Act 1999.

20. The rehabilitation of these patients outwith the State Hospital is problematic. The development of a specialist team (psychiatry, psychology, nursing, social work, occupational therapy) for the resettlement of patients with a primary diagnosis of personality disorder outwith the State Hospital should be considered to provide outreach support to and shared clinical responsibility with the local team in an inpatient or outpatient setting. In combination with the MAPPA style arrangements proposed (12) this may encourage local teams to engage
with these patients. These arrangements involve police, criminal justice social workers, prison officers, health professionals and staff from a wide variety of social services in the identification, assessment and management of people with forensic personality disorder.

21. The Forensic Network should ask the Scottish Executive for a view on the referral of cases to the Scottish Criminal Cases Review Commission, where the Responsible Medical Officer considers that the primary diagnosis is one of personality disorder but evidence was given in court at the time of the trial and/or disposal regarding a primary diagnosis of a different mental disorder.

**Prison**

22. The group supported the focus of the Scottish Prison Service during the initial sentence management process on identifying problems and needs rather than diagnosis. There is a comprehensive assessment process for identifying risk and needs and there is a structure in place to deal with those identified as high risk or problematic through the Risk Management Groups.

23. The group recognised that the issue of personality disorder is central to many problem behaviours found in prisons, to failure to engage with therapeutic programmes and to an excessive drain on health service resources within prison by continual demands for assessment and medication. The group therefore recommended that in these contexts assessment of individuals for the presence of personality disorder would assist in their subsequent management.

24. The group identified a need to strengthen mental health teams within prisons. All prisons should have a multidisciplinary health team of a standard set out in the policy document “Positive Mental Health” (Scottish Prison Service, 2002). At the present time these are focussed entirely on the identification and treatment of those with mental illness, and struggle to fulfil this role. In addition, they are rarely truly multidisciplinary.

25. The group identified a need for visiting mental health professionals to engage more widely with the therapeutic work of the prison service, including offender based programmes.

26. One or more pilot prison and mental health team should be identified to carry out detailed assessments of problematic prisoners, and to develop management plans in conjunction with the prison’s Risk Management Group. These pilots should develop clear referral criteria, an assessment battery, and an agreed management strategy tailored to each individual. Additional resources will be required. Any pilot must be evaluated.

27. Staff training and supervision will be required to work with people with personality disorder in prison. This will be required on two levels: firstly, for staff to assess and manage these individuals; and secondly, for staff carrying out specific programmes which may contain these individuals within the prison.

28. There is evidence from HMP Grendon that prisons or special units run on the principles of a therapeutic community can improve aggressive behaviour within that setting. It is recognised that these units require strong leadership and a clear psychotherapeutic principle basis to succeed and that focus may be lost over time. The group recommends that the
Forensic Network examines the evidence, as it becomes available, from the DSPD units in England and findings from the Scottish prison pilot recommended above (26) before making any recommendation on re-establishing such units within the Scottish Prison Service.

29. The Group acknowledged the day programme approach developed in HMP Barlinnie (Open Doors Programme) and HMP Perth for vulnerable prisoners or prisoners with major mental illness. To succeed, any such day programmes must have a defined client group and therapeutic focus, and access to multidisciplinary input. The group recommends that the Forensic Network examines the evidence, as it becomes available, from the Scottish prison pilot recommended above (26) before making any recommendation on establishing day programmes for people with personality disorder within the Scottish Prison Service.

Training and Supervision

30. Training and supervision will be essential in any setting for the successful engagement of staff with individuals with personality disorder. This will require:
   - A change of culture
   - The development of a competency framework for practice
   - The development and use of robust risk management procedures

Specific training programmes should be created for the pilots recommended above (13 and 26) and at the State Hospital (18-21). The training programmes should subsequently be rolled out to all forensic mental health settings in Scotland.

31. All individuals acting as key workers or carrying out interventions with people who have a personality disorder should receive 1 hour of clinical supervision per week, from a suitably experienced professional.

Specific Considerations

32. The Forensic Network should ask the chairs and nominated members of the working groups on women and learning disability to consider the particular issue of personality disorder for their respective cohorts in light of the recommendations contained in this report.

Resources

33. The development of services for the assessment and management of individuals with forensic personality disorder will require resources. The various recommendations, if accepted, will require implementation plans including detailed financial plans.

Prevention

34. Adult forensic mental health services should make their expertise in the causation, assessment and management of personality disorder readily available to child and adolescent psychiatric services, social services and youth criminal justice services, to assist in the development of programmes designed to prevent the development of antisocial personality disorder.
35. The Forensic Network should, in conjunction with appropriate child and adolescent psychiatric services, develop forensic child and adolescent forensic mental health services.
INTRODUCTION
The Serious Offender Liaison Service (SOLS) was established in October 2012 to provide clinical consultation, assessment and management advice to help criminal justice agencies manage complex and/or high risk violent and sexual offenders in the community. This service developed from its predecessor, the NHS Lothian Sex Offender Liaison Service (also shortened to SOLS), which was established in 2007, with funding from NHS Lothian, when Multi-Agency Public Protection Arrangements (MAPPA) was introduced. The aim is to provide clinical support to multi-agency partners.

The primary remit of the service is to provide clinical input for violent and sex offenders who have personality disorders and/or sexual deviations managed by criminal justice social work or the police. We also take referrals from other agencies. We provide consultation, assessment and management advice. We do not provide psychological treatment or case management. We aim to reduce risk and improve risk management through helping frontline staff to implement psychologically informed interventions and management strategies.

The extension of the service from sexual to violent offenders occurred through additional funding from the Scottish Government in recognition of the success of the SOLS model for joining up clinical and criminal justice agencies in working with personality disordered offenders. The service is funded for two years, during which it will be evaluated as a potential model for the development of similar services throughout Scotland.

The service is funded by NHS Lothian and the Scottish Government (Mental Health and Criminal Justice Divisions). The service is provided by NHS Lothian (Forensic Mental Health Service) and the City of Edinburgh Council (Criminal Justice Services). It provides a service for the Lothian and Borders Community Justice Authority Area. The service is in partnership with and collaborates with the following agencies and services: East Lothian Council, Mid Lothian Council, West
LEVELS OF INPUT
We provide the following levels of input:

1. We attend level 2 and level 3 MAPPA meetings where we provide clinical advice.
2. We are happy to provide telephone advice and consultation.
3. We have established regular meetings with multi-agency partners (specifically police offender management units and criminal justice social work services).
4. For any case referred we provide a 1-2 hour detailed case discussion meeting with referring agencies.
5. Where necessary we will undertake a comprehensive structured clinical assessment of the offender.

REFERRALS
Who should be referred?
Our focus is on violent and sexual offenders with personality disorders and/or sexual deviations. We realise it is difficult for professionals from a non-clinical background to apply such labels, so if a case is unusual, complex, concerning or high risk, we encourage an initial discussion with us.

We will consider individuals where there appears to be a risk of serious physical and/or psychological harm to others through sexual abuse, non-sexual violence, stalking, domestic violence or fire-raising. We envisage that in most cases individuals will have convictions for these offences, but we will provide input if individuals have not been convicted where there are concerns about such risks.

There are established mental health services for the assessment and treatment of offenders with mental illnesses and learning disabilities, so we do not provide a service for such cases. Having said that, if there is doubt about diagnosis, the most appropriate service, or mental health services want consultation on sexual or violence risk, then we will discuss cases, point cases towards the most appropriate mental health service and, in complex or unusual cases, we will undertake assessments.

If a case is already involved with a specialist criminal justice service (such as the Community Intervention Service for Sex Offenders (CISSO) or the Caledonian Team), then those services must be consulted before a referral to SOLS. If a case is already in contact with mental health services, then the clinician(s) already involved should be consulted before making a referral.

How should referrals be made?
Any potential referral should be discussed with SOLS staff first. This could be at a MAPPA meeting, at another multi-agency meeting, over the telephone, or by email. If the referral seems appropriate, then we will ask for a written referral via email or through the post. We do not need long detailed referral letters, but it is useful to get copies of relevant documents (e.g. sentencing reports, reports on offences, risk assessments). We do not want to create a lot of work for referrers, so we are just looking for documents which are readily available.

What will happen after a referral is made?
Within 1 or 2 months we will arrange a detailed case discussion meeting. The referrer and other professionals involved will be invited to meet with us for 1 to 2
hours. We will provide consultation and advice on understanding offending behaviour, clinical issues, risk assessment and risk management. At this meeting a decision will be made as to whether a full clinical assessment is required or not. The detailed case discussion meetings will usually be arranged at the Orchard Clinic, but in some cases these discussions may take place elsewhere, for example during our regular meetings with criminal justice social work and police teams. After the case discussion meeting we will produce a report, unless we are going to undertake a full assessment.

**What geographical area is covered?**
We will take referrals from anywhere within the Lothian and Borders Community Justice Authority (CJA) area.

**Will legal reports be undertaken?**
We can produce psychological and/or psychiatric reports, for example in relation to Sexual Offences Prevention Order (SOPO) applications, criminal proceedings and child protection proceedings. But, as with any other legal reports prepared by the forensic mental health service, there will be a fee charged for such work. We cannot prioritise cases based on short legal timescales, as our primary remit is to help criminal justice agencies to manage concerning high risk offenders in the community.

**Will you take referrals from out with Lothian and Borders?**
We will take referrals from out with Lothian and Borders, but as with any out of area forensic referral, there will be a charge for these assessments.

**ASSESSMENTS**
If a full assessment is required this will be undertaken by two clinicians and will involve interviews with the offender, a review of records held by all agencies and perhaps interviews with third parties. These comprehensive assessments aim to provide a detailed structured assessment, based on the structured professional judgement approach to risk assessment and risk management planning. This will involve the use of appropriate instruments to assess personality, sexual and/or violent behaviour and risk. The approach we take is similar to that recommended by the RMA for complex/high risk cases, and the assessments and management advice we give will be in accordance with the principles and standards set out in the RMA’s Frame Work for Risk Assessment, Management and Evaluation (FRAME).

Assessments will take no more than 3 months to complete (from the date of the first interview with the individual), given the amount of work involved (usually 30 – 50 hours for a case). We will produce a report, and will feed back the assessment to the referrer verbally. We are also happy to discuss our assessments at Risk Management Case Conferences (RMCCs), MAPPA meetings, or similar meetings. We will usually feedback the assessment to the individual and provide them with a copy of the report. If there are concerns about third-party information or the risk of doing this, then this may be done differently on a case-by-case basis. After completing an assessment we are happy to provide ongoing consultation and advice, and we may re-assess cases if this is felt to be necessary.

Given the number of referrals we receive and the resources we have there is a waiting list for assessments. We will prioritise cases based on the apparent imminent risk of serious harm. Cases where there is a history of very serious offending will be given the highest priority. We will always give referrers an indication of when an assessment will commence. For offenders being released
from prison to the community, referral at a very early stage will allow us to assess the case before release, so we can help with the development of the community risk management plan.

**MULTI-AGENCY WORKING**
The primary goal of the service is to provide clinical input and expertise to help multi-agency partners to manage difficult cases. Therefore we are committed to working in partnership with other agencies, particularly criminal justice social work and the police. To facilitate this we provide direct input to MAPPA level 2 and 3 meetings, and will meet regularly with criminal justice social work and police teams who manage high risk violent and sexual offenders.

**TRAINING**
The main aim of SOLS is to support staff in their work with difficult/challenging offenders, so the service provides a range of training, covering areas including:

- Working with personality disordered offenders
- Using Structured Professional Judgement approaches to assess and manage risk (e.g., HCR-20, SARA, SAM, RSVP)
- Using case formulation and scenario planning to inform risk management

Our training program will be planned in collaboration with multi-agency partners.

**CLINICAL SUPERVISION**
Offenders with personality disorders: can be difficult for staff to understand; cannot be assessed fully with the standard tools used by criminal justice agencies; often do not respond to standard criminal justice interventions; can be difficult to work with; and, can cause burnout, psychological distress and boundary violations for staff. A psychological understanding of the case (also known as a formulation) and time to reflect on cases (including staff reactions) can help to address these difficulties.

The service will provide clinical supervision to front line staff through:

- Regular meetings with criminal justice social work and police teams in Lothian and Borders
- Time for reflective discussion of cases referred

**TREATMENT**
The aim of SOLS is not to provide direct psychological treatment to offenders but to support criminal justice staff to use psychologically informed approaches in their interventions.

If medication to address sexual preoccupation, high sex drive or sexual deviation is indicated in a particular case, then this will be prescribed on a voluntary basis and out-patient follow-up will be provided by the team psychiatrist.

**RESEARCH & EVALUATION**
SOLS is being evaluated as a potential model for similar services elsewhere in Scotland. It is a requirement of the funding we have received that we evaluate the service over the next two years. Therefore for all referrals we will require referrers to complete a brief one page evaluation form immediately after they receive an assessment report and 6-12 months after the assessment. These forms will only take a couple of minutes to complete.
The service has also received funding to undertake research on sexual and violent offenders. We may therefore contact staff from other agencies for information about the outcome of cases.
Appendix 10C
Improving the care, treatment and support of women with personality disorders in Edinburgh and Cornton Vale Prisons

1. Introduction
This paper sets out a proposal for a two year pilot programme which will improve the care, treatment and support of women with personality disorders in Edinburgh and Cornton Vale Prisons.

2. Adhering to international developments and good practice

2.1 The WHO Health in Prisons Programme (HIPP) has argued that the health of women in prisons is an area which requires careful consideration. Most women are imprisoned for non-violent offences such as property or drug-related offences. Many women in prison are mothers, with the separation from their families providing unique stresses on the woman herself and disruption to the current and future stability of the family home for her children. Data from across the HIPP suggests that women in prison:
- have higher rates of identifiable mental illness than male prisoners, with as many as 4 in 5 women being affected;
- have a 3 in 4 likelihood of entering prison with problematic drug and alcohol use and are more likely to inject drugs than male prisoners
- are more likely to self-harm and attempt/complete suicide than male prisoners
- are three times more likely than male prisoners to report having experienced physical or sexual abuse prior to their imprisonment.

2.2 The Scottish Government Commission on Women Offenders reported in April 2012, setting out 37 recommendations covering alternatives to prosecution and remand, prison, community reintegration, leadership, structures and delivery. The Cabinet Secretary for Justice accepted 33 of these 37 recommendations within the June 2012 response.

2.3 The Commission highlighted that many women in the criminal justice system are frequent reoffenders with complex needs related to their social circumstances, previous histories of abuse and mental health and addiction problems. For women with repeated lower level offence convictions, their offending is often linked to significant underlying issues, e.g. drug or alcohol addiction and mental health problems, that could be better addressed in the community than through incarceration.

2.4 A higher proportion of women than men become prisoners on remand (25% versus 18%). Around 30% of women on remand (either pre-trial or post-custody) go on to receive a custodial sentence. Remand prisoners experience the same increased risk of suicide and mental distress, disintegration of social supports and family ties, and disruption to employment as prisoners serving short sentences.

2.5 The Commission reiterated the strong evidence base which supports the view that a distinct approach should be taken with women offenders, which is compliant with domestic and international law and obligations.

2.6 Research suggests that key factors play different and distinct roles in the risk and needs analysis for women who are at risk of offending, have offended or reoffended:
- Mental Health and self-injury
• Dysfunctional family relationships, in particular family or marital conflict and poor parent child attachment, especially for young people
• Poverty, deprivation and debt.
• Immediate needs, such as accommodation, childcare and welfare benefits, need to be addressed before women are ready to address longer-term needs
• Women are more likely than men to lose their housing while in custody and then be homeless on release.
• The role played by criminal peers and partners. Many women may be controlled by drug using and abusive partners.
• Drug abuse is more strongly related to reoffending than alcohol abuse

2.7 International evidence suggests that the following factors are of critical importance:
• Trauma informed practice
• Prevalence of mental health problems
• Effective interventions around thinking to challenge antisocial attitudes in women
• Empathetic practitioners who develop good relationships with women offenders and provide practical and emotional support
• A focus on motivation and providing women offenders with the confidence and skills to change.
• Holistic interventions rather than stand-alone interventions.
• Basic services need to be addressed before they will be ready to deal with longer-term needs such as education or employment
• Mentoring as part of a package of interventions
• Residential drug treatments, if delivered alongside other programmes aimed at improving healthcare, child care and mental health issues.
• Interventions for women prisoners to forge and sustain positive and emotional bonds with their families e.g. improving parenting skills can reduce substance misuse
• The provision of alternatives for court disposals to take a sentence’s impact on any children into account

2.8 The Commission recommended that:
• Gender specific training is provided to all professionals working with women prisoners.
• Community reintegration support is available for all women offenders, during and after their custodial sentence is completed, irrespective of the local authority they are from.
• Mental health services and approaches should be developed in such a way that facilitates women with borderline personality disorder to access them.
• Mental health programmes and interventions for short-term prisoners are designed so that they can continue to be delivered in a seamless way in the community.
• An urgent review of the provision and resourcing of services for women with borderline personality disorder and post-traumatic stress disorder (in relation to previous abuse and neglect) should be carried out.
• Mental health training for police, prison officers, criminal justice social workers and third sector must be widely available, with ongoing supervision.
2.9 Scotland’s recently published National Mental Health Strategy (2011) has committed to improve the mental health of offenders, with a particular focus on interventions likely to reduce offending.

2.10 Locally in Lothian the new Re:D Collaborative which brings stakeholders and partners together to improve outcomes for people with multiple and complex needs has developed an ambitious implementation plan on best practice and evidence of what works. The Mental Health Division at the Scottish Government has committed funding to Re:D to concept test an enhanced psychological interventions programme (including mentalisation and interpersonal therapy) provision for women who with multiple and complex needs who have been imprisoned.

3. Care and Treatment Model

3.1 Improving the therapeutic milieu

As the ‘readiness to change’ literature makes clear, the impact of interventions on offenders is influenced by the context within which they are delivered. The attitudes and behaviours of women with personality disorder in prison settings can arouse powerful feelings which impact on client engagement and staff morale and effectiveness. It is important for staff to avoid being drawn into collusive or abusive “enactments” with clients and to be aware of the ways in which the clients’ psychopathology can be enacted within the whole team. Supervision and reflective practice, for both individuals and teams, are essential to deal with this.

Traditional In-Reach psychiatric services are not ideally suited to the management of these individuals. Medication has only a limited role in their management and a more holistic assessment and care plan is required.

It is proposed that additional capacity for women who have behaviour which is challenging to prison and healthcare staff within the prison setting in custody is introduced. This would involve the introduction of an Assessment and Consultation Model which is currently being used successfully by the Serious Offender Liaison Service in Edinburgh.

Referrals would be made to the service through the prison’s multi-professional healthcare team (MDMHT). Managing referrals through the Team will ensure that all parties currently involved in the prisoner’s care and management would be informed of the referral decision and able to contribute to that process. In most institutions the MDMHT is chaired by the Deputy Governor and attendance includes a forensic psychiatrist. This would provide senior oversight into the process. We would ask the MDMHT to assemble the relevant prison/criminal justice social work documents to be used in the assessment process.

3.2 Assessment

Assessment of these personality disordered offenders will be robust and comprehensive but also completed in a timely manner. It should include relevant sections on the individual’s background, psychiatric history, and offending history. It will also include a detailed assessment of personality. Ratified instruments including the IPDE and PCL-r will be completed. Risk assessment tools will be used including an actuarial baseline (risk matrix 2000) and an appropriate

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structured clinical risk assessment tools (HCR-20, RSVP, SARA etc depending on offence and behaviour). Key to this is a psychological formulation of the prisoner’s behaviour.

The assessment process will result in a report which is provided back to the Prisons; multi-professional healthcare team. This should include a comprehensive document which can be included in the prisoners’ casefiles, and a shorter document which can be provided directly to prison officers.

3.3 Feedback/Supervision
Working directly with prison officers will form an important part of this proposed service. The purpose of this is to help work through some of the issues highlighted in the reports, and to help in the composition of psychologically guided management plans. Insight plans will be constructed with the prisoner’s personal officer, and feedback given to the appropriate senior prison management.

3.4 This Assessment and Consultation Model would enhance the re:Dinitiative which is focused on improving psychological support using relational models such as mentalisation and interpersonal therapy for women in prison and community settings.

The recent review of evidence stated that cognitive behavioural programmes can lead to modest reductions in reoffending especially when they are rigorously implemented and combine with support in solving practical problems.³ In Scotland no outcome evaluations of accredited programmes have been conducted as yet but process evaluations have highlighted similar problems to England – high attrition rates, long waiting lists, lack of booster work prior to release and ineffective targeting, A recent UK review of offender supervision highlighted that accredited programmes cannot operate effectively in isolation, without addressing the broader context in which offending takes place and the multiplicity of offenders needs.

There are criticisms of CBT Programmes which ignore the contextual factors such as friends and families, do not focus on strengths and do not recognise women’s pathways in to crime.⁴ Interventions that help offenders develop prosocial social networks have significantly higher chances of success in reducing reoffending. Rebuilding ties with families, friends and the wider community and developing new prosocial relationships through work or marriage are important aspects of desisting from crime.⁵ People who offend are more likely to desist from offending if they have an improved sense of agency, self efficacy and good problem solving skills.

Given the criticisms as highlighted above, regarding rigid reliance on one model of psychological intervention, which clearly has limitations, Cognitive Behavioural Therapy, we are keen to include other theoretical models that specifically target:

- Contextual factors of criminal behaviours, such as friends and families
- Recognition of women’s pathways into crime, as being within an interpersonal context.

³ What works to reducing offending, 2012
⁴ Kendall, 2002 cited in What works to reducing offending, 2012
⁵ Marona, 2012 cited in What works to reducing offending, 2012
Two year funding has been allocated by the Scottish Government’s Mental Health Division to provide a fulltime clinical psychologist, research assistant and sessional input from psychodynamic psychotherapy concept test:

- The use of Individual Interpersonal Psychological Therapy (IPT: Weismman et al, 1984) with women on an **individual basis** specifically to target those who may present with an undiagnosed and unrecognized Post Traumatic Stress Disorder. IPT will target rebuilding ties with families, friends and the wider community and develop new prosocial relationships through work or marriage which are important aspects of desisting from crime. 6[1]

- Group based approaches aimed specifically at those who work with women imprisoned using Mentalisation which will raise the awareness and psychological mindedness of staff and compliment the individual approach of using IPT. It is acknowledged that staff have been trained in HMP Cornton Vale and have already received 'mentalisation' training. Our proposal is to build on and extend that training, expertise and psychological mindedness.

4. **Resources**

4.1 The enhanced service would comprise:

<table>
<thead>
<tr>
<th>Post</th>
<th>WTE</th>
<th>Cost inc oncosts</th>
<th>Funding Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>1.00 WTE</td>
<td>62,327</td>
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<tr>
<td><strong>Consultant Forensic Psychiatrist</strong></td>
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<td>Requested</td>
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<td>Forensic Psychologist</td>
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<td></td>
<td>Funded by Scottish Prison service</td>
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<tr>
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<td>Nurse Therapist</td>
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<tr>
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<td>8,301</td>
<td>Core NHS Lothian Funding</td>
</tr>
</tbody>
</table>

4.2 The total amount requested to support this enhanced service is £105,345 p.a for a two year period.
5. **Outcomes**

5.1 Work is underway in Lothian and Borders to create a hub and spoke model for women at risk of offending, who have offended or are at risk of reoffending due to their multiple and complex needs. The work of the hub and the associated spokes will be based on empirical evidence of effectiveness and on the need to address the specific and distinct needs of women; it will include three key components:

<table>
<thead>
<tr>
<th>Enabling / Early Intervention Services to prevent women being drawn into the Criminal Justice System</th>
<th>Prompt interventions on entering the Criminal Justice System</th>
<th>Acute interventions through enhancing comprehensive planned programmes, facilitating access and providing a central hub for delivery of specialist interventions in prisons and in-reaching to prisons and other settings where vulnerable women may be.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing harm before it occurs, equipping women to deal with setbacks and seize opportunities</td>
<td>Detecting and responding to early signs of difficulty, forestalling problems which could lead to more serious consequences. Can happen before or after a problem has begun to occur, but before it has become extremely serious,</td>
<td>Reducing the impact of an already-occurring strongly negative situation</td>
</tr>
<tr>
<td>Working well away from the cliff edge</td>
<td>Working on just over the edge of the cliff</td>
<td>Working far down the bottom of the cliff</td>
</tr>
</tbody>
</table>
5.2 This proposal relates in particular to acute interventions

5.3 The developing Logic Model

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes (based on the national 9 Offender Outcomes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate funding</td>
<td>Group work towards understanding and dealing with offending behaviour</td>
<td>Women offenders to attend programmes at the Hub and spoke services</td>
<td>Women able to rebuild their lives in a fulfilling and, law-abiding way</td>
</tr>
<tr>
<td>Committed and trained staff</td>
<td>Development of personal plan for each woman to address her particular needs &amp; circumstances</td>
<td>Achievement of goals and targets in women’s personal plans</td>
<td>Increased confidence and self esteem</td>
</tr>
<tr>
<td>Woman-centred approach</td>
<td>Access to drug and alcohol detox facilities &amp; programmes (abstinence; maintenance) One to one interpersonal therapy</td>
<td>Women completing drug or alcohol detox / abstinence programmes Women completing therapy Women completing trauma skills programme</td>
<td>Healthy relationships with others (including children, partners, family members, friends and peers)</td>
</tr>
<tr>
<td>Appropriate premises</td>
<td>Women centred Crèche facilities</td>
<td>Women attending scheduled programmes, activities and drop in</td>
<td>Women accessing and sustaining community support</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Relationships between statutory and 3rd sector partners – housing, welfare, health, communities</td>
<td>Support to access primary health care</td>
<td>Women accessing the mainstream services they need</td>
<td>Sustained or improved physical, mental and emotional health Women able to deal with financial debt issues/ legal issues Women sustaining own tenancies / own homes</td>
</tr>
<tr>
<td>Capacity building with local community resources</td>
<td>Employment and education programme Programme of community activities</td>
<td>Women participating in community projects and events</td>
<td>Women able to make decisions and plans about education, training and employment opportunities</td>
</tr>
<tr>
<td>Social and cultural capacity building</td>
<td>Meaningful activities to develop individual and social skills</td>
<td>Women participating in education and employment opportunities (paid and unpaid)</td>
<td>Women accessing and sustaining community support</td>
</tr>
</tbody>
</table>
5.3 A set of specific indicators would be developed for this programme. The Re:D Research Manager would lead the audit and research programme, supervised by senior clinicians and programme lead, supported by the assistant psychologist.

6. **Knowledge Transfer**

6.1 There is a commitment to ensure that early learning is shared with colleagues across Scotland working in the arenas of Criminal Justice, Mental Health, and Substance Misuse and more generally with colleagues focused on early intervention programmes and health inequalities. This may be through seminars, workshops or web based learning. There will be a particular focus on ensuring we are actively engaging with the Judiciary, this may be through teaching sessions or workshop based activities.

6.2 A Re:D interactive web hub is currently in development. This will be used to foster a wider community of practice and interest and provide links to related research and initiatives.

The *Kyiv Declaration on Women’s Health in Prison* was finalised in 2009 (UNODC & WHO 2009) and sets out key principles in relation to the health needs and treatment of female prisoners, including:

- As women in prison are frequently victims of physical and sexual abuse, prison authorities and custodial staff should promote their dignity and safety and protect women in prison from bullying and abuse of any type. Male custodial officers should not be responsible for the direct supervision of women. They should never have routine physical contact with them, or have access to living and bathroom areas.
- The prison environment does not always take into account the specific needs of women, including the need for adequate nutrition, health and exercise for pregnant women. There are also greater hygiene requirements due to menstruation such as the availability of regular showers and sanitary items that are free of charge and may be disposed of properly.
- Gender-sensitive training and training on the specific health needs of women in prison should be widely available in all systems.
The provision of an effective system of prison inspection and oversight carried out by an independent body and with a confidential complaint system is essential.

Continuity of care (throughcare) upon release is of utmost importance and should be the collective responsibility of prison staff, health care staff and social-care authorities in the community.

Health service provision and programming should specifically address mental illness, in particular, substance use disorders and post-traumatic stress disorder;

Health service provision in prison must recognise women’s gender-specific health care needs and should be individualised, framed and delivered in a holistic and humane manner; and key services to be provided should include:

- comprehensive and detailed screening when first admitted to prison and regularly throughout their stay; this should cover socioeconomic and educational background, health and trauma histories, current health status and an assessment of skills held or required;
- an individualised care, treatment and development plan, to be prepared jointly between different health care providers and all other staff likely to be involved in care and custody and in consultation with the women themselves;

Primary health care services provided in the prison, which are outlined during the induction period, including her rights to access, confidentiality, privacy and to health information and promotion activities. These should be made clear, preferably by means of an easily understandable written pamphlet.

Specialist health care, which is readily provided and adjusted to meet individual needs such as for mental health (including help with legacies of abuse and post-traumatic stress disorder), chronic health conditions, HIV and AIDS (including counselling and support), hepatitis, tuberculosis and other infectious diseases; drug and alcohol dependence; learning disabilities; and reproductive health, with access to specialist health care being explained to the woman in prison when discussing her individual care plan;

Violence and abuse within the prison; pre-release preparations that are adequately planned and provided in order to ensure continuity of care and access to health and other services after release.

Health and social care cannot be provided in isolation from community services; just as health and nursing staff must maintain professional contacts with their peer groups, so must all services within prisons have good links to the equivalent services in the community.
APPENDIX 11

Expected Competencies of Psychiatrists working in Prison

1. Medical Degree
2. Member of the Royal College of Psychiatrists
3. Fully registered with GMC
4. Certificate of completion of training in Forensic Psychiatry or another branch of Psychiatry with training in the appropriate competencies (see below).
5. Appointment as a Consultant Psychiatrist
6. Alternatively a Psychiatrist in training under the supervision of the Consultant Psychiatrists within the Prison setting.
7. Experience and training in the following (competencies):
   - Working in prisons and with prisoners
   - Working in low, medium and high security facilities
   - Community management of forensic patients
   - Criminal Courts
   - Court Diversion Schemes
   - Mental Health Tribunals
   - Preparation of reports
     - Parole Boards Reports
     - Court Reports
   - Care Programme Approach
   - Multi Agency Public Protection Arrangements
   - Mental health legislation, in particular regarding transfer of mentally disordered offenders to Hospital.
   - Assessment of risk of self harm and familiarity with Act to Care system
   - Assessment and management of risk of harm to others
   - Understanding of Prison Case Management System
   - Understanding of prescribing issues within prison
   - Knowledge of the voluntary sector working with prisoners
APPENDIX 12

SURVEY: SAFETY OF PSYCHIATRISTS IN PRISON

1. Which prison(s) do you work in, how frequently do you work there & how long (approx) have you worked there?

<table>
<thead>
<tr>
<th>Prison</th>
<th>Frequency</th>
<th>How long have you worked there</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

2. Where do you interview prisoners as part of your clinic & do you always use the same room?

<table>
<thead>
<tr>
<th>Interview location</th>
<th>Always use this location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Do you interview prisoners alone or is it usual practice (yours or the prison's) to have a RMN or prison officer present?

<table>
<thead>
<tr>
<th>Alone</th>
<th>Always RMN</th>
<th>Always prison officer</th>
<th>Sometimes RMN</th>
<th>Sometimes prison officer</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Are you given a personal / pin-point alarm before interviews with prisoners?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Are there wall-mounted alarm buttons in the interview room(s) you use & are they located conveniently?

<table>
<thead>
<tr>
<th>No alarm buttons</th>
<th>Alarm buttons present and conveniently located</th>
<th>Alarm buttons present but NOT conveniently located: please describe location in relation to your seat in the room</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. How frequently do you find that you’re interviewing prisoners without access to an alarm (either personal / pin-points / not within touching distance of a wall-mounted alarm)?

<table>
<thead>
<tr>
<th>Always</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Are you satisfied that the safety measures currently available in the prison(s) you work in are sufficient to maintain your personal safety during interviews with prisoners?

<table>
<thead>
<tr>
<th>Yes – safety measures adequate</th>
<th>No – safety measures not adequate</th>
</tr>
</thead>
</table>
8. Do you have any thoughts on how the safety of psychiatrists could be improved upon in the context of prison clinics?

9. Have you been in dialogue with prison authorities in your area on this issue & if yes, have you found them responsive to concerns raised and receptive to any suggested improvements?

<table>
<thead>
<tr>
<th>Yes - have been in dialogue and they have been responsive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - have been in dialogue but they have not been responsive</td>
</tr>
<tr>
<td>No - have not been in dialogue</td>
</tr>
<tr>
<td>Please elaborate if required</td>
</tr>
</tbody>
</table>

10. Any other comments?