

Prison psychiatry: adult prisons in England and Wales

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Executive summary and recommendations

A joint Department of Health and Home Office Working Party on 'The Future Organisation of Prison Healthcare' in 1999 produced recommendations for a radical overhaul of prison healthcare. Those recommendations were accepted, leading to a responsibility for the provision of healthcare in prisons moving from the Home Office to the Department of Health; this transfer was completed in April 2006.

This report concerns itself with the development of psychiatric services in prisons in England and Wales. It is hoped that the guidance will be of relevance to other jurisdictions. The report concerns adult prisons and is therefore not applicable to younger people in prison establishments for those under the age twenty one. It concentrates on generic services in prisons and does not generate recommendations on the needs of prisoners with special needs, nor the particular needs of women or people from Black or minority ethnic groups with mental health problems in prison. The report makes 26 recommendations to improve mental healthcare in prisons.

PSYCHIATRIC MORBIDITY IN PRISONS AND THE WORKING ENVIRONMENT

Prison healthcare is provided within a larger institution that is primarily centred upon security and control, and resources are likely to be limited both in quantity and diversity. The epidemiology of mental disorder and the nature of the prison environment result in a challenging role for the psychiatrist in prison. The distribution and prevalence of mental disorder in prisons differs substantially from the general population. Prisoners with mental disorders are significantly overrepresented in the prison population, and these individuals commonly have a diagnosis in more than one category. Substance misuse is a particularly significant problem for prisoners.

The main body of the report provides a review of the psychiatric and social exclusion problems of women in prisons, prisoners of Black or minority ethnic origin, those with learning disability and older prisoners.

PSYCHIATRIC PRACTICE IN PRISONS

We endorse the Department of Health Policy on mental health services, which in essence states that services should be provided as in the community and in line with national policy. We recognise that the practice of psychiatry in prisons will require specific competencies to a greater

extent than might be the case for other consultant roles in multidisciplinary teams. Those specific competencies involve 'jail craft' (an understanding of work within enclosed secure institutions), working in the interface with the Criminal Justice System and understanding diversity issues in the provision of care and competencies in the management of substance misuse. We make recommendations for consultant appointments and suggest norms for consultant roles and responsibilities in prison mental healthcare.

COMMISSIONING MENTAL HEALTH SERVICES IN PRISONS

In commissioning mental health services in prison, we recommend that the model to be used should be that applicable to general adult psychiatry. In general, in most prisons, we would expect initial assessments to be carried out through generic multidisciplinary teams (drawn from general adult and forensic expertise) and referrals made to more specialist services, as would be the case in a general adult team in the community. We believe effective prison mental healthcare is most likely to be achieved through service agreements between primary care trusts (PCTs) and large mental health trusts. Within such a contract, psychiatric specialties would be expected to provide specialist consultation services as they would for any other part of the trust. A particular issue was identified in the operation of in-patient healthcare centres in prisons. We have made recommendations to tackle this problem.

SPECIALIST PSYCHIATRIC SERVICES IN PRISON

A number of recent developments have made it important that addiction specialists increase their input into prison healthcare. We conclude that the addiction services within prisons are far too complex and fragmentary and we recommend that various treatment services in prisons be drawn together into dedicated substance misuse teams.

Prisoners with borderline IQ may have particular difficulty in understanding or coping with demands of prison life and may have their coping abilities overwhelmed by the social and personal demands of living in a prison environment. We give recommendations for when to consider learning disability expertise, and when commissioning for mental health services that the particular needs of patients with learning disability are accounted for, ensuring that there are protocols for the assessment and treatment of these individuals. The needs of prisoners with pervasive development disorders are also considered here. Progression through the Criminal Justice System to release often depends on participation in prison-based programmes. We acknowledge the problems those with learning disability and borderline learning disability may have with such programmes and give recommendations to tackle this.

This report highlights important differences between male and female prison establishments and male and female prisoners, including differences in the epidemiology of mental disorder and particular issues around childcare and separation from children.

A brief overview of prisoners of Black and minority ethnic origin is included. The evidence is that individuals from Black and minority ethnic groups experience a different pathway through the Criminal Justice System compared to White defendants. The net result is their overrepresentation

within the prison population. Black and Asian prisoners are significantly less positive about healthcare than White prisoners. We recommend that future revision of this report or a separate report addresses the complex interaction between being a member of a Black or minority ethnic group, imprisonment and service provision.

A consequence of current trends towards longer prison sentences is that an increasing proportion of prisoners will be older. We consider the epidemiology of mental health disorder in older prisoners and the provision of training for those who are responsible for their care.

Within a group of long-term prisoners there will be those who continue to suffer from severe enduring mental illness. If they present a minimal management problem on a day-to-day basis they may not be judged a priority for transfer to hospital. However, as for patients with learning disability, individuals who have a severe enduring mental illness may be unable to engage in offence-related programmes leading to a disadvantage and perhaps a longer period in prison. Under the remit of rehabilitation psychiatry we consider the specialist needs of these prisoners with severe enduring mental illness who are not transferred to the NHS and make recommendations for their appropriate care.

PSYCHOTHERAPY PROVISION

This report recognises that prisons will be served by community mental health teams (CMHTs) operating largely as their counterparts in the community and providing the same access to psychological therapies. We list a number of roles for psychotherapeutic input to CMHTs in prisons and give recommendations to achieve these. Recognising the small size of prisons the expertise of NHS psychotherapeutic services might be best provided for at the level of a regional cluster of prisons with service provision varying between prisons depending on the nature of the population.

TRAINING

The main recommendation of this report in relation to the psychiatrist's role in prison multidisciplinary teams is that the consultant role should be based on a competency model rather than opting for recommendations on particular psychiatric specialties. Following on from this is that training for prison consultant roles should be competency based. The body of the report details the competencies that should be developed by psychiatrists undertaking a substantial role in prison psychiatry. Educational requirements for doctors providing mental health services in prison are discussed and recommendations for training are given.

RECOMMENDATIONS

ROLE OF THE CONSULTANT PSYCHIATRIST IN PRISON

1. We recommend that a good psychiatric practice guide be created specifically for psychiatric practice in prisons.
2. We recommend that a competency-based approach to the appointment of consultants in a prison setting be employed rather than opting for either general adult or forensic psychiatrists fulfilling those roles.

Depending on local circumstances, appropriate services might be drawn from either speciality. Where psychiatric sessions are provided to a large prison there may be merit in having sessions from both general and forensic practitioners. In dispersal prisons where prisoners are serving long sentences, forensic rehabilitation skills may be particularly useful.

3. We recommend that appointments to consultant posts in prison should follow the appointment procedure for other consultant appointments and therefore include a college assessor on the appointment panel.
4. We recommend the development and use of a College model job description for consultant appointments to prisons. That model job description should take account of the specific competencies for work in prisons set out in this report and address the particular competencies required of psychiatrists in respect of gender and ethnicity.
5. We recommend the adoption of our provisional norms for consultants working in prisons. We further recommend that the College and Prison Health Unit of the National Offender Management Service (NOMS) partnership jointly review indicative staffing for mental health teams in prisons and review norms for consultant sessions accordingly.

COMMISSIONING MENTAL HEALTH SERVICES IN PRISONS

6. We recommend that the commissioning model for adult psychiatric services be adopted for commissioning mental healthcare in prisons.
7. We recommend that services should be provided through generic multidisciplinary teams, including addiction specialist expertise in remand prisons, with clear pathways to access specialist services such as learning disability, old age psychiatry or psychotherapy. In our opinion it is likely that such comprehensive service provision will be best provided through large mental health trusts. Where services are primarily provided by consultant adult psychiatrists, we recommend that service agreements include specific access to tertiary forensic psychiatry. Commissioning plans that address need across a cluster of prisons have the potential to match need with the appropriate expertise within a trust.
8. We recommend that Royal College of Psychiatrist's reports CR96 and CR124 be reviewed and modified to provide prison specific guidance on the role and responsibilities of a consultant psychiatrist taking a leadership role within prison-based psychiatric services. That review should include consideration of the recommendations on 'New Ways of Working' for consultant psychiatrists (see Department of Health, 2005).
9. We recommend that the Royal College of Psychiatrists, Royal College of General Practitioners and the Prison Health Unit of the Department of Health review the operation of healthcare centres in prison providing in-patient care to include a review of the appropriate doctor to take responsibility for mental healthcare (whether general practice, secondary or tertiary psychiatry), service models for healthcare centres and appropriate staffing norms.

ADDICTION SERVICES IN PRISONS

10. We recommend that there should be sessional input from addiction specialists, who will establish protocols of care; advise in complex cases; initiate audit and research; provide an input into training; help develop drug strategy; and liaise with other professionals, for example forensic psychiatrists and hepatologists.
11. We recommend that dedicated substance misuse teams are established in prisons. These will provide care for prisoners throughout their residence, and will work closely with mental health in-reach teams and healthcare staff.
12. We recommend that teams should consist of addiction nurses and specially trained prison staff, with input from GPs and specialists in addictions as appropriate. They should link closely with CARAT and PASRO staff, or possibly merge with them and be responsible for detoxification; drug counselling; methadone maintenance and other pharmacological treatment; and for ensuring seamless throughcare.

LEARNING DISABILITY SERVICES IN PRISON

13. We recommend for screening and assessment purposes, that those with borderline learning disability (IQ=70–80) should have benefit of learning disability expertise, including, where appropriate, assessment from consultants in learning disability. We recognise that currently learning disability services are not resourced to provide this service and implementing this recommendation will require dedicated funding.
14. We recommend that the Grubin screening tool used at reception in prisons be modified to include screening questions to identify prisoners with a potential diagnosis of learning disability
15. We recommend that when commissioning for mental health services within prisons consideration is taken of the particular needs of patients with learning disability, ensuring that each prison had agreed access to learning disability specialists within a protocol for the assessment (and treatment) of those prisoners with learning disability. Where demand can justify it, prison based CMHTs could benefit from having a dedicated member of a learning disability service within the team.
16. We recommend that the Prison Service consider the particular needs of those with learning disability (including those with borderline disability) and adapt existing treatment programmes to the needs of those with mild and borderline learning disability. This may require concentrating expertise in particular prisons.

FEMALE PRISONERS

17. We recommend that either as a separate report or in the future revision of this report, that the particular needs of female prisoners be addressed with recommendations on service provision in female prisons.

OLD AGE PSYCHIATRY IN PRISONS

18. We recommend that the Old Age Faculty of the Royal College of Psychiatrists should consider the need for specialist training for old age psychiatrists in the special needs of old age prisoners with mental health problems

REHABILITATION PSYCHIATRY IN PRISON

19. We recommend that a needs assessment be carried out on the needs for specialist treatment, including specialist rehabilitation, for those prisoners with severe enduring mental illness who are not transferred to the NHS.
20. We recommend that a forensic rehabilitation model of care be considered for those prisoners (and the healthcare systems within prisons housing them) who are serving long term sentences.
21. We recommend that the Prison Service carry out an assessment of the special needs of those with severe mental disorder (including severe mental illness, personality disorders and other severe mental health problems) who are excluded from prison-based treatment programmes because of their disorder. This could be usefully combined with the similar recommendation above relating to those with learning disability (see recommendation 16).

PSYCHOTHERAPY SERVICES IN PRISON

22. We recommend that CMHTs in prison should have at least one senior psychotherapist (providing a minimum of three sessions) who organises psychological therapy of Type B and C and provides a broad range of consultation and co-ordinating roles for psychological therapies. The skills for such a role would need the training of a consultant psychotherapist in psychotherapy, consultant forensic psychotherapist or a senior adult psychotherapist.
23. We recommend that the Prison Service and NHS jointly plan, coordinate and assess through clinical governance, the quality of prison-based psychological therapy services, making best use of the expertise of both organisations. This may be best implemented at the level of regional clusters of prisons.
24. We recommend an assessment of need, based on national guidelines and priorities, for psychotherapeutic services in prisons, recognising that services provided will vary between prisons depending on the nature of their population.

TRAINING

25. We recommend that the majority of trainees in psychiatry should experience psychiatry provided in prison settings during their training. Training programmes should include guidance on minimum exposure to prison psychiatry tailored to the needs of the trainee and speciality.

26. We recommend that the workforce review team (Department of Health) training programme directors and College specialist advisory committees develop specialist training opportunities in prison in the light of the major changes in organisation and management of prison health care, the need to develop specific competencies to lead multidisciplinary teams in prisons and likely demand for psychiatrists competent to work in the area.

Introduction

This report is concerned with the development of psychiatric services in prisons in England and Wales. It is hoped that the guidance will be of relevance to other jurisdictions.

The guidance in this report concerns mental health provision in adult prisons and is therefore not applicable to younger people in prison establishments for those under the age of 21 years.

Prison health is the oldest publicly funded health service in the UK. When the National Health Service (NHS) was developed, prison health did not form part of the NHS but remained under the jurisdiction of the Home Office. Disquiet about standards of healthcare in prisons can be traced back to the earliest reports on prison welfare. Concern about healthcare in prisons was prominent during the 19th century and this continued through the 20th century with campaigns by the British Medical Journal and the Royal College of Psychiatrists to transfer healthcare from the Home Office to the NHS. Publications by the Health Advisory Committee for the Prison Service (1999) and the Chief Inspector of Prisons (Patient or Prisoner) (1996) led to a joint Department of Health and Home Office Working Party on 'The Future Organisation of Prison Health Care' (1999). The recommendations of that Committee were accepted by the government leading to joint responsibility for healthcare in prisons passing from the Home Office to joint responsibility between the Department of Health and the Home Office. Symbolically, the management base for prison healthcare moved from prison headquarters to the Department of Health at Wellington House. For the first time since the inauguration of the NHS, prison healthcare became part of mainstream NHS planning. In 2003, there was a further announcement by government that, following this partnership arrangement, responsibility for the provision of healthcare would move fully from the Home Office to the Department of Health during a transitional period from April 2003 to 2006; this transfer is now complete.

Guidance on the broad strategy for mental healthcare in prisons prepared by the Department of Health *Changing the Outlook* (Department of Health & HM Prison Service 2001a), endorsed the principle of equivalence placing service development within the framework of the National Service Framework for mental health. This guidance assumes that secondary mental healthcare in prisons will be provided by a multidisciplinary mental health care team with leadership by a qualified psychiatrist on the specialist register for psychiatry.

The Department of Health has issued detailed guidance on the training, role and career progression of doctors working in prisons in *Report of the Working Group on Doctors Working in Prisons* (Department of Health & HM Prison Service, 2001b). That report made a number of recommendations which have been accepted by the Department of Health.

- Healthcare should be delivered by multidisciplinary teams.
- Doctors in such teams should have appropriate qualifications for their work.
- Care should be provided as in the community by primary care teams, with specialist teams providing secondary care.
- Doctors in prison primary care teams should be eligible to be principals in NHS general practice.
- Psychiatrists should be on the specialist register for psychiatry.
- Prisons should cease employing visiting psychiatrists but instead enter into service level agreements with primary care or mental health trusts to provide secondary or tertiary healthcare.
- The Working Group recommended the development of a prison specific 'good medical practice' guide modelled on both the College of General Practitioners and the College of Psychiatrists Good Medical Practice guides.
- Competencies for prison healthcare should be drawn up and a check list of competences made available to help training and professional development, the appointment of doctors and appraisal of doctors in prison health.

A list of current policy guidance on prison healthcare can be found in the reference list (distinguished by asterisks). That policy guidance will not be summarised further in this report. Similarly a number of council reports from the Royal College of Psychiatrists are relevant to the work of psychiatrists in prison (some of which are listed in the reference list) but this report will not discuss them in detail.

LIMITATIONS OF THIS REPORT

This report is concerned with the development of psychiatric services in prisons in England and Wales. It is hoped that the guidance will be of relevance to other jurisdictions.

The guidance in this report concerns mental health provision in adult prisons and is therefore not applicable to younger people in prison establishments for those under the age of 21 years. It concentrates on generic services in prisons. Women represent only 6% of the average daily population in adult prisons and there are significant differences between the profile and needs of prisoners from Black and minority ethnic groups and other prisoners. The Working Group hopes that this is the first of a series of reports from the Royal College of Psychiatrists that will inform best practice in prison mental healthcare. If this is accepted, there will then be an opportunity to look in more detail at the specific needs of women in prison and people from Black and minority ethnic groups in prison. We have provided (above) a brief overview on the particular issues affecting these individuals. In this report we have endeavoured to ensure that all recommendations made would apply equally to all prisoners irregardless of gender or ethnicity.

We have not attempted to summarise the literature on prison healthcare in a systematic way as this was well beyond the capacity of the Working Group and not within its remit.

We have concentrated above on the limitations of this report in regard to gender and ethnicity. These limitations apply even more starkly to other groups with particular needs in prison. The Working Group were not aware of any specific work undertaken on the particular needs of prisoners who are gay or lesbian. The report does not address the needs of those with special needs such as prisoners with acquired brain injury.

We hope that this report is the first of a series of reports on prison mental health services. A number of recommendations made in this report may lead to future work on particular aspects of prison mental healthcare. In addition, the specific needs of women in prison and prisoners of Black and minority ethnic origin should be the focus of future College reports.

Psychiatric morbidity in prisons and the working environment

The prison environment is radically different from that which most psychiatrists are familiar with. Patients in prison are, by the very nature of prison, deprived of their liberty, autonomy and right to self-determination. There is no freedom to choose who to consult when health problems are experienced. Prisons can be bleak places to live in, with bullying, loneliness and fear a common feature of the prisoner's life. Loss of contact with family and children is particularly likely to impact on mental health. Although doctors may have limited control over health facilities in prisons, nevertheless the delivery of healthcare exists within a larger institution with a radically different philosophy and culture, being principally centred upon security and control. Resources are likely to be limited both in quantity and diversity.

The epidemiology of mental disorder and the nature of the prison environment result in the role of the psychiatrist in prison being a particularly challenging one.

PSYCHIATRIC MORBIDITY

The distribution and prevalence of mental disorder in prisons differs substantially from the general population. It is clear that prisoners with mental disorders are significantly overrepresented in the prison population. A single diagnosis is rare, with prisoners with disorders usually having a diagnosis in more than one category. The Office of National Statistics study (Singleton *et al*, 1997) found that 9 out of 10 prisoners met their criteria for at least one mental disorder, with no more than 2 out of 10 having only one disorder. Psychosis, personality disorder, anxiety/depressive disorders and drug/alcohol dependency are for instance grossly overrepresented in the prison population. About 140000 persons pass through English and Welsh prisons in any one year. As of 2003 there are approximately 72000 in prison and that figure is set to rise to 100000 by 2010. In an average male prison (for example Brixton with 800 prisoners) the ONS study (Singleton *et al*, 1997) would suggest that up to 720 prisoners will have mental health symptoms meeting a research definition for a mental disorder, including 48 with schizophrenia, 320 with a neurotic disorder, 272 dependent on drugs and 512 with personality disorder. Self-harm and completed suicide is present at a substantially higher level than in the general population.

The social characteristics of prisoners suggest a lifetime of social exclusion. Compared to the general population, prisoners are 13 times more likely to have been in care as a child, 13 times more likely to have been unemployed and 10 times more likely to have been a regular truant from school. In the general population 15% leave school with no qualifications but 52% of male prisoners and 71% of female prisoners leave school with

no qualifications, and 65% of prisoners are numerate at or below Level 1 (that of an 11-year-old) compared to 23% of the general population. There are 67% of prisoners who were unemployed before imprisonment and 32% who were homeless.

The overall pathway from commission of offence through arrest, conviction and sentence results in a population with multiple and complex disadvantages across a wide range of intellectual, social and personal domains.

SUBSTANCE MISUSE

Studies have consistently supported a very high misuse of drugs and alcohol among prisoners. About 50% of prisoners have used cocaine or heroin recently before imprisonment, the prevalence for each drug being about 30%; this can be compared with a prevalence of less than 1% in the general population outside prison. Over 60% of prisoners used cannabis and 40% used amphetamine, as opposed to about 10% and 2% respectively in the general population; 82% of those using heroin and 37% of those using crack cocaine were consuming it every day; 66% of those using heroin were also consuming crack cocaine.

If all illegal drugs are taken into account, 54% of prisoners were using at least one type of illegal drug daily before imprisonment, and about 50% give evidence of moderate or severe dependence. Severe dependence is found more frequently in women (Borrill *et al*, 2003).

About 25% of prisoners were injecting drugs, the large majority injecting heroin, but about 50% were injecting more than one drug.

There were 30% of prisoners who were using tranquillisers, about 10% on a daily basis. Over 80% of prisoners smoke nicotine before and during imprisonment. About 60% engaged previously in 'hazardous drinking', and about 30% had 'severe alcohol problems' (Bullock, 2003; Litiano & Ramsey, 2003).

Drug withdrawal on admission may be a causative factor for self-harm; 11% of suicides occur during the first 24 hours in prison, 33% in the first week and 47% in the first month; 62% of these are those with problematic drug misuse (HM Prison Service, 2001).

While in prison 54% of prisoners use cannabis, 27% heroin and 15% illicitly obtained tranquillisers. Use of other drugs is less common. Prisoners prefer depressant drugs because they 'relieve boredom' and 'block out the present situation' (Swann & James, 1998). However 7% still use cocaine, 3% on a daily basis (Singleton *et al*, 1999). Frequency of use for all drugs is much less than outside prison, although 14% of those using cannabis and 3% of those using heroin claim to use daily, and 30% and 36% respectively on a near-weekly basis. Only 2% of those misusing drugs admitted injecting in prison; 81% report a reduction in drug misuse while in prison, but 6% report an increase; 44% of those misusing drugs before imprisonment abstain while in prison; about 25% of those who reported ever having used heroin used it for the first time while in prison (Bullock, 2003).

During the first few months after release, drug misuse is slightly less prevalent than before imprisonment; 70% use cannabis, 28% heroin and about 20% cocaine and amphetamine. Drug misuse initially is generally less frequent than before imprisonment, but we do not have long-term data (Bullock, 2003). The risk of death during the first week after release is 40 times higher than expected in this population, usually as a result of opiate

overdose (Singleton *et al*, 1999). Prisoners using heroin before imprisonment and treated with methadone while in prison are less likely to die or come back into prison (Dolan *et al*, 2003).

LEARNING DISABILITY

It has proved difficult to estimate the number of prisoners in the UK who have a learning disability (or mental retardation as defined in the International Classification of Diseases). Research in the UK has found wide variations in the estimates on the prevalence of offenders with learning disability in prisons. In a recent review Judith McBrien (2003) concluded that it is not clear how many offenders have a learning disability and how many people with learning disability offend. Murphy *et al* (1995) surveyed 157 male prisoners in HM Prison Belmarsh and found that 33 of them reported that they had a learning disability or had attended special school; 21 of the 33 were tested using the Wechsler Adult Intelligence Scale-R (WAIS-R) but none of these were found to have an IQ of less than 70 (although 5 men in this group and 4 in a comparison group of 21 had an IQ of between 70 and 74). Brooke *et al* (1996) used a semi-structured interview and case note review of 651 male prisoners whose first language was English, and found, using Ammons' Quick Test, that 7 (0.8%) had a mild learning disability. Birmingham *et al* (1996) tested IQ using Ammons' Quick Test in 441 remand prisoners and found that 57 of them (13%) scored 70 or less, and they made an ICD-10 diagnosis of mental retardation in 6 of these (1%). The ONS survey (Singleton *et al* 1997) found that 11% of male remand prisoners had an IQ as measured with Ammons' Quick Test of 70 or less (25 or below on the Quick Test) and 5% of male sentenced prisoners. Little is known about the prevalence of learning disability in female prisoners in the UK.

FEMALE PRISONERS¹

Women commit much less crime than men do. The differences between male and female crime patterns are marked and relatively stable over time. In surveys of recorded crime in England and Wales, crime is overwhelmingly committed by males; in 1999, for example, the figure was 83% for male perpetrators of recorded crime. The type of offences committed by female prisoners differs from male prisoners. In March 2005, 35% of women were held for drug offences, and only 10% of adult women sentenced to prison are convicted of offences involving violence. The majority of women serve short sentences in comparison to male prisoners.

Reflecting the difference in crime rates, female prisoners represent a minority of all prisoners. In May 2005, the prison population stood at 76000, and 4496 of these were female prisoners, representing around 6% of the average daily population. Those from a minority ethnic background were overrepresented, with 29% of the female population being from a Black or other minority ethnic background, and 1 in 5 female prisoners are foreign nationals. Over the past decade there has been a steep increase in the prison population with an overall increase of 25% in 10 years. However, the

1. References are not provided for every figure in this section. For accurate data on female prisoners refer to the Prison Reform Trust's quarterly review of prison statistics (Prison Reform Trust, 2006). For an overview of gender and crime see Heidensohn, 2002 and the report *Troubled Inside* (Prison Reform Trust, 2003).

rise in the female population is particularly striking, with a doubling of the female population in prisons in the past decade. At magistrate's courts, the chances of a woman receiving a custodial sentence have risen 7-fold over the past decade.

An earlier section provided an overview of psychiatric morbidity in prisons. The general pattern holds true for female prisoners with some important differences:

- rates for most mental disorders for female prisoners are greater than for male prisoners
- for any personality disorder, the rate for male remand prisoners is 78% compared to 50% for female prisoners
- rates for neurotic symptoms for female prisoners are significantly higher than male prisoners and markedly elevated compared to a community sample. In the ONS study (Singleton et al, 1997), rates of drug misuse/dependence were similar for male and female prisoners. However, in more recent surveys by the Prison Service, the rate of drug dependence was particularly marked with two thirds of female prisoners reporting drug problems
- rates of self-harm differ between male and female prisoners. In 2003 30% of female prisoners had reported self-harm in prisons, compared to 6% of the male population.
- general indices of social exclusion are as marked for female as male prisoners. Female prisons may experience domestic violence and sexual abuse at a greater rate than male prisoners. Over half of women in prisons say that they have suffered domestic violence and one in three report experiences of sexual abuse.

In addition to the problems experienced by all prisoners, female prisoners experience particular problems in prison:

- more than half of all women in prison have a child under 16 years and over one third have a child under 5 years. Most recent statistics on the women's prison population found that 61% were either pregnant or mothers of children under 18 years. A recent survey estimated that 650 babies under the age of 2 years are separated from an imprisoned mother at any one time. There is evidence that women experience separation from family as particularly distressing. This is compounded by the relatively small number of female establishments, which means that female prisoners are often held a long distance from home, making it difficult for families, particularly children, to visit
- women tend to access medical services more frequently than men
- women's prisons are guided by the same rules as those for men and take no account of the special needs of women. A series of reports from various prison organisations, including the Chief Inspector of Prisons, has recommended that female establishments are managed separately and have prison regimes designed specifically to meet the needs of female prisoners
- there are currently 90 places located in 7 prisons for mother and babies. On reception into prison, women are advised if they have a baby or are expecting one, that a place on the mother and baby may be available if it is considered to be in the best interests of the child.

Birmingham *et al* (2004) have studied women in prison-based mother and baby units. The pathways into these units and psychiatric care around the time of childbirth merit further study.

PRISONERS FROM BLACK AND MINORITY ETHNIC GROUPS²

People from Black and ethnic minority groups are overrepresented within the prison population. The reasons for this are complex; any consideration of offending by people from minority ethnic groups must be embedded within a wider consideration of discrimination and exclusion within society, a task well beyond the remit of this Working Group. None the less certain conclusions regarding offending by those from ethnic minority groups can be highlighted.

- British crime survey data has found where no injury was inflicted (for example domestic robbery) victims were more likely to report crimes to the police where the offender was from a minority ethnic group. Conversely, victims were more likely to report crimes involving violence where the offender was White than when he or she was from a minority ethnic origin.
- The criminological literature contains much discussion on the 'over policing' of African–Caribbean people, including the differential use of stop and search operations and surveillance. The number of deaths in police custody has been disproportionately high for Black people compared to both the general and arrest populations. There is some indication that the number of deaths in police custody of individuals from minority ethnic groups has decreased significantly in recent years
- Official statistics show that the number of Black people arrested tends to be 4 times higher than would be expected from the numbers in the general population. This applies also, but to a lesser extent, for Asians. Once in custody, there is evidence that the police may use a less punitive method of dealing with White offenders.
- Once arrested, Black people are significantly more likely to be remanded in custody. Such evidence has documented higher rates of committal to the Crown Court for those from minority ethnic groups, particularly those of African–Caribbean origin. There is limited evidence that there is a small but significant bias in favour of Black people being sentenced to custody compared to their White counterparts. There is more limited evidence for Asian individuals, but once again the evidence suggests that sentence length may be greater for Asian individuals compared to those who are White.

Whatever the reasons are for the different pathways through the Criminal Justice System for defendants from Black and minority ethnic groups, the net result is their overrepresentation within the prison population. Certain findings stand out:

2. For accurate data on prisoners from Black and minority ethnic groups refer to the Prison Reform Trust's quarterly review of prison statistics (Prison Reform Trust, 2006). For an overview of race, crime and imprisonment see Phillips & Bowling (2002) and the report *Race and Prisons: Parallel Worlds* (Her Majesty's Inspectorate of Prisons, 2005).

- As of February 2003, 1 in 4 of the prison population were from a minority ethnic group, compared to 1 in 11 of the general population. In Feltham and Brixton Prisons prisoners from minority ethnic groups represent the majority of the prison population.
- Over the past decade, the prison population has risen by 50%. However, the minority ethnic prison population increased by 124% between 1993 and 2002; the rate of increase for Black prisoners was 185% and that for Asian prisoners 220%. Overall Black prisoners account for the largest number of minority ethnic prisoners. It is estimated that more African-Caribbean go to prison than to UK Universities.
- The imprisonment rate for Black people has been estimated as 1140 per 100 000 compared to 170 per 100 000 for the White population.
- Black and Asian prisoners are significantly less positive about healthcare than White prisoners. In focus groups, Black and Asian prisoners reported that healthcare providers did not recognise or provide for their specific needs. There is relatively little literature available on the particular healthcare needs of prisoners from Black and minority ethnic groups. This is an area that requires further study.
- There is a distinct lack of information relating to the mental health of prisoners from Black and minority ethnic groups. This is despite the prominence given to strategies for improving mental health services to those from Black and minority ethnic groups in the general population.
- Prisoners from Black and minority ethnic groups report that they felt discriminated against in terms of the prison regime such as allocation to jobs, being subjected to disciplinary systems, segregation, access to early release or home detention curfew and release on temporary licence. There was concern about the availability of food required by religious affiliation. In healthcare settings, choice of doctor, nurse or therapist is limited because of the size of the healthcare systems within relatively small populations. This means that prisoners from Black and minority ethnic groups have less access to choice than they might be able to exercise within the general population. There are obvious implications for the training of psychiatrists in prison health which will be addressed later in this report.

FOREIGN NATIONALS³

Foreign nationals (defined as those without a UK passport) are an important group within the prison population. All together around 12% of the average daily population in prisons are foreign nationals; 1 in 5 women in prison are foreign nationals. In 2004, foreign nationals came from 168 countries; 50% from just 6 countries, namely Jamaica, the Irish Republic, Nigeria, Pakistan, Turkey and India. Jamaicans represent 25% of foreign nationals. The majority of foreign national prisoners (4 out of 10 sentenced men and 8 out of 10 sentenced women) have committed drug offences, mainly drug

3. For data on foreign nationals refer to the Prison Reform Trust's quarterly review of prison statistics (Prison Reform Trust, 2006). For data on foreign nationals in prison and for an overview of the issues see the review *Foreign National Prisoners* (Her Majesty's Inspectorate of Prisons, 2006).

trafficking. There is no dedicated policy or strategy for foreign nationals within English and Welsh prisons. Relatively little is known about the particular health problems of individuals from Black and minority ethnic groups but this is even more so for foreign national prisoners. There is currently no specific mental health strategy or research programme targeted on the needs of foreign national prisoners. Such survey evidence as exists suggest that individuals of foreign nationality experience additional difficulties because of cultural and language barriers. The uncertainty surrounding emigration status is likely to have a significant impact upon the mental health of foreign nationals. Psychiatrists working in prison report uncertainty on how they should deal with foreign nationals, particularly where extradition is likely and where prisoners have mental health problems. Because foreign nationals are dispersed in small numbers throughout the prison service, there is little opportunity for healthcare workers to develop specific skills or experience in managing the particular needs of foreign nationals within prisons.

OLDER PRISONERS⁴

The number of sentenced older male prisoners has significantly increased in recent years. Prisoners aged over 60 years are in the fastest growing age group in prisons. The majority of men in prison aged 60 years and over have committed sex offences. The number and proportion of older prisoners serving long sentences has increased significantly. In 2001 80% of older prisoners were serving sentences of 4 years or more. There is evidence that courts are sentencing a greater number of men over 60 years old to prison. Between 1995 and 2000 the number of older males given custodial sentences increased by 55%. In 1995 fines accounted for the majority of sentences for men over 60 years, while in 2000 imprisonment accounted for the majority of sentences. According to the Prison Reform Trust (see <http://www.prisonreformtrust.org.uk>), this significant rise in the number of male prisoners aged over 60 years is not matched by a corresponding rise in the number of men convicted by the courts for indictable offences.

Fazel *et al* (2001) has studied the psychiatric morbidity in older prisoners. Their main finding was that 32% of their sample of sentenced older prisoners had a diagnosis of psychiatric illness and 30% had a diagnosis of personality disorder. Depression was particularly striking, with 30% of the older prisoners meeting criteria for a depressive disorder, a rate higher than that found in studies of younger adult prisoners and strikingly elevated compared to a community sample. Using their figures at any one time in England and Wales they estimate that 52 older sentenced men would be psychotic, most with depressive psychosis. They estimated, however, that only 12% of the prisoners with depression were being treated with antidepressants, suggesting significant unmet need. The situation regarding treatment seems to be worse than that reported for younger prisoners in England and Wales. They found that older inmates were, however, in contact with health services, suggesting that there was under-recognition of psychiatric disorder. The rate of dementia in the older prison population was comparable to that of the general population.

4. For accurate data on older people in prison refer to the Prison Reform Trust's quarterly review of prison statistics (Prison Reform Trust, 2006). For an overview of older people in prisons see *No Problems: Old and Quiet* (Her Majesty's Inspectorate of Prisons, 2004).

Despite the rise in the older population in prisons, there is no specific strategy for older prisoners. Although there are a small number of prisons which have a higher number of older prisoners, older prisoners are dispersed throughout the prison system. As the majority of mental health teams in prisons will be drawn from adult or forensic psychiatry backgrounds, it may be difficult to provide older prisoners with a specialised service, which leads directly (in a later part of this report) to a recommendation that there are specific policies within trusts for mental health teams in prisons to have prompt access to old age psychiatry services within the wider trust.

Psychiatric practice in prisons

We endorse Department of Health policy on mental health services in prisons, which in essence states that services should be provided as in the community and in line with national policy frameworks. Thus existing College policy on the role and responsibilities of psychiatrists working in community settings should apply to psychiatrists working in prisons. Psychiatrists working in prisons should work within the framework of *Good Psychiatric Practice* (Royal College of Psychiatrists, 2004a). The Royal College of General Practitioners has identified particular practice issues in prisons and accordingly adapted their general guidance to general practitioners for the particular setting of prisons. Similarly we recommend that the Royal College of Psychiatrist's *Good Psychiatric Practice* guide be adapted and modified to create a good psychiatric practice guide specifically for prisons. The earlier comments on the challenges of working therapeutically within a closed secure environment require the doctor to particularly ensure that practice is sensitive to the particular ethical demands of prison work. That advice will need to take account of the reported experiences of prisoners from Black and minority ethnic groups who report a lack of understanding by healthcare staff of their particular cultural and religious needs. Aspects of clinical governance and professional responsibility are important to effectively and sensitively deal with the needs of the mentally disordered offender within the penal system, even influencing the system to change where it is appropriate.

RECOMMENDATION

1. We recommend that a good psychiatric practice guide be created specifically for psychiatric practice in prisons.

COMPETENCIES REQUIRED OF PSYCHIATRISTS IN PRISONS

The practice of psychiatry in prisons will require specific competencies to a greater extent than might be the case for other consultant roles in multidisciplinary teams. In particular, specific competencies are required in:

- 'Jail craft'; this is an understanding of work within enclosed, secure institutions. Psychiatrists working in prisons need to understand the

culture and function of prison, including how a health system can function in what is otherwise a custodial setting; they should be familiar with the routines of prison life, have knowledge of prison rules and the management of prisons; they must understand the systems that operate within prisons, the balance of therapy and security and the interface issues, which can be challenging as well as rewarding when it comes to administrating healthcare within prisons.

- Interface with the Criminal Justice System; specific knowledge of how the Criminal Justice System works and how the health service interfaces with it. Psychiatrists working in the prison environment will need greater knowledge of the function of courts, probation, police and multi-agency public protection arrangements (MAPPA) than psychiatrists working in community mental health teams (CMHTs).
- Substance misuse; below we discuss the particular issue of substance misuse. Psychiatrists in a prison setting need to have knowledge

Box 1 Provisional guidance for consultant norms and appointments

CATEGORY B LOCAL REMAND PRISON OF 500 PLACES

- 0.5 wte consultant (general adult or forensic)
- 0.5 wte. non-consultant grade
- Plus 0.2 wte addiction specialist sessions and psychotherapy input as recommended below.

CATEGORY A LOCAL REMAND PRISON OF 500 PLACES

- 0.75 wte consultant (general adult or forensic)
- 0.5 wte non-consultant grade
- Plus 0.2 wte addiction specialist sessions and psychotherapy input as recommended below.

CATEGORY B DISPERSAL PRISON OF 500 PLACES

- 0.5 wte (forensic or forensic rehabilitation)
- 0.5 non-consultant grade and psychotherapy input as recommended below.

CATEGORY C AND D DISPERSAL PRISON

- Unlikely to require full psychiatric team so perhaps 0.3 wte per 500 places but with same access to specialist services through a mental health trust

A consultant spending for example 5 sessions in a prison setting will need to combine that role with another part-time commitment within the employing trust. We believe that there may be merit in such joint appointments to ensure that the consultant does not become isolated within a full-time prison post.

If psychiatrists take on direct responsibility for patients in prison healthcare centres who are deemed to need secondary or tertiary care, then these provisional figures (above) will need to be increased significantly to account for that extra work. Similarly, if secondary services take responsibility for on call duties this will require extra sessional input.

The consultant input to prisons must be provided within the guidance to the new consultant contract. This means that the contract will require pro-rata sessions for continuing professional development and professional activities.

Addictions and psychotherapy sessional input might best be provided through appointments covering clusters of prisons.

and skills in management of substance misuse and most particularly management of 'dual diagnosis'.

In the introduction to this document, we highlight particular issues concerning gender and ethnicity. As well as demonstrating competencies in jail craft and interface with the Criminal Justice System, those working in prisons need to have a detailed understanding of the interaction between crime, imprisonment, gender and ethnicity. We returned to this theme again in the section on training.

Psychiatrists in prison will need to work across primary, secondary and tertiary levels of care. It follows that the competencies expected of a psychiatrist in prisons are likely to be found in those psychiatrists trained in general adult or forensic psychiatry. The desirable mix of general and forensic skills may differ depending on the type of prison and local factors. Forensic psychiatry has up to now generally provided input to prisons but there is no reason why general psychiatry should not provide consultant leadership in prisons in the future. Currently only forensic psychiatry training addresses the competencies required of psychiatrists working in prisons and training for general psychiatry trainees is likely to be provided by special interest sessions in forensic psychiatry. We discuss below the need for a different approach to remand and longer-term sentenced prisons. For the latter the skills of forensic psychiatry and forensic rehabilitation may be particularly needed. Similarly the approach to addictions treatment will be different in remand and sentenced populations, with the emphasis in the latter on maintenance treatments and rehabilitation programmes. Particularly in prisons with significant numbers of individuals from Black and minority ethnic groups, job descriptions should require candidates to demonstrate knowledge and skills in the provision of mental healthcare to this specific group of individuals. For appointments to female establishments, knowledge and skills in the particular needs of female prisoners should form part of the required competencies of the psychiatrist for such establishments. Recognising that training may not have focused on these issues, appointments may need to be made with a plan in place to develop these competencies through continuing professional development.

RECOMMENDATION

2. We recommend that a competency-based approach to the appointment of consultants in a prison setting be employed rather than opting for either general adult or forensic psychiatrists fulfilling those roles. Depending on local circumstances, appropriate services might be drawn from either speciality. Where psychiatric sessions are provided to a large prison there may be merit in having sessions from both general and forensic practitioners. In dispersal prisons where prisoners are serving long sentences, forensic rehabilitation skills may be particularly useful.

CONSULTANT NORMS AND APPOINTMENTS

We believe that it is important for the College to exert as much influence upon consultant appointments in prisons as with other consultant appointments, and that job descriptions should adhere with current College

guidance. The College should also ensure the consultant appointments to multidisciplinary teams in prison follows the formal appointment system for consultant appointments. Job descriptions require approval from the regional advisor and a College assessor appointed to the appointment committee. Job descriptions should include specific time allocation for continuing professional development, service development and clinical governance.

The role and responsibilities of psychiatrists working in prisons have altered so significantly with the reform of prison health that norms for consultant posts in prison do not exist. It is not possible to directly lift the tried and tested norms for community adult psychiatrists and apply them to a prison setting. This is because of the radically different morbidity to be expected in prisons, turnover factors and the wide range of types of prison within which psychiatrists operate. One argument is to wait for services to mature and then finalise norms for prison psychiatry. On the other hand services are being developed now and (in our opinion) some guidance, however provisional, is better than none. We recognise the weakness of this approach as these norms have been created through discussion with psychiatrists familiar with the new consultant roles within prisons. Though we cannot test out our assumptions, from our collective knowledge of prisons we have suggested the norms shown in Box 1 as a reasonable guide.

We make recommendations here on norms for psychiatrists. We believe there is an equal pressing need to determine indicative staffing norms for other disciplines in prison-based multidisciplinary teams; however, this is beyond the remit of this report.

RECOMMENDATIONS

3. We recommend that appointments to consultant posts in prison should follow the appointment procedure for other consultant appointments and therefore include a college assessor on the appointment panel.
4. We recommend the development and use of a college model job description for consultant appointments to prisons. That model job description should take account of the specific competencies for work in prisons set out in this report and address the particular competencies required of psychiatrists in respect of gender and ethnicity.
5. We recommend the adoption of our provisional norms for consultants working in prisons. We further recommend that the College and Prison Health Unit of the National Offender Management Service (NOMS) partnership jointly review indicative staffing for mental health teams in prisons and review norms for consultant sessions accordingly.

ROLE OF CONSULTANTS IN PRISONS WITH SPECIAL REFERENCE TO COMMISSIONING MENTAL HEALTH SERVICES

In commissioning mental health services in prisons, we conclude that the service model should mirror the range of local psychiatric services. Flexibility must be preserved so that local areas can respond to their particular situation within the general framework of a competency-based approach to

the consultant role in prisons, indicative budgets and 'norms' for services. The range of different prisons, including male and female establishments, means that service provision to these different populations will require individual responses within an overall commissioning framework.

It is important that multidisciplinary mental health teams in prison have dedicated psychiatrist leadership. It would not in our view be desirable for services to be delivered simply by catchment area, general or forensic psychiatrists assessing patients as required.

For the generality of prisons, we would expect initial assessment of patients to be carried out through a generic multidisciplinary team (drawn from general adult and forensic expertise) and referrals made to more specialist services, depending on need, as would be the case in a general adult team within the community. Thus, if somebody with significant learning disability needed assessment, a referral should be made to that speciality, and the referral dealt with as any other referral for that trust. Prison-based teams should have access to trust specialist teams regardless of the patient's area of residence. As is the case in the community, initial assessments may be carried out by appropriately qualified members of the team, and the consultant's role may be one of consultancy and input to complex cases. Within prisons, mental health teams can create effective liaison with other expertise within that setting, for example forensic psychology, probation and prison-based education. As the available resources will differ between prisons, it is important to maintain flexibility around the composition and nature of the multidisciplinary team.

This report does not address specific guidance on the composition or operation of community psychiatric teams in prisons. Existing guidance is available through the College's council reports CR96 and CR124 (Royal College of Psychiatrists, 2001a, 2005) which provide guidance on the role of the consultant general adult psychiatrist and on community care. Specific guidance is provided by the Prison Health Unit on the operation of mental health services in prisons including the application of the care programme approach and clinical governance in a prison setting. We consider that it would be helpful to review CR96 and CR124 to determine if modifications are necessary for the particular conditions of prison. The National Service Framework should also be applicable to prisons, and work has begun on how the standards can be applied to prisons. Last, as this report was nearing completion, the joint Department of Health and Royal College of Psychiatrists' recommendations on 'New Ways of Working' for consultant psychiatrists was also nearing completion (now published, see Department of Health, 2005). The recommendations within that report will be applicable to the role of the consultant psychiatrist in the prison setting. In our view the role of the psychiatrist should encompass direct clinical work but also involve developing service models, developing mental health knowledge and understanding within primary care, supporting the work of other disciplines within the prison and providing a leadership role within prison mental health services.

We believe that effective prison mental healthcare is most likely to be achieved through contracts between primary care trusts and large mental health trusts. Within such a contract, specialities (learning disabilities, old age etc) would be expected to provide specialist consultation services as they would for any other part of the trust. The aim should be for a CMHT in a prison to be treated as other community multidisciplinary team within that trust and have access to specialist services. Contracts with providers

other than reasonably large trusts are likely, in our view, to be less effective in that the wider resources of the trust might not be as readily available to prisoner patients. There is considerable merit to an approach to commissioning on a cluster basis so that a large trust provides services to a range of prisons, both remand and dispersal, and at different levels of security. In this way the available expertise could be effectively harnessed to match the type of prison to particular expertise within the trust.

It is important that the College ensures that mental healthcare in prison is not just another burden hoisted on overloaded services. To this end, work is needed to define indicative budgets for prison healthcare. A capitation formula could be developed to take account of the particular nature of the prison population and the 'turnover factor' in certain types of prisons, for example remand prisons.

There is no reason why secondary healthcare in prisons should operate differently from counterparts in the community where the bulk of mental healthcare is provided through primary care teams. Psychiatric services in prisons need to operate within the overall framework of the National Service Framework and work to NICE guidance on clinical treatment. Modification will be required to take account of the lack of access to the wide range of services that might be available to the general public, such as the voluntary sector, social services, or psychotherapy departments. Where general psychiatrists primarily provide input, service agreements should include provision for forensic tertiary level assessment/management.

There is a particular problem with psychiatric input to healthcare centres in prisons. These are not hospitals recognised as such by the NHS but they often provide care to people awaiting transfer to an NHS bed (including high-secure or medium-secure placements), include patients with complex withdrawal states from drugs and alcohol and provide assessment and management of prisoners with complex mental health problems. Although current prison strategy envisages patients with complex needs (as might be addressed through enhanced care programme approach) will be under the care of a multidisciplinary team with a consultant psychiatrist, nevertheless, the responsibility for healthcare centre patients rests with primary care. Few prisons have access to psychiatric cover within the prison out of hours and at weekends, and available local assessment procedures are not utilised in contrast to those for physical illness. This means that general practitioners find themselves in charge of patients who are assessed by psychiatrists to be in need of in-patient NHS care or who have complex mental health problems. The management of patients within in-patient units in prison needs to be reviewed by the Royal College of Psychiatrists, Royal College of General Practitioners and Prison Health Unit of the Department of Health.

In one respect CMHTs in prisons are different from their counterparts in the community in that prison-based CMHTs do not have direct admission rights to in-patient NHS beds. There is no obvious reason why a CMHT in a prison setting which considers that a patient needs in-patient NHS care should not be able to admit directly without having to refer to an outside hospital. As informal care systems as might be available in the community will not be available in prisons, the threshold for admission may need to set at a lower level.

RECOMMENDATIONS

6. We recommend that the commissioning model for adult psychiatric services be adopted for commissioning mental healthcare in prisons.
7. We recommend that services should be provided through generic multidisciplinary teams, including addiction specialist expertise in remand prisons, with clear pathways to access specialist services such as learning disability, old age psychiatry or psychotherapy. In our opinion it is likely that such comprehensive service provision will be best provided through large mental health trusts. Where services are primarily provided by consultant adult psychiatrists, we recommend that service agreements include specific access to tertiary forensic psychiatry. Commissioning plans that address need across a cluster of prisons have the potential to match need with the appropriate expertise within a trust.
8. We recommend that Royal College of Psychiatrist's reports CR96 and CR124 be reviewed and modified to provide prison specific guidance on the role and responsibilities of a consultant psychiatrist taking a leadership role within prison-based psychiatric services. That review should include consideration of the recommendations on 'New Ways of Working' for consultant psychiatrists (see Department of Health, 2005).
9. We recommend that the Royal College of Psychiatrists, Royal College of General Practitioners and the Prison Health Unit of the Department of Health review the operation of health care centres in prison providing in-patient care to include a review of the appropriate doctor to take responsibility for mental healthcare (whether general practice, secondary or tertiary psychiatry), service models for healthcare centres and appropriate staffing norms.

Specialist psychiatric services in prison

ROLE OF ADDICTION SPECIALISTS IN PRISON HEALTHCARE

Recent developments in this area highlight the importance of increased input by addiction specialists into prison healthcare.

- The advent of PCT commissioning of prison healthcare has emphasised the need to provide similar standards of treatment in prison as within the community.
- The National Treatment Agency (2003) has established new quality standards for treatment within the community, and has adopted new organisational standards for services (Alcohol Concern and Standing Conference on Drug Abuse, 1999).
- There is greater awareness of the extent of substance misuse in prisons, and its association with ill health, overdose, and suicide, and also with criminal recidivism.
- The drug intervention programme (DIP) includes several initiatives stressing the importance of seamless throughcare, linking prison addiction treatment with treatment outside (for example, the counselling, assessment, rehabilitation, advice and through-care service (CARATS), drug treatment and testing orders and enhanced arrest referral).
- The Prison Office is now recommending maintenance treatment with methadone or buprenorphine for certain opiate-dependent inmates.
- Inmates themselves are beginning to demand better treatment for their addictions, and a number have initiated compensation proceedings as a result of alleged clinical negligence.

The National Treatment Agency (Models of Care, 2003) provides guidance on medical roles in addiction services.

'These Guidelines recognise that the management and treatment of drug misusers present medical practitioners with particular challenges. The range and complexity of treatment and rehabilitation produces the need for a continuum of medical practice, skills and experience, ranging from the contribution that can be made by all doctors to that made by specialised practitioners ... Involving GPs in the care of drug misuse and expansion of shared care is not seen as an alternative to the current role of the specialist services. Some drug misusers will continue to need specialist support which it would be unreasonable to expect a GP to provide in general practice. GPs should, however, be sufficiently skilled to identify a problem drug misuser, who is consulting them for other, perhaps related problems. This is likely to require a programme of training for GPs.' (Department of Health, 1999)

At present the Royal College of Psychiatrists and the Royal College of General Practitioners are in discussion with the National Treatment Agency concerning competencies necessary to practise at specialist level. The two Colleges envisage the possibility of GPs or other practitioners acquiring specialist status equivalent to that of an addiction psychiatrist. The Royal College of Psychiatrists has produced guidance on the role of the addiction psychiatrist (Royal College of Psychiatrists, 2002). This advice is echoed in its advice to commissioners of addiction services (Royal College of Psychiatrists, 2001*b*). This advice is as relevant in prison healthcare as it is in the community, and should be seen as also applying to addiction specialists in general when the competencies for this role are agreed.

The following roles and responsibilities for addiction specialists should apply to prison work:

- Addiction specialists have a specialist training in the wide range of disciplines relevant to case management. It is logical, therefore, that they must (and do have, within the NHS setting) ultimate clinical responsibility and leadership for the management of cases within substance misuse services. This includes accessibility and availability for consultation with other medical professionals (for example general practitioners and the primary healthcare team, other psychiatric specialists, general physicians (and their teams), counsellors and other professionals in statutory and non-statutory agencies. The addiction specialist may then coordinate a range of closely related health interventions which may lead to the formulation of joint care plans.
- Patients who have the following problems are appropriate for referral to addiction specialists: severe dependence or dependencies, chaotic patterns of use, polysubstance misuse, psychological complications including concomitant mental illness, physical complications, social instability, familial dysfunction, criminal activity.
- Range of skills of the consultant addiction specialist: identification and assessment of the nature and degree of substance problems, including the physical and psychiatric antecedents or consequences; provision of appropriate psychological treatments; provision of appropriate pharmacological treatments; case management from assessment to after-care; provision of advice on and support for assessment and treatment interventions, risk assessment, liaison and collaboration with professionals (other medical specialists, social work and primary healthcare team) and other agencies; education and training; audit research; prevention: primary and secondary; strategic planning of best service configuration.
- Thus specific, specialist, clinical skills should concentrate on dealing directly with complex cases; support in routine management by advice and consultation; support in the establishment of protocols and strategies; training activities; advice regarding effectiveness.

It can be seen therefore that specialist input is particularly important in prisons because inmates are often polydrug misusers with complex mental, physical and social problems; uptake of new treatments is often slow, and maintenance of quality standards may be poor as a result of deficient local leadership; there is very little research or audit to establish best practice; and drug strategy in prison often meshes poorly with that in the community.

RECOMMENDATION

10. We recommend that there should be sessional input from addiction specialists, who will establish protocols of care; advise in complex cases; initiate audit and research; provide an input into training; help develop drug strategy; and liaise with other professionals, for example forensic psychiatrists and hepatologists.

ROLE OF GENERAL PRACTICE IN PRISON ADDICTION SERVICES

A programme of training for GPs has been established by the Royal College of General Practitioners, with advice and input from members of the Royal College of Psychiatrists. Many prison doctors have now been on this certificate course, which is a welcome development. It is desirable that in future the majority of routine addiction treatment in prison should be carried out by GPs supported by appropriately qualified nurses and counsellors. However, there is also a definite need for specialist input. This may also be provided by some GPs or other practitioners who have appropriate extra training and experience and are therefore functioning at a specialist level.

ADDICTION TEAMS IN PRISON

A much more co-ordinated approach is required to substance misuse treatment in prison than obtains at present. The drug intervention programme (DIP) has now been established (formerly named the Criminal Justice intervention programme). One of its aims is to attract potential offenders into treatment and also to ensure that they do not lose contact with treatment agencies when they are imprisoned, but rather that they are tracked throughout their prison stay and picked up again as soon as they are released. There are also various other criminal justice initiatives that place extra pressure on drug users to receive treatment. These include arrest referral and prolific offender schemes, local developments such as the Blackpool Towers and Dordrecht initiatives, as well as various provisions in the latest Criminal Justice Act relating to withdrawal of benefit and refusal of bail for non-compliant drug users.

All these schemes encourage the idea of 'seamless treatment'. However, at present this idea is abandoned when patients enter prison, where their care is divided between a number of different organisations, even though their period of admission is usually less than 6 months. Typically detoxification is carried out by one agency, frequently a local treatment provider. Prisoners are then referred where appropriate to CARAT workers, who may provide counselling, occasionally organise external rehabilitation places, and attempt to liaise with outside treatment agencies. This latter role may soon be taken over by DIP in-reach workers. In fact, CARAT workers have struggled with this task, partly because of long waiting lists in the community, but also because of a certain cultural divide between usually non-statutory CARAT workers and usually NHS treatment providers.

If prisoners remain on methadone or require other clinical care, this is now most commonly provided by prison healthcare, which would also be responsible for immunisation and blood-borne virus testing. Coincidental psychological problems are addressed by the psychiatric in-reach team. As

well as this, the government has now set up a new drug-counselling scheme called PASRO (prisoners addressing substance related offending). PASRO workers deliver, after brief training, short courses of cognitive therapy to prisoners who are misusing drugs who may or may not be suitable candidates for this type of treatment. This activity takes place independently of other aspects of drug treatment, and is seen more as offender education rather than treatment. Voluntary and mandatory drug-testing take place within a different system, as does the management of drug-free wings within prisons where these exist. With regard to commissioning treatment, the various relevant drug action teams and PCTs, local and regional prison managers and the Prison Health Policy Unit may all have different views as to what should happen.

We believe this system is far too complex and fragmentary, and does not encourage comprehensive assessment, or the establishment of affective multi-agency/multidisciplinary approaches to substance misuse problems in prison. Instead we have made the following recommendations for teams that will therefore mirror drug misuse treatment in the community outside prison.

RECOMMENDATIONS

11. We recommend that dedicated substance misuse teams are established in prisons. These will provide care for prisoners throughout their residence, and will work closely with mental health in-reach teams and healthcare staff.
12. We recommend that teams should consist of addiction nurses and specially trained prison staff, with input from GPs and specialists in addictions as appropriate. They should link closely with CARAT and PASRO staff, or possibly merge with them and be responsible for detoxification; drug counselling; methadone maintenance and other pharmacological treatment; and for ensuring seamless throughcare.

LEARNING DISABILITY PSYCHIATRY AND PRISONS

Most community (NHS) learning disability services in the UK treat only those patients with a learning disability in the narrow sense, with an IQ typically of lower than 70. There are a number of factors in prison which argue for a relaxation of that cut-off point in determining when the expertise of a learning disability practitioner might be appropriate for a prisoner.

- As well as having actual or borderline low IQ (perhaps IQ below 80 instead of 70), many prisoners will have significant social and educational deprivation as well as histories of abuse. This adds to the disability arising from low intelligence.
- The prison environment is a difficult one and those with borderline IQ may have particular difficulty understanding or coping with the demands of prison life. This will include vulnerability to exploitation and bullying, bringing in its wake risk of suicide.
- A person with limited intellectual abilities, who in the community will live independently with family and other supports, may have their

coping abilities overwhelmed by the social and personal demands of living in a prison environment.

- The demands of participation in the Criminal Justice System may be particularly taxing to those with borderline IQ, adding to the unusual demands placed on the limited resources of these individuals.

The Criminal Justice System recognises this and accordingly relax the usually stringent criteria for recognition of learning disability. The courts often accept recommendations that offenders with an IQ in the lower ranges of borderline learning disability suffer from mental impairment as defined in the Mental Health Act 1983, particularly if they have additional disabilities such as autistic-spectrum disorder, acquired brain injury or specific genetic disorders. Many NHS, private and charitable secure units in the country accept patients who would fall within the lower end of borderline learning disability. The skills of learning disability psychiatrists could be used in the assessment and treatment of offenders who have a (low-) borderline learning disability in prison. However, many non-forensic learning disability services do not accept referrals of people without a significant learning disability and this may cause problems as patients may fall between two services. We therefore conclude that there is a role for learning disability teams and psychiatrists in undertaking assessments and advising on those with a borderline learning disability within a prison setting. Learning disability teams in the community would not normally be expected to provide a service to this group of people and therefore in making this recommendation it should be recognised that special funding would be required to it.

We recognise the potential problems that may arise when this group of individuals leave prison, as then they may not be taken on by learning disability services in the community. Nevertheless while in prison they may be functioning at such a low level that their disability needs to be recognised. Prison assessment may be in any case helpful for generic mental health services in the community.

RECOMMENDATION

13. We recommend for screening and assessment purposes, that those with borderline learning disability (IQ=70-80) should have benefit of learning disability expertise, including, where appropriate, assessment from consultants in learning disability. We recognise that currently learning disability services are not resourced to provide this service and implementing this recommendation will require dedicated funding.

IDENTIFICATION OF PRISONERS WITH LEARNING DISABILITY

It is not always easy (even for experienced learning disability psychiatrists) to recognise those with a learning disability, particularly in a setting away from home, such as prisons. Screening questions may help, but questions such as 'have you attended a special school?' and 'how good are you at reading?' can include a large number of people with borderline learning disabilities.

Current screening of prisoners in the UK does not usually include questions regarding learning disability. In research articles a number of

questions have been used such as whether the person had 'reading problems or learning difficulties or had been to special school' (Murphy *et al*, 1995). Simple (untested) screening could include questions such as:

- Does the interviewer think the person has a learning disability?
- Does the person think he or she has a learning disability?
- Does the person have any problems in reading, writing or filling in forms?
- Has he or she been to special school or special educational support in mainstream school?
- Any history of learning disability or of contact with learning disability services (community services, hospital)?
- Is the person capable of living independently?
- Does the person have the ability to drive?

A potential model in remand prisons is to employ a dedicated and experienced learning disability nurse working within the prison to follow up those who have screened positive to such a questionnaire and to ensure that those who may have mental health needs associated with their learning disability are then referred to a psychiatric team for people with learning disability. In cases where there is doubt that the person has a learning disability a referral to a psychologist for psychological testing is appropriate. An earlier section has recommended the adoption of a commissioning model based on initial screening from a CMHT with follow-on assessment and treatment from specialist teams within the same trust (see recommendations 6 & 7). In the case of those thought to have learning disability, the input from the local learning disability service should form part of the service agreement for prison mental health services. For larger prisons, especially remand prisons, there may be enough demand to justify dedicated sessions from a learning disability practitioner within prison CMHTs. It is important that the nurse working with the offenders with learning disorders in prison has a good relationship with the learning disability forensic services, as few non-forensic learning disability psychiatrists have had formal training in prison psychiatry. Larger prisons may want to consider sessional input from a (forensic) psychiatrist for people with learning disability.

RECOMMENDATIONS

14. We recommend that the Grubin screening tool used at reception in prisons be modified to include screening questions to identify prisoners with a potential diagnosis of learning disability
15. We recommend that when commissioning for mental health services within prisons consideration is taken of the particular needs of patients with learning disability patients ensuring that each prison had agreed access to learning disability specialists within a protocol for the assessment (and treatment) of those prisoners with learning disability. Where demand can justify it, prison-based CMHTs could benefit from having a dedicated member of a learning disability service within the team.

PERVASIVE DEVELOPMENTAL DISORDERS

Many learning disability psychiatrists have become experts in the assessment and treatment of autism and Asperger syndrome. Little is known about the prevalence of autism and autistic-spectrum disorders in prisons. In many parts of the UK learning disability psychiatrists have become involved (and indeed have taken the lead) in the assessment and treatment of non-learning disabled people with autistic-spectrum disorder. A similar arrangement could be adopted within prisons.

The Royal College of Psychiatrists (2006) has provided guidance on the treatment and service provision for psychiatric services for adolescents and adults with Asperger syndrome and other autistic-spectrum disorders and that guidance is applicable to prisons.

TREATMENT PROGRAMMES

A number of treatment programmes are available for prisoners, particularly including the sex offender treatment programme (SOTP) and a 'thinking skills' programme. The SOTP has been adapted for use for people with a (borderline) learning disability, but many long-stay prisoners with a learning disability have difficulties in participating in appropriate offence related work in prison, which can lead to parole being refused. This could be discriminatory and at variance with the drive to eliminate social exclusion. At times it may be possible to transfer prisoners with learning disability to hospital for specific treatment programmes. Recognising that this will leave significant numbers in prison with special needs, the Prison Service should consider adapting more programmes for use with people with a mild or borderline learning disability. For those serving lengthy sentences, this may require the prison service to concentrate in a small number of prisons those with learning difficulties excluded from programmes because of their disability.

RECOMMENDATION

16. We recommend that the Prison Service consider the particular needs of those with learning disability (including those with borderline disability) and adapt existing treatment programmes to the needs of those with mild and borderline learning disability. This may require concentrating expertise in particular prisons.

SERVICES FOR PATIENTS WITH OTHER DISABILITIES OR RARE CONDITIONS

This report does not intend to include recommendations on all disabilities or mental health conditions encountered in prisons but instead concentrates on the bulk of problems encountered in prisons. We recognise that the special needs of particular groups merit review but this was beyond the recourses of this review team. When this report is reviewed (or separately) we suggest that services in prisons for groups with special needs should be considered.

Those groups include:

- patients with acquired brain injury
- patients who are deaf and have mental health problems
- patients with gender dysphoria
- patients with multiple handicaps.

MENTAL HEALTHCARE IN FEMALE ESTABLISHMENTS

Earlier in this report, we highlighted important differences between male and female prison establishments and male and female prisoners, increased levels of self-harm, histories of sexual abuse and particular problems of substance dependence. A range of issues around childcare and separation from children have greater importance within the female prison population compared to their male counterpart. This does not mean that male prisoners do not have problems related to separation from children but we wish to emphasise the particular female experience of separation from children which is reported by surveys conducted within the female prison population. Birmingham *et al* (2004) have recently reported on the needs of women in mother and baby units within the prison service. As set out in the earlier section on the limitations of this report, no attempt is made to address either the specific needs of male prisoners, prisoners from Black and minority ethnic backgrounds or female prisoners. We recognise this limitation and therefore make a recommendation below that further work should be carried out to address the particular needs of female prisoners.

We have looked at the literature on female prisoners and concluded that there is currently insufficient knowledge of their specific needs to be able to recommend particular service models within female establishments. In our view it likely that future work in this area will require wholesale review of mental healthcare to female prisoners.

RECOMMENDATION

17. We recommend that either as a separate report or in the future revision of this report, that the particular needs of female prisoners be addressed with recommendations on service provision in female prisons.

OLD AGE PSYCHIATRISTS AND THE MENTAL HEALTH OF PRISONERS

OLDER PEOPLE IN PRISON

In the introduction to this report, we summarise the epidemiology of mental disorder in older prisoners and review trends in prisons towards an increasing older population. A consequence of the current trend towards longer prison sentences is that an increasing proportion of prisoners will be older. Community mental health teams within prisons should retain

core competency in the assessment and treatment of common psychiatric problems in older people and should be helped to develop competency in screening for cognitive impairment. The provision of effective care, either within prison or NHS facilities, for older people with complex mental health needs (specifically, moderate to severe cognitive impairment or affective disorder) would not be considered to be within the core competency of a generic prison CMHT. Service protocols for CMHTs in prisons will therefore need to include provision for consultancy with local old age psychiatry teams. This might involve in-reach from community psychiatric nurses, clinical psychologists or the consultant from the older adult mental health team.

CLUSTERS OF OLDER PEOPLE IN PRISONS

There is already a trend within the prison service for certain prisons to provide care for older prisoners. Such prisons will need to be clearly identified so that a specific regular input can be negotiated with the local old age psychiatry service provider.

TRAINING IMPLICATIONS

Old age psychiatrists, particularly those asked to provide a service to prisons used for older prisoners, will need to develop competencies in jail craft and the role of the psychiatrist in the Criminal Justice System. At present there is no provision for this within old age specialist registrar training. Such competencies might be addressed through induction procedures for old age psychiatrists who at consultant level are required to take specific responsibility for prison liaison. Provision of forensic psychiatry special interest sessions for old age specialist registrars would be a further potential training route.

RECOMMENDATION

18. We recommend that the old age faculty of the Royal College of Psychiatrists should consider the need for specialist training for old age psychiatrists in the special needs of old age prisoners with mental health problems.

REHABILITATION PSYCHIATRY AND PRISON SERVICES

Rehabilitation psychiatry is predominantly concerned with the long-term care of those with severe enduring mental illness but also provides for some other patients with complex long-term needs (Royal College of Psychiatrists, 2004b). There is frequently comorbidity with personality disorder, substance misuse problems, low IQ and acquired brain injury. The majority of rehabilitation psychiatry services provide a combination of long-term NHS in-patient services for active rehabilitation and continuing care (sometimes including low secure care), a variety of supported accommodation options within the community and community teams providing rehabilitation and long-term support for patient groups, almost all of whom are on enhanced

care programme approach. There is a developing sub-speciality of forensic rehabilitation focused around the longer-term population within secure services who are increasingly being provided with dedicated long-term secure services, within low, medium and high security. Again, these are predominantly those with severe enduring mental illness but include other groups with long-term complex conditions.

The majority of needs assessments studies within the Criminal Justice System that we are aware of have, for good reasons, concentrated on remand prisoners. There is little detailed information about the needs of longer-term prisoners, although high rates of psychosis and of other mental disorders have been identified by the Office of National Statistics among serving prisoners (Singleton *et al*, 1997). There is little known about the particular needs of patients from Black and minority ethnic groups serving long sentences. Their particular rehabilitation needs are poorly understood or researched. The number of prisoners serving life sentences has increased dramatically over recent years with changes in sentencing policy, with over 5000 recorded in March 2004. Within this group of long-term prisoners there will be those who continue to suffer from severe enduring mental illness who will be receiving treatment but who remain symptomatic with positive and/or negative symptoms. Although, almost by definition, they pose a high risk in the longer-term, they present little management problem on a day-to-day basis within the prison service. Consequently they are unlikely to be judged a priority for transfer to hospital. They are also, however, unlikely to be able to engage in the offence-related programmes run by the prison service due to the effects of their mental disorders. They are therefore at high risk of both receiving suboptimal care for their mental disorder and are unlikely to move through the penal system in the usual way. This group of patients, particularly those with severe enduring mental illness, would benefit from a rehabilitation model of service within the penal system.

RECOMMENDATION

19. We recommend that a needs assessment be carried out on the needs for specialist treatment, including specialist rehabilitation, for those prisoners with severe enduring mental illness who are not transferred to the NHS.

REHABILITATION PSYCHIATRY INPUT TO IN-REACH SERVICES TO LOCAL REMAND PRISONS

Local remand prisons usually serve a defined catchment area, sometimes co-terminous with trust and social services boundaries. There will be a high turnover of prisoners, often on short remands or short sentences. This report has already identified that there is a need for an assessment-loaded service to identify mentally disordered offenders, provide short-term interventions and divert to local health and social care services where appropriate. In terms of rehabilitation psychiatry the most common scenario in which they would be involved would be the arrangements for ongoing care of current

service clients who are remanded following alleged offences. This would be a relatively rare event and would be unlikely to involve more than an ad hoc input from the rehabilitation services. There may be rare occasions where people are newly identified by psychiatric services while on remand as in need of rehabilitation services. The most likely route into rehabilitation services would be referral following admission to local general or forensic services.

FORENSIC REHABILITATION IN LONGER-TERM ESTABLISHMENTS

Whereas the in-reach model is very appropriate for local remand prisons a different model is likely to be required for longer-term establishments. For those establishments taking prisoners with long determinate or life sentences, an assessment, short term-treatment and diversion model is inappropriate. Prisoners will have been convicted of serious offences and, although some will undoubtedly require diversion to health services, predominantly medium or high security, many will require long-term treatment within the prison system. This is an environment where the skills of forensic and rehabilitation psychiatrists seem more appropriate than those of general psychiatrists. There are likely to be a number of offenders with severe enduring mental illness and other long-term complex combinations. In cases where these meet the criteria, and where services are available, the treatment of choice would be transfer to NHS services. The involvement of rehabilitation psychiatrists at this stage would likely be from the longer term forensic rehabilitation services and only very rarely to local open rehabilitation services. For those that remain within the prison system and those who return after periods of in-patient treatment, services need to be provided within the prison working closely with elements of the Criminal Justice System, such as probation and prison psychology services.

A forensic-rehabilitation service operating within a long-term prison setting should provide treatment for mental disorder at a standard equivalent to that which would be received by an NHS patient in the community. This would include access to atypical neuroleptics, including clozapine. It is now possible to start clozapine as an out-patient and although this is starting to happen within prisons it is not widespread. There are probably large numbers of people with psychosis in the long-term prison system. Multiple factors predictive of poor outcome and treatment resistant (for example poor pre-morbid adjustment, long duration of untreated illness, poor compliance with treatment, difficulty in engagement) are also common in the prison population. There could therefore be substantial but currently unquantifiable numbers of prisoners who should be considered for clozapine according to NICE guidelines. In addition other interventions such as structured daytime activities, psychosocial education, psychological treatments for psychosis, would need to be delivered by such a service. Recipients of such a service would usually be cared for under enhanced care programme approach arrangements.

Care programme approaches should be integrated with sentence planning and identification of offence-related needs that should be addressed. There are a variety of programs run by the prison and probation service such as enhanced thinking skills, anger management, substance misuse, sex offender treatment programs. Most of these programs are not accessible to those with severe mental health problems who are unable to cope with the group format and intensity of sessions. Some

programs operate an IQ cut-off of around 80 although some of these run in an adapted form. Other more intensive programs such as therapeutic communities specifically exclude those with a history of psychosis or those receiving psychotropic medication. In forensic rehabilitation there is an acknowledgement that many patients are unable to complete the standard offence-related programmes but the provision of additional support and supervision through mental health services may go some way to ameliorate the risks prevented. This is particularly so as deficits in social functioning and cognitive abilities associated with severe enduring mental illness may reduce patients' versatility as offenders. Individual interventions by forensic clinical psychologists can be effective in assessing and modifying risk when group-based programs are inappropriate, this level of intervention is rarely available from prison psychology services. With appropriate support and treatment many patients could then move through levels of security within the prison service, and be transferred eventually to supported placements within community forensic and/or rehabilitation services in the longer term. Many patients will be subject to statutory supervision under licence or life licence at the point of discharge.

As longer-term secure services develop there may be the opportunity for integrated care planning with in-patient services. This could include, for example, transfer to hospital for specific interventions such as a trial of clozapine, an intensive psychosocial rehabilitation programme or adapted offence-related group with transfer back to the prison service at a later stage in their sentence. Given the paucity of information about the prevalence and needs of this group in the prison population it is very difficult to be specific about the resources required in this area. It is, however, almost certain that this population is far in excess of current long-term secure services provision within the health service. The provision of a consultant lead team including consultant (1.0 whole time equivalent; WTE), medical support (possibly via general practice input), clinical psychology (1.0 WTE), occupational therapist (1.0 WTE), community psychiatric nurse (3.0 WTE), all with forensic and rehabilitation skills for each long-term establishment (Category B and A) with 24 hour healthcare is likely to be an absolute minimum.

Box 2 Categories of psychotherapy (adapted from the NHS Executive guidance, NHS Executive, 2000)

- Type A integral: general psychotherapeutic skills provided by any mental health worker within a multidisciplinary care package (these skills maybe informed by generic or formal psychotherapeutic approaches).
- Type B generic: a complete ('stand alone') psychological treatment intervention informed by a range of different models, tailored to individual goals.
- Type C formal: a complete ('stand alone') and clearly delineated psychotherapeutic intervention based on clear theoretical underpinnings with implications for the use of different treatment interventions to achieve different aims. Any mental health service should make available to patients the full range of major formal psychotherapies, including as a minimum, cognitive, behavioural, psychoanalytic and systemic psychotherapies.

RECOMMENDATIONS

20. We recommend that a forensic rehabilitation model of care be considered for those prisoners (and the healthcare systems within prisons housing them) who are serving long-term sentences.
21. We recommend that the Prison Service carry out an assessment of the special needs of those with severe mental disorder (including severe mental illness, personality disorders and other severe mental health problems) who are excluded from prison-based treatment programmes because of their disorder. This could be usefully combined with a similar recommendation above relating to those with learning disability.

PSYCHOTHERAPY PROVISION IN PRISON

The underlying principle of mental healthcare to prisoners is that they should receive the same access to and quality of psychological therapies services as the non-prison population. The NHS Executive advises that psychological therapies are an important part of mainstream NHS mental healthcare, being one of the two main approaches to the treatment of the mentally ill. The NHS Executive recommends 'comprehensive, co-ordinated, user friendly, safe, clinically effective and cost effective psychological therapies services'. In what follows it is assumed that the guidance on the provision of psychological therapies as set out in the NHS Executive guide *Psychological Therapies Working in Partnership* (NHS Executive, 2000) should apply to prisons. This section will concentrate on the adaptation of guidance to the particular conditions of prison. The categories of psychotherapy (taken from the NHS Executive guidance) utilised here are shown in Box 2.

PSYCHOTHERAPY SERVICES WITHIN CORE PRISON-BASED CMHTs

This report has already recognised that prisons will be served by CMHTs operating largely as their counterpart in the community. It follows that these prison CMHTs should provide the same access to psychological therapy services as their counterpart in the community. The NHS Executive recommends that CMHTs require members to be well-trained in Type A therapeutic skills (Box 2). They should also have at the very least one psychotherapist who is appropriately qualified giving dedicated time (a minimum of 3 sessions). However, we recognise that no proper needs assessment has been carried out on norms for psychotherapy; therefore the suggested sessional input, as with other norms in this document, must be treated as provisional.

The psychotherapist in a prison-based CMHT will have a number of roles as follows:

- contribute to referral screening, case discussions and psychological therapy management strategies
- carry out initial psychotherapeutic assessment for appropriate treatments
- provide some psychotherapy and supervision of Type B and C psychotherapies
- organise the placements of trainees and honorary therapists

- contribute to the teaching of prison-based staff
- serve as a direct link to the broader range of psychological services available within the psychological therapy resource service
- CMHTs should have access to consultation, supervision and treatment in the range of appropriate major models (as a minimum cognitive behavioural, psychoanalytic and systemic) in all modalities, (individual, couple, group and family therapy as appropriate).

Throughout this document we have noted that the needs of women prisoners and Black and ethnic minority prisoners are poorly understood. We note here that care should be exercised in developing psychological therapy services in prison to ensure that therapies are available to address the particular needs of female prisoners and prisoners from Black and minority ethnic groups. Therapists working in prison need to develop specific competencies to deliver therapeutic services to these individuals.

As well as the specific role above a number of tasks are of importance across all prisons:

RECOMMENDATION

22. We recommend that CMHTs in prison should have at least one psychotherapist (providing a minimum of 3 sessions) who organises psychological therapy of Type B and C and provides a broad range of consultation and coordinating roles for psychological therapies. The skills for such a role would need the training of a consultant psychotherapist in psychotherapy, consultant forensic psychotherapist or a senior adult psychotherapist.

- The document *Personality Disorder: No longer a diagnosis of exclusion* (National Institute for Mental Health, 2003) recognises the need for new services for this patient group. As 78% of the prison population is estimated to fulfil research criteria for a personality disorder this will represent a major component of the work of prison-based mental health teams. The psychotherapist can contribute to this in the provision of short- and longer-term treatments as recommended in the treatment policy advice of 'Not a Diagnosis of Exclusion'. Treatment of those with personality disorder will increase the need for staff support, training and supervision from suitably qualified psychotherapists and the need for effective coordination of such treatment with non-prison-based treatment programmes.
- There is a pressing need for the present psychological therapies services in prison-based treatment programmes to be coordinated and organised. It would be important for good working links to be made with forensic psychologists and counsellors working within the prison system. The assessment, coordination and provision of a comprehensive service for these prisoners will need specialist psychotherapy provision. This will include:
 - support of prison-based staff
 - support and supervision of mental health in-reach teams
 - training and supervision in Type A and some Type B treatments,

- provision of Type C treatments
- a consultancy service.
- Psychological therapies work carried out by prison-based workers, particularly Type B therapies, will need supervision from experienced psychotherapists. This might be obtained by an improved liaison with the local psychotherapy services, including forensic psychotherapy services or from psychotherapists directly contracted to the prison from local NHS-based psychotherapy services.

It would be wasteful for each prison to carry out such tasks on a stand-alone basis. Prisons for management purposes are clustered and this clustering could provide a basis for coordination of psychological therapies. Such arrangements should include appropriate arrangements for clinical governance. The expertise of NHS psychological services should be available to prisons, but recognising the small size of prisons that expertise might be best provided for at the level of regional clusters of prisons.

RECOMMENDATIONS

23. We recommend that the Prison Service and NHS jointly plan, coordinate and assess through clinical governance the quality of prison-based psychological therapy services, making best use of the expertise of both organisations. This may be best implemented at the level of regional clusters of prisons.
24. We recommend an assessment of need, based on national guidelines and priorities, for psychotherapeutic services in prisons, recognising that services provided will vary between prisons depending on the nature of their population.

PSYCHOLOGICAL THERAPIES WITHIN SPECIFIC PRISON UNITS

The provision of a coordinated psychological therapies service to remand prisoners presents a particular challenge. However, it should not be assumed that this precludes the provision of a psychological therapies service tailored to the needs of the prisoners within the reality of their sentence. For example counselling services and brief focused psychological therapies services of different modalities could be effectively used in the remand population to both target specific symptoms or behaviours and to prepare prisoners for the possibility of longer-term work once sentenced. Some prisoners charged with the most severe crimes will be in remand for longer periods and longer-term psychotherapy work has been usefully carried out in this period.

It might be envisaged that particular units within prisons, for example the vulnerable prisoner unit, close supervision centres and special secure units would have a greater need for staff support and consultation. The staff in these units work closely with the most disturbed prisoners and will be carrying the anxieties inherent in such work. The aim of support work and consultation would be to allow discussion of these inevitable tensions and difficulties with a view to reducing the chances of them being acted upon in

less healthy ways. One way in which such feelings are sometimes expressed is by prison staff becoming unwell. The high sickness rates in Holloway are being addressed in one unit by the introduction of external staff support facilitators.

The 160 places for inmates with dangerous and severe personality disorder at HMP Whitemoor and HMP Frankland will present staff with the particular difficulties of working with this patient group. It is important that staff support and consultation are available for this group of individuals.

As forensic psychotherapy services grow some consultant posts might have a direct link to their prisons or prison clusters as part of the overall structure of their post. In the absence of a local forensic psychotherapy service such supervision might be negotiated with the district psychotherapy service or through contracts with a national provider of forensic psychotherapy. Whether the providers of such a service are general or forensic psychotherapists it is essential that there are established links with both the prison and external psychotherapy services for any psychotherapist working in a prison. This would entail that not only are they accepted as members of the prison-based team but that they also have opportunities for supervision and continuing professional development with peers.

Prisoners from category D prisons might be considered for treatment in the local services rather than prison-based services.

It is important that the various psychological inputs to prisoners are coordinated across the services within a prison. It could be envisaged that the prison-based psychologists and counsellors have regular meetings with the prison-based mental health services and prison-based psychotherapists. Such coordination would also be aided by an integrated clinical record to which all these professionals have access.

The provision of activity-based therapies (for example art and drama therapy) should be considered as an integral part of psychological provision to a prison. This would reflect the propensity of prisoners to use action rather than verbal communication.

For some prisoners such treatments might be stand-alone but for others they might be the prelude to moving into a more verbal therapeutic interaction reflecting the increasing maturity of the patient's emotional responses.

Training psychiatrists for roles in prison psychiatry

Psychiatrists form the largest group of specialists working in prisons; it is essential that medical support to mental health teams working in prison settings is appropriate in terms of training and competence and that psychiatric services adhere to the same professional guidance on roles and responsibilities as the wider NHS.

EDUCATIONAL REQUIREMENTS FOR DOCTORS PROVIDING SPECIALIST MENTAL HEALTH SERVICES IN PRISONS

The *Report of the Working Group on Doctors Working in Prisons* (Department of Health & HM Prison Service, 2001b) recommended that secondary specialist care should be provided through multidisciplinary teams with an appropriate skill mix in liaison with NHS primary care and mental health trusts.

Consultants providing psychiatric care to prisoners should be on the specialist register in the most relevant specialty area. Earlier sections of this report describe the composition and function of multidisciplinary teams in prisons together with recommendations on commissioning a comprehensive psychiatric service specifically designed for the particular conditions of prisons. The main recommendation of this report in relation to the consultant role in prison multidisciplinary teams is that the consultant role should be based on a competency model rather than opting for recommendations on particular psychiatric specialties. The advice that follows in this section that training for prison consultant roles should be competency-based logically follows that recommendation. Generic multidisciplinary teams in prisons will, as detailed earlier in this report, need access to specialist services, particularly addiction psychiatry. Prisons with specialist functions may require consultants qualified in a particular psychiatric specialty, for example old age psychiatry or psychotherapy. The approach taken here to base training on the acquisition of specific competencies means that training can be adapted to and complement the training of general adult, forensic or other psychiatric specialty to prepare for specialist roles within prisons.

Where staff grade or associate specialist posts are utilised within a prison mental health service these appointees should similarly be appointed in line with national guidance. Doctors in training grades and career grade psychiatrists must work within a multidisciplinary team and be supervised by their consultants.

APPRAISAL AND CONTINUING PROFESSIONAL DEVELOPMENT

Consultants and career grade psychiatrists working in prison mental health teams should have formal arrangements in place for appraisal such that

each doctor's competencies in their specialist area are reviewed on a regular basis.

Working in a prison environment is potentially isolating and all providers in this area need to ensure that regular time is identified for continuing professional development to ensure that doctors can enhance their clinical skills, integrate new knowledge and respond to changing needs. All doctors should be members of a peer-group network appropriate to their developmental needs to facilitate reflective practice.

COMPETENCIES OF PARTICULAR RELEVANCE TO PRISON MENTAL HEALTHCARE

Psychiatrists providing mental health services in prison will need to develop enhanced skills in certain areas that will allow them to adapt their practice to this particular setting. The following competencies are intended to highlight those of particular relevance for psychiatrists working in prison mental health. These areas of knowledge skills and experience must be viewed as enhancing a strong foundation of general psychiatric competencies developed during specialist training and during further training in substantive posts.

The range of skills in routine use will vary with the type of prison mental health service but should include:

- familiarity with a variety of models of community mental healthcare and ability to adapt these to best meet prisoners' mental health needs
- understanding of the suicide awareness strategy for the prison as a whole and the role of the mental health team within this overall approach
- ability to support the mental health team and consult with primary care in approaches to crisis management involving a wide range of interventions including self-harm, refusal of food and fluids and unusually disruptive behaviour
- understanding and ability to influence and facilitate referrals and transfers of prisoners to community teams, in-patient units, units within medium and high security
- an understanding of Part III of the Mental Health Act and of the role of the Home Office in dealing with mentally disordered offenders
- identification and assessment of substance misuse problems in those patients under the care of the mental health team. Provision of information and advice on harms and risks in this area and ability to develop an immediate management plan. Familiarity with local specialist services, referral pathways and the full range of treatment models. Knowledge of the relationship between mental health, offending and substance misuse
- knowledge and skills in the assessment and management of individuals with personality disorders within prison, including knowledge of the referral process and guiding principles of specialist service provision within the prison, community and hospital systems
- expertise, knowledge and application of diversity issues relevant in prison mental health, including an understanding of the cultural and diverse needs of ethnic minority groups and sensitivities associated

with dealing with prisoners from overseas. Some ability to work with interpreters and telephone language lines

- an awareness of the needs of particular client groups such as those with a history of trauma or torture, women, adolescents, the older person and those with a degree of learning disability and knowledge of systems within prisons relating to these groups
- awareness of the impact of imprisonment both short- and long-term including the impact on social and psychological function and family and occupational ties
- understanding the functioning, governance, structures and systems within prisons; their impact on the care of mentally disordered offenders, the use of segregation or close supervision cells and what specific challenges they bring to the assessment and management of an individual placed in those systems.

MANAGEMENT

- Developing an awareness of multidisciplinary functioning, being an effective team member and leader. Understanding of pressures and team dynamics within a prison mental health setting.
- Understanding of organisational dynamics and skills in conflict avoidance and conflict resolution.
- Understanding principles of clinical governance and how these can be developed in a prison mental health team.
- Developing skills in inter-agency functioning, liaising and understanding the roles of other prison disciplines such as probation, forensic psychology, chaplaincy and resettlement, multi-agency public protection panels (MAPPPs) and National Offender Management Service (NOMS) partnerships.
- Understanding of models of mental healthcare in prison and ability to drive service development relevant to prisoners' needs.
- Developing skills in designing services that are sensitive to the particular needs of prisoners from Black and minority ethnic groups.

PROFESSIONAL

- Awareness of legal and ethical practice in complex situations.
- Understanding of confidentiality and application of principles regarding confidentiality in prison settings.
- Development of skills to maintain good practice and sustain professional standards within secure institutions.

TRAINING OPPORTUNITIES IN PRISON MENTAL HEALTHCARE

Modernising Medical Careers (Department of Health, 2003) set out far-reaching changes to the structure of postgraduate medical education with the introduction of the foundation years (F1 and 2) followed by up to 5 years in specialist training leading to a certificate of specialist training

(CCT). The areas of *Good Medical Practice* (General Medical Council, 2001) will form the basis of the generic skills learned in the early years and developed through later specialty specific training. The greater flexibility that these changes allow may be particularly useful to psychiatric trainees who wish to gain a range of competencies that would meet the skills and knowledge required for working within prison mental health. Those training to be general practitioners will also have more opportunities to develop special interests such that they are competent to deliver care at special interest or specialist level. The development of a continuum between postgraduate training and continuing professional development as a consultant will similarly offer the potential to gain competencies in a structured manner in areas that may have been less well-developed during higher training.

Specialist training in psychiatry needs to reflect the need for psychiatrists competent to lead multidisciplinary teams in prison settings. A minimum exposure of a visit and workshop designed to provide trainees with an understanding of service provision and challenges relating to the practice of their specialty in a prison setting. Some trainees will have the opportunity to spend several months working with mental health services in prisons or to attend on a regular basis over 1 or 2 years learning experiences.

RECOMMENDATIONS

25. We recommend that the majority of trainees in psychiatry should experience psychiatry provided in prison settings during their training. Training programmes should include guidance on minimum exposure to prison psychiatry tailored to the needs of the trainee and specialty.
26. We recommend that the workforce review team (Department of Health) training programme directors and College specialist advisory committees develop specialist training opportunities in prison in the light of the major changes in organisation and management of prison healthcare, the need to develop specific competencies to lead multidisciplinary teams in prisons and likely demand for psychiatrists competent to work in the area.

References and further reading

- *Alcohol Concern and Standing Conference on Drug Abuse (1999) *QuADS: Organisational Standards for Alcohol and Drug Treatment Services*. SCODA
- Birmingham, L., Mason, D. & Grubin, D. (1996) Prevalence of mental disorder in remand prisoners: consecutive case study. *BMJ*, **313**, 1521–1524.
- Birmingham, L., Gregone, A., Kam, M., et al (2004) *Psychiatric Morbidity and Mental Health Needs Among Women in Prison Mother and Baby Units*. Report MRD 12/39. National Forensic Mental Health R/D programme. Available via <http://www.nfmhp.org.uk/research.htm>
- Borril, J., Maden, A., Martin, A., et al (2003) *Differential Substance Misuse Treatment Needs of Women, Ethnic Minorities and Young Offenders in Prison: Prevalence of Substance Misuse and Treatment Needs*. Home Office Online Report Series.
- Brooke, D., Taylor, C., Gunn, J., et al (1996) Point prevalence of mental disorder in unconvicted male prisoners in England and Wales. *BMJ*, **313**, 1524–1527.
- *Brooker, C., Repper, J., Beverley, C., et al (2003) *Mental Health Services and Prisoners: A Review*. <http://www.dh.gov.uk/assetRoot/04/06/43/78/04064378.PDF>
- Bullock, T. (2003) Changing levels of drug use before, during and after imprisonment. In *Prisoners' Drug Use and Treatment: Seven Research Studies*. Home Office Research Study 267 (ed. M. Ramsey). Home Office Research, Development & Statistics Directorate.
- *Department of Health (2001) *Clinical Governance in Prison Health Care*. Department of Health.
- *Department of Health (2005) *New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Service through New Ways of Working in Multidisciplinary and Multiagency Contexts*. Department of Health.
- *Department of Health & HM Prison Service (2001a) *Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons*. Department of Health.
- *Department of Health & HM Prison Service (2001b) *Report of the Working Group on Doctors working in Prisons*. Department of Health.
- *Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health & Social Security in Northern Ireland (1999) *Drug Misuse and Dependence: Guidelines on Clinical Management*. TSO (The Stationery Office).
- Dolan, K. A., Shearer, J., MacDonald, M., et al (2003) A randomised controlled trial of methadone maintenance treatment versus wait list control in an Australian prison system. *Drug and Alcohol Dependence*, **72**, 59–65.
- Fazel, S., Hope, T., O'Donnell, I., et al (2001) Hidden psychiatric morbidity in elderly prisoners. *British Journal of Psychiatry*, **179**, 535–539.
- *Health Advisory Committee to the Prison Service (1999) *The Provision of Mental Health Care in Prisons*. Prison Service.
- Heidensohn, F. (2002) Gender and crime. In *Oxford Textbook of Criminology* (3rd edn), (eds M. Maguire, R. Morgan & R. Reiner). Oxford University Press.
- Her Majesty's Inspectorate of Prisons (2004) *No Problems: Old and Quiet: Older Prisoners in England and Wales*. HM Inspectorate of Prisons. Available at <http://inspectorates.homeoffice.gov.uk/hmiprison/thematic-reports1/hmp-thematic-older-04.pdf>
- Her Majesty's Inspectorate of Prisons (2005) *Parallel Worlds: A Thematic Review of Race Relations in Prisons*. HM Inspectorate of Prisons. <http://inspectorates.homeoffice.gov.uk/hmiprison/thematic-reports1/parallelworlds.pdf>

- Her Majesty's Inspectorate of Prisons (2006) *Foreign National Prisoners: A Thematic Review*. HM Inspectorate of Prisons. <http://inspectors.homeoffice.gov.uk/hmprisons/thematic-reports1/foreignnationals.pdf.pdf?view=Binary>
- *HM Prison Service (2001) *Prevention of Suicide and Self-harm in the Prison Service, an Internal Review*. HM Prison Service.
- *Home Office Online Report Series Singleton, N., Pendry, E., Taylor, C., et al (2003) *Findings 187, Drug-related Mortality Among Newly Released Offenders*. <http://www.homeoffice.gov.uk/rds/pdfs2/r187.pdf>
- *Joint Prison Service & National Health Service Executive Working Group (1999) *The Future Organisation of Prison Health Care*. Department of Health.
- Litano, S. & Ramsey, M. (2003) Prisoners' drug use before prison and the links with crime. In *Prisoners' Drug Use and Treatment: Seven Research Studies*. Home Office Research Study 267 (ed. M. Ramsey). Home Office Research, Development and Statistics Directorate.
- McBrien, J. (2003) The intellectually disabled offender: methodological problems in identification. *Journal of Applied Research in Intellectual Disabilities*, **16**, 95–105
- Murphy, G. H., Harnett, H. & Holland, A. J. (1995) A survey of intellectual disability amongst men on remand in prison. *Mental Handicap Research*, **8**, 81–98.
- *National Institute for Mental Health (2003) *Personality Disorder: No longer a Diagnosis of Exclusion*. NIMH(E).
- *National Institute for Mental Health (2004) *Organising and Delivering Psychological Therapies*. Department of Health.
- *National Treatment Agency (2003) *Models of Care*. National Treatment Agency.
- NHS Executive (2000) *Psychological Therapies Working in Partnership*. NHS Executive.
- Phillips, C. & Bowling, B. (2002) Racism, ethnicity, crime and criminal justice. In *Oxford Handbook of Criminology* (3rd edn) (eds M. Macquire, R. Morgan & R. Reiner. Oxford University Press.
- Prison Reform Trust (2003) *Troubled Inside: Responding to the Mental Health Needs of Women in Prison*. Prison Reform Trust.
- Prison Reform Trust (2006) *Bromley Briefing: Prison Statistics* (updated quarterly). Prison Reform Trust.
- Royal College of Psychiatrists (2001a) *Consultants as Partners in Care: The Roles and Responsibilities of Consultant Psychiatrists in the Planning and Provision of Mental Health Services for People Suffering from Severe Mental Illness* (Council Report CR96). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2001b) *Role of Consultants with Responsibility for Substance Misuse (Addiction Psychiatrists)* (Council Report CR97). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2002) *Advice to Commissioners and Purchasers of Modern Substance Misuse Services* (Council Report CR100). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2004a) *Good Psychiatric Practice* (2nd edn) (Council Report CR125). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2004b) *Rehabilitation and Recovery Now* (Council Report CR121). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2005) *Community Mental Health Care* (Council Report CR124). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2006) *Psychiatric services for adolescents and adults with Asperger syndrome and other autistic-spectrum disorders* (Council Report CR136) Royal College of Psychiatrists.
- Singleton, N., Farrell, M. & Meltzer, H. (1999) *Substance Misuse Among Prisoners in England and Wales*. Office for National Statistics
- Singleton, N., Meltzer, H. & Gatward, R. (1997) *Psychiatric Morbidity among Prisoners in England and Wales*. Office for National Statistics. TSO (The Stationary Office).
- Swann, R. & James, P. (1998) The effect of the prison environment upon inmate drug taking behavior. *The Howard Journal*, **37** (3).

*References on current policy guidance in prison healthcare.