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WELCOME

Welcome to the first edition of the Quality Network for Prison Mental Health Services' Newsletter. It does not seem that long since Steffan Davies and I talked about the idea of creating a Quality Network for prison mental health teams. As many of you will know, we developed a completely new set of standards for prison mental health teams by consulting and discussing these with a wide group of stakeholders. These standards were published in June 2015 and appeared to have been very well received. Almost immediately, we began working with the CCQI to develop a Quality Network for these services.

We are currently in the middle of a pilot of this Quality Network and we were heartened by the fact that 18 prisons, including one in Ireland, volunteered to take part in the pilot. All of these prisons have now completed the self-review and we will shortly be completing the peer-reviews. The Quality Network has also been recognised by the Prisons and Probation Ombudsman and the Welsh Government.

We will shortly be reviewing the standards in the light of the experience from the pilot programme. We look forward to continuing

the work of the Quality Network into its first full year and hope that all of the current prisons and many of those who were not members of the pilot will want to be part of this exciting development in prison mental health services. We hope to see you all at our Annual Forum at the Royal College of Psychiatrists on 7 July 2016.

We would like to thank all of the contributors to the first edition of this newsletter.

Dr Huw Stone
Advisory Group Co-chair



Artwork: Anthony Walsh

Developing an occupation-focused day service at Pentonville Prison

Occupational therapists took over the day-care centre at HMP Pentonville in August 2014. Rebranding it 'The Wellbeing Centre' in 2016 reflects the change from a leisure-based to a therapeutic service. The team is comprised of four OTs, two OT assistants and four specialist sessional workers and works closely with the prison mental health team and inpatient unit. Pentonville houses approximately 1300 prisoners, all at risk of significant occupational deprivation. The day service opens a third option for meaningful productive activity alongside work and education in the prison. Any prisoner can refer themselves to the centre and any staff member in the prison can make a referral also. Service users are prioritised based on their needs so those struggling most can attend within a few days.

While funded by Barnet, Enfield and Haringey Mental Health Trust (BEH-MHT), the centre aims to encompass well-being for all. Primarily the service is offered to those with a complex mental illness, physical health problem, and learning disability or personality disorder. However, referrals are also considered for people who are struggling to cope in prison, presenting with low mood, self-harming behaviours, those who are in prison for the first time or who have social needs that make them more vulnerable.

HMP Pentonville is predominantly a remand prison for men who are 18 years and over. A typical service user might be waiting for several weeks before attending court and this is the time that he is most at risk of losing hope and considering suicide or deliberate self-harm, particularly if it is his first time in prison. His past coping

strategies might have involved misusing substances, using aggression, avoiding others, ending relationships and disengaging with services. In prison, using these coping strategies make life more difficult for him, put him at risk of extending his sentence, negatively impact on his health and wellbeing, and increase the likelihood of him returning to prison in the future.

Once a referral to the centre has been accepted, the service user will have an initial assessment of his current legal situation, mental and physical health needs and occupational history. An initial engagement plan is then made with goals for how he will structure his time at the centre and what he hopes to gain from attending. This initial plan is followed up with regular key working sessions to review goals periodically. The day-care centre offers him the opportunity to engage with meaningful activity and a support system where he can receive advice and suggestions on how to cope with the harsh prison environment. The day-care centre has been described by service users as "a bit of freedom" and a "friendly environment" and the OTs have worked hard to create a safe and secure space where roles other than that of prisoners can be explored.

The centre itself is part of the healthcare wing at the prison, with primary care clinics next door and an inpatient unit upstairs. The centre is made up of eight rooms with facilities for art, music, pottery, and group rooms that are used for a variety of sessions. Specialist sessional workers offer music, pottery, art, yoga and massage sessions. The OTs are joined by psychologists, social workers and a dual diagnosis worker to run an assortment of psycho-educational and life skills groups including relaxation, creative writing, current affairs, anger management, anxiety management, cooking, smoking cessation and a voices and visions support group for those who experience auditory and/or visual hallucinations.

An array of information is available to take away including leaflets and factsheets about mental illness and relevant topics. Further development of this into a resource room will allow a space where service users can access information about community resources, and read stories of hope to inspire and empower them. The current kitchen is soon to be transformed due to a recently win of £20k grant from BEH-MHT 'Dragons' Den' initiative.

Initially improving the service users' well-being and self-worth in the prison environment, the future vision of the OT department at HMP Pentonville goes beyond this to promote the development of daily living, coping and other transferrable skills that can reduce recidivism. The introduction of OT assessments and individually tailored interventions will help service users to consider their interests and abilities, place value on the importance of occupation and

begin to open up the possibilities for a more active and successful life in the community.

Rachel Kidd and Debbie Murphy
HMP Pentonville
Barnet, Enfield and Haringey Mental Health Trust



Artwork: Paulo Jorge

West Midlands Regional 24-hour Inpatient Unit Rota

In March 2015, Birmingham and Solihull Mental Health Trust and Birmingham Community Healthcare Trust took over the running of the Regional Rota for 24-hour inpatient beds across the West Midlands prisons. This was following a tender process which was commissioned by Offender Health Commissioners. Following the successful tender the Healthcare department based at HMP Birmingham took over the running of the rota for a 12 month trial period. One of the main priorities of the pilot was to ensure that the allocation of inpatient beds across the West Midlands became a more clinically focused process.

There are 3 prisons within the West Midlands that have 24-hour healthcare beds:

- HMP Birmingham with 15 mental health beds and 15 physical health beds
- HMP Hewell with 18 beds
- HMP Dovegate with 11 beds.

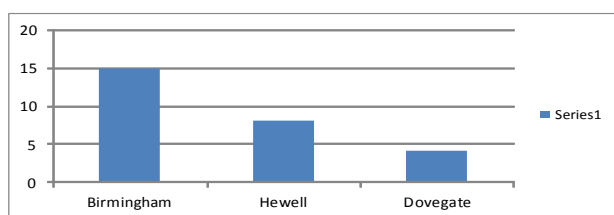
Prisons referring patients into the Regional Rota include Swinfen Hall, Stafford, Featherstone, Oakwood and Stoke Health.

In order to set out a clear process for both referring and receiving prisons a rota was set out for the whole of 2015/16. The rota is run on a weekly basis with the prisons on a cycle of Birmingham, Hewell, Birmingham, Hewell, and Dovegate. A referral form was agreed and sent out to all of the referring prisons in order to ensure that clear consideration was being given to people referred in for an inpatient bed. This proved to be a very successful part of the rota as the referring prisons took this on extremely well and included as much detail on each

referral as they could. All referrals are sent to HMP Birmingham and a nurse from HMP Birmingham Healthcare goes to access the patients referred. Where a decision is made to allocate an inpatient bed, then this in the first instance is allocated to the prison that is on the rota for that week. Once the bed allocation is agreed then the referring prison and the receiving prison liaise with each other in order to ensure the transfer of the patient to the 24-hour healthcare bed as soon as possible.

At the time of writing this report, a total of 61 referrals have been received to the Regional Rota. All referrals received were assessed. From the assessments carried out 27 referrals have required an inpatient bed and these have been allocated as follows:

Table 1



42% of referrals received were physical health related, 52% mental health related and 6% of referrals were identified as requiring both physical and mental health input.

Summary

- To date the key benefits of running the rota in this way have been that there is a clear process that clinical staff follow in order to request an inpatient bed.
- There is consistency with assessments as the same staff are carrying out the assessments.

- The assessing staff from HMP Birmingham have established good links with the clinicians in the other prisons.
- This has led to good working relationships and the ability to make decisions in a timely manner based on individual patient need.

There is a clear expectation that referring prisons will remain in contact with the receiving prison and the receiving prison will keep the referring prison informed of the pathway for each individual. For some of the mental health referrals the pathway has included onward transfer to a medium secure unit or a period of stabilization resulting in the patient being able to return to the referring prison to normal location. Physical health referrals have included mainly periods of stabilization following a stay in hospital. The follow on pathway has been to return to the referring prison once the individual's healthcare needs are within the remit of the referring prison.

A key challenge that has arisen recently is difficulties when there are no available beds and this will be the subject of on-going review with clinical staff, operational staff and Commissioners to ensure that we continue to make the best use of the regional resource that we currently have in place.

Based on some positive feedback and the ability to allocate beds relatively quickly up until some recent challenges has resulted in the pilot being extended for a further 12 months.

Derek Tobin
Head of Healthcare
HMP Birmingham
Birmingham and Solihull Mental Health Foundation

Join the **Email Discussion Group** to network with colleagues in the field of prison mental health.

Email 'join' to prisonnetwork@rcpsych.ac.uk

Book Review

Psychiatric Services in Correctional Facilities Paperback – 24 Sep 2015

By American Psychiatric Association (Author)

Paperback: 155 pages

Publisher: American Psychiatric Press Inc.; 3rd Revised edition (24 Sept. 2015)

Language: English

ISBN-10: 0890424640

ISBN-13: 978-0890424643

Product Dimensions: 15.4 x 0.5 x 22.8 cm
£25.23 from Amazon (but may be able to get for less).

This slim (0.5 cm) volume is essentially a report from the American Psychiatric Association covering guidelines for psychiatrists working in Correctional Facilities in the USA. The main body of the report consists of around 70 pages covering: Principles Governing the Delivery of Psychiatric Services (legal and ethical issues, quality, resources); Guidelines for Services (reception screening, treatment, community re-entry planning); and Special Applications of Principles and Guidelines mainly for specific disorders (substance misuse, PTSD, ADHD, and specific populations such as young people and veterans). There are 40 pages of appendices, APA positions statements, covering issues such as mentally ill prisoners on death row, use of restraint and seclusion, access to comprehensive services and access to care for transgender individuals.

There are many parallels with working in the UK Criminal Justice System but also significant differences. Correctional Facilities itself needs defining and includes lock-ups, jails, State and Federal prisons; reflecting the US legal system and different jurisdictions. Military prisons, immigration

and customs detention centers and Bureau of Indian Affairs detention centers are also included. In the UK these would include police custody, all prisons and Immigration Remand Centers. Whilst the legal system and organization of the prison services seems very different the service and clinical issues the book deals with are very familiar.

Part 1: Principles Governing the Delivery of Psychiatric Services in Correctional Facilities begins by outlining the legal (constitutional) rights to care and treatment upheld by the US Supreme Court and paralleling ECHR and UK 'equivalence of treatment' principles. Discussions on quality of care includes resources, milieu, staff and staff training. Consent, confidentiality and suicide prevention will again all be familiar to UK readers. Sections on relationships between healthcare administration, custody administration and inter-professional and supervisory roles again highlight familiar issues and familiar attempts at solutions but not often as clearly articulated in the UK. Diversion and alternatives to incarceration are again familiar but in some areas more advanced with the use of mental health and drug courts.

Part 2: Guidelines for Psychiatric Services in Correctional Facilities deals with the bread and butter of prison mental health services. Whilst some terms such as Post-classification Referral and Segregation Clearance are unfamiliar reception screening, brief and comprehensive mental health evaluation, treatment and discharge (community re-entry) and transfer planning are very similar even to the timescales. Screening is supposed to take place within 4 hours of reception, a brief mental health assessment of those screening positive within 72 hours and a more comprehensive intake mental health screening for everyone not referred already at 14 days. There are brief guidelines as to how to undertake these including gathering co-lateral information,

the qualifications of assessors and the need for an office with sound privacy whenever possible.

Part 3: Special Applications of the Principles and Guidelines was the most interesting. It covers a number of epidemiologically common disorders such as PTSD, ADHD, sleep disorders which are not always properly detected and treated in the UK. I found the pragmatic approach to ADHD particularly useful. Substance misuse and infectious diseases, which tend to be addressed by dedicated services are included. The chapter concludes with consideration of specific populations including women, young adults, geriatric, LGBT and veterans (of whom there are higher numbers in the US) and learning disabilities. There is a long section on seclusion and mental health and brief

mention of areas such as hospices, tele-psychiatry and spiritual issues.

Overall this brief book provides a useful overview of the APA guidelines for correctional psychiatry. In terms of a quick read to get a flavour of how one's own services compare to those in the US it is a very useful read and I certainly came away with some ideas of how to improve services and gaps in provision. The £25 price tag seems quite a lot for such a short book but it may be possible to get it for less or persuade your library to get a copy. The time spent reading it was certainly well spent.

Steffan Davies

**Consultant Forensic Psychiatrist
HMP Gartree**

**Northamptonshire Health Foundation
Trust**

My Experience of the Norwegian 'Ideal'

Recently I went to visit a high secure Norwegian prison in a town called Halden to compare how their low reoffending rates tallied with their prison system and what impact this has on mental health.

Halden prison is Norway's second largest prison with 251 inmates, and here we touch on one major contrast between the UK prison service and Norway because they have a total of 290 staff (all staff, correctional and others). This prison was built in 2010 and was from the onset designed specifically to think about reintegration and a system that would work – their vision being “punishment that works – change that lasts”. It has also colloquially been known as the iron fist with a silk glove on.

So first let's talk about the prison environment. The first thing that struck me was its large scale, a total of 150,000 square meters and over half of that is outdoor space. There is a forest inside the walls with a walking track running through for prisoners to be able to let off steam and walk around in nature. Each of the exercise yards is large and has access to recreational activities such as a tennis net and football posts.

The prison has a large activities centre which the majority of prisoners attend; here they can access learning and training development opportunities such as mechanics, metal work, woodwork, art and catering. There's a large, impressive music studio (with its own record label) and a printing studio (with its own company to take orders from local businesses).

Within the walls there is a 'visiting house' and this is where trusted prisoners (who have completed a parenting course) can spend up to 24 hours with their family. It has a children's bedroom alongside a lovely

garden and looks much nicer than one would expect from a prison.

One thing I should mention at this point is that I had noticed a distinct lack of damage anywhere, there was no graffiti, no broken equipment, not even any chips or scratches in the walls. It all looked like it had just been built. The manager of the mental health team said that this was because they give prisoners a lot of trust and respect and in turn they respect their surroundings. There is very little violence and self-harm noted in this prison. The custodial staff are all trained in different communication techniques and mental health.

All of the prisoners have their own cell, no one is sharing here! On the drug and alcohol wing that I went onto all the prisoners are divided up into these 'wards' each with 10 cells and a living room/kitchen. The prisoners have keys to their own cells and can come out to the living room when they wish; giving them much more autonomy over their lives. A psychologist leads the patient journey from start to finish at that unit and the therapeutic treatment they need.

One stark contrast I noticed was the lack of bars anywhere, all the windows (even in the cells) had large panes of glass which I was

reliably informed were unbreakable; most of which overlooked some part of the forest.

There is not an inpatient unit for mental health at the prison so any patients needing inpatient treatment were transported to the local hospital – When I spoke with staff they said that there was no waiting list for this and that they can access this easily but rarely do so because they can provide a lot of support here. There's even a staff choir – worth looking at on Youtube! (www.youtube.com/watch?v=xnpDpz6GcA8)



Image: Halden Fengsel (prison) from the air.

Luc Taperell
Mental Health In-reach Team Manager
HMP Pentonville
Barnet, Enfield and Haringey Mental Health Trust

Patient Artwork

The Prison Network is looking for artwork produced by patients of prison mental health services on our upcoming reports and publications, including the annual report which will be published this summer.

If any of the individuals you work with would be interested in submitting a piece of artwork for consideration, please email it to prisonnetwork@rcpsych.ac.uk.

A huge thank you to those of you that have sent through some brilliant pieces.

Anthony Walsh kindly submitted the excellent artwork on the first page of this newsletter.

Piecing Together Our Incredible Journey

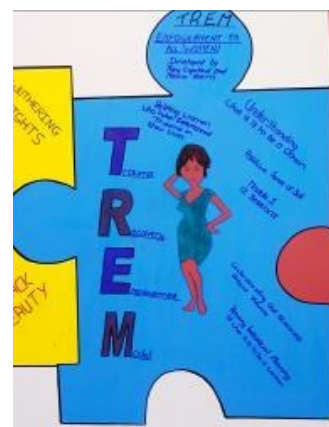
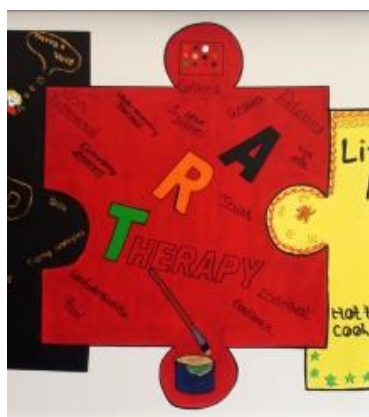
The following artwork was completed by women in the Primrose Service at **HMP Low Newton** and it recently won a silver Koestler Award.

The Primrose Service is the highest tier service in the Offender Personality Disorder Pathway for women in a prison setting. There are twelve places on the service and it is designed for high-risk women with severe personality disorder.



One of the women wrote this extract about the art piece:

"Each of our jigsaw pieces is to show the different therapies and alternative activities we do on Primrose. It is not about the level of art, but coming together and making something that represents who we are and what we do. *Piecing together our incredible journey* is to show what we are trying to achieve on the Primrose Service. We are slowly piecing our lives back together as a whole."



HMP Low Newton
Tees, Esk and Wear Valley NHS Foundation Trust

In the Spotlight: HMP Peterborough MHIRT “An Integrated Mental Health Service”

Who are we?

We are the MHIRT at HMP Peterborough. We are employed by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and the prison itself is operated by Sodexo as opposed to HMP. The team is comprised of 1 FT team manager (senior nurse), 6 FT senior mental health nurses, 1 FT social worker, 1 FT administrator, 1 PT administrative assistant, 1 PT principal psychologist, 1 FT senior psychologist, 1 FT assistant psychologist, 1 FT substance misuse/primary care worker and 1 FT psychiatrist.

In terms of prison population we are a Local Category B prison holding both remand and convicted prisoners, including adults, young offenders, as well as vulnerable prisoners. We are the only prison in the country which accommodates both males and females. Our current roll count is approximately 1500, split roughly 2/3 male to female and we have an annual turnover of over 10,000. The prison has recently expanded by building an entirely new residential block to house 400 male Cat C prisoners and with the prison population increasing alongside nationwide prison closures, there is increasing pressure for us to expand our walls and increase the population we serve even further over the next few months.

What do we do?

We operate a unique integrated mental health service. When the service was initially developed it adopted the traditional ‘in-reach’ framework where the focus was

upon stabilising those with severe and enduring mental health problems, organising hospital transfers and helping to prevent suicides and violence. However, much like community services this left a significant gap in resources for those with mild to moderate problems such as depression and anxiety. Furthermore, the primary services which did exist tended to be patchy and poorly resourced with pharmacological treatments often the only available support (Adamson, Gibbs & McLaughlin, 2014).

Since the inception of IAPT in 2007, there has been a massive increase in the awareness of primary mental health problems across society and since the statement of equivalence guidance (Bradley, 2009; HMIP, 1996; HMPS & NHS executive, 1999) there has been a significant demand for prisons to review their services to ensure that they are on par with those offered in the community. Whilst many services have acquired specific IAPT services as a means of addressing this, our service won a commissioning bid to provide a primary mental health pathway within our existing MHIRT. Offering an integrative model of care such as this is not a new phenomenon and it is fastly becoming a highly recommended approach to service delivery and something which is favourable with commissioners within a range of health care settings.

How does it work?

Since winning this bid our MHIR service has been developed over the last 2 years where the overarching aim has been to combine both a primary and secondary care services using a stepped care model as recommended by NICE (NICE 2004a; 2004b).

In line with the community we wanted to allow an ease of access to the service, so we designed a primary care alert form which any member of prison staff can complete

about a prisoner who asks to be seen or gives them cause for concern. These alerts are then screened by the duty nurse each morning and booked into a routine appointment within 28 days. This is exceptionally better than IAPT waiting times whereby they aim to offer an initial appointment within 6-18 weeks (NHS England, 2015). In addition to this we also accept direct referrals from prison and community based GPs and mental health services. We aim to see these within 7 days, attending to urgent matters within 24hrs.

We run focus groups with prisoners to allow them to help us develop the service. Alongside this we have also allowed them to help design a user friendly leaflet as well as encouraging prisoner's to design artwork to advertise the service. We have noticeboards which advertise these materials throughout the prison and we regularly attend prison meetings to talk about what we do and deliver training to staff to help them identify and support prisoners with mental health problems. In time, we hope that we can work towards a self-referral system as in line with community well-being services. Once a patient is discussed, like most services we discuss our findings within our weekly MDT and decide which pathway they fit into. Within primary care we offer a range of low and high intensity interventions, in individual sessions as well as small trans-diagnostic groups for depression, anxiety as well as mixed presentations via a dual intervention we've named 'mood management', anxiety, PTSD and anger. All of these take place at step 2 or 3. Ideally we start with step 2 which is delivered by a primary care worker or assistant psychologist (under supervision) or a nurse. The step 3 interventions, which tend to focus more on formulation as well as specific psychological assessments (e.g. ADHD, WAIS) issues are conducted by trained psychologists. These interventions are also available to our CPA patients as part of their care package and we are currently developing protocols for DBT skills and

hearing voices. We currently do not operate a waiting list for 1:1 interventions. We do have a waiting list for groups which is often 8-12 weeks. Again, this remains sufficiently less than community IAPT services whereby their aim for 2016 is to offer 75% of patients an initial appointment with a key worker within 6 weeks and 95% within 18 weeks of referral (NHS England, 2015).

Aside from these structure interventions, we also have a 'monitoring' level at step 1 which is likened to the 'watchful waiting' protocol adopted within the community. This is aimed at those patients who simply struggle to adjust to coming into prison and require short term support and behavioural activation to aid them through the settling in process rather than require formal treatment. Equally, this step is also used as a step down from other more intensive steps within the service. Furthermore, someone who shows a change in presentation or risk can automatically be stepped up into a higher level of care at any time without the need for an onwards referral.

For those that we do not accept into the service, we have a wide range of liaisons with other prison based services, whom we can refer to for onwards support depending on their needs requirements. This also now includes care act assessments.

What are the advantages?

The main advantage of this model of care is that it allows patients a seamless flow through services where they are able to access a wider range of interventions within the care plan approach and a fluid step up/down in care in response to their evolving needs. Although very limited, existing research indicates that low level psychological interventions are just as effective in prisons as they are in the community (Adamson et al., 2014; Leigh-Hunt and Perry, 2014; Maunder et al., 2009) and this ultimately reduces the number of patients that go onto require secondary care

input and increases their functioning within prison. Our data thus far shows some very promising outcomes, which are comparable to the recovery targets set by NHS England for IAPT interventions. The government's IAPT agenda aimed at reducing the cost of low level mental health problems on the welfare system by increasing people's ability to cope with daily life and get back to work (Layard et al., 2006). What we have demonstrated thus far is that similar functional outcomes can be shown in prison populations where these interventions have led to reduced numbers of ACCTs, ASBIPs and IEPs/Adjudications as well as progression in terms of gaining positive IEP rewards and increasing the number of prisoners who are able to comply with the regime thus reducing the overall costs of mental health related operational problems on the prison estate.

For patients this results in better access to services and through-care and over the last few years we have seen an increase in our patients' positive responses on experience/satisfaction surveys. We certainly feel the integrated model enhances the CPA approach and allows for a more rapid response to changes in risk and complexity which we feel offers a greater safeguard for patients as well as a more comprehensive package of care thus preventing patients falling through the gaps in services. It has also led to better relationships between ourselves and the prison as well as other agencies so that there is a greater sense of collaboration and through-care for both patients as well as staff.

What are the drawbacks?

Given that research suggests that mental health problems in prison can be up to 10 times higher in prisons than in the community with at least 59% experiencing anxiety and 7% suffering depression (Singleton, Lee & Meltzer, 2000; Singleton, Meltzer & Gatward, 1998). Introducing this pathway has significantly increased the

number of referrals into the service, especially since prevalence rates are thought to be even higher in remand prisoners (Singleton et al., 1998). This has increased staff workload which has the potential to increase stress which is a key factor in staff burnout (Edwards et al., 2000). It has also led to an increased expenditure of staff training for psychological interventions as well as increased need for supervision. Furthermore, given the uniqueness of our service in comparison to existing MHIRTs and community services, making onwards referrals can be difficult e.g. a prisoner on primary care step 3 may well be excluded from mainstream IAPT services in the community due to their forensic background, however, their mental health alone is not sufficient to warrant a referral to CMHT. Another massive problem we face being a remand prison is the high turnover which often results in very high attrition rates.

What happens next?

We are currently in the process of seeking permission to publish some of our outcomes over the last 2 years in order to share the success of our primary care interventions given the current lack of existing literature. We also help to increase the range of interventions we offer and would welcome any support from our colleagues at other prisons, particularly with regards to any services running integrative models. We found our recent peer review to be a very helpful and supportive experience and certainly welcome the comments of our colleagues in the wider prison quality network.

Please contact the Network for the full reference list relating to this article.

**Dr Becky Dunmore,
Senior Clinical Psychologist & Primary
Care Pathway Lead
HMP Peterborough
Cambridgeshire and Peterborough NHS
Foundation Trust**

Occupational Therapy within a Young Offenders Institution

Occupational therapy within YOI's in Britain has been on the increase, although the number of occupational therapists working in this setting are unknown. Occupational therapy is focused on the belief that to achieve full health, people need to be engaged in meaningful occupations, occupational therapy aims to help achieve this.

Traditionally, sadly, those offenders who end up serving time in a Young Offenders Institute have not been engaging in occupations considered as productive and 'pro social', by wider society, they often engage in illicit drug misuse, gang culture, robbery, theft, violence and aggression. This whilst simultaneously, generally not engaging in productive occupations such as attending school, pursuing outside interests such as football, sport, music and other interests and activities, leaves young people without generally accepted and meaningful occupations.

Working with young offenders is often a difficult balance between acknowledging the role of engaging in activities has offered to the young offender whilst encouraging them to engage in productive and 'prosocial' activities. Working with offenders means trying to encourage them to engage in productive and 'prosocial' activities, however this often means establishing new friendships and encouraging them to engage in activities that may previously have been viewed as a negative experience and activity such as education.

However the role of an occupational therapist is also essential and a fulfilling one to hold. Occupational therapists are skilled at adaptation, such as viewing someone's

previous occupations without judging them, whilst simultaneously considering how these roles and interests could be met in another ways.

Occupational therapists focus on the positive aspects and strengths someone has had, for example instead of viewing someone who has been part of a gang as solely negative, that person could be viewed as wanting to be part of a group, a team player, even possibly to have good leadership skills, i.e. appreciating the role of being part of a gang fulfils for that person rather than judging them for being part of a gang. Young offenders often need to be guided into choosing alternatives that still meet these roles, whilst simultaneously offering an alternative to the previous antisocial lifestyle, which often led to them being brought into custody in the first place. Young offenders have amazing drive, aspirations and dreams which need to be encouraged as opposed to squashed. That drive and energy is often infectious when working with offenders, each day, despite their surroundings, there is often laughter and banter going on throughout the day. An occupational therapist needs to encourage and channel these aspirations and dreams. One example of this happened a few years ago. A young person had been brought to the time and separation area, he had been placed in a room where he proceeded to cover the room almost entirely in expletives, mostly using one word, this was being shown to staff as an example of how disturbed and hopeless this young person was. However, when looking at the room I noticed that, in fact, the way the words were laid out was quite artistically done, so when talking to the young person, instead of telling him not to do this, or express disgust or concern, his artistic ability was complimented and he was encouraged to continue this as a form of art work, being given art pencils and paper, in addition being encouraged to enter The Koestler Art Exhibition. He agreed to clean off the expletives from the wall himself, started to

focus his art work, each time he was seen he was encouraged to share the work he had been doing. Whilst at times this still contained expletives, they were now contained on the art paper instead of all over the walls.

Occupational therapists' work with young people is trying to ensure they do not become repeat offenders, helping them to identify future positive goals. Occupational therapists work in both individual and group settings within a young offender's institution.

Working with young offenders has enabled me to view young people in a very different way from when I started, appreciating the many talents of the young people and enjoying the infectious energy they give to your work environment.

Hannah Lukacs
Clinical Lead Occupational Therapist
HM YOI Feltham
Barnet, Enfield and Haringey Mental Health Trust

A Peer-review Visit

I previously worked as a Project Worker on the Quality Network for Forensic Mental Health Services. I have recently moved projects but remain working within the CCQI department. I knew that the Quality Network for Prison Mental Health Services was being developed and thought it was an extremely worthy cause and there was a need for a Network to be developed for patients suffering from mental health issues within prisons. I was lucky enough to shadow a peer-review and I chose to visit HMP Wandsworth partly because it was easy for me to get to but also because it is one of largest prison in the UK and therefore it is quite well known.

Although I have visited countless medium and low secure hospitals, I have never been inside a Category B prison before. I was feeling quite apprehensive about the visit especially because I had recently read an article by The Guardian about the 'UK's most overcrowded jail' having extreme shortages in prison officers which has led to a large majority of prisoners being locked up for 23 hours a day. The article also wrote about the drug drones and deaths in custody which HMP Wandsworth has had to deal with this past year.

On the morning of the review visit, the peer-review team met at reception, handed our ID

cards over and put all of our contraband items into the tiny lockers provided which we were asked to share. An officer escorted us into the prison, through a series of locked doors, and up about three flights of stairs into the prison mental health office area. I was feeling quite anxious by this point as I did not know what to expect and we had walked past a number of empty cells. However, as soon as I met the key contact I was instantly put at ease. She was very accommodating and pleasant and once we had discussed the process of the day, I began to realise that it would not differ much from a forensic mental health review. I was taken onto the wings to meet the patients. Due to the staff shortages most prisoners were only allowed out of their cells for an hour a day therefore we escorted staff to sessions with the patients to see if they wanted to speak to us.

I was really impressed with the dedicated, hardworking staff that I met throughout the visit. However, it is clear that prisons across the UK would benefit from peer-review visits which allow services to reflect on the ways in which the prison mental health teams can improve practice by receiving visits from other teams as well as visiting other prisons to share ideas and processes. I found the day really interesting and it gave me valuable insight into life inside prisons.

Amy Lawson
Deputy Programme Manager (CCQI)

Quality Network for Prison Mental Health Services Annual Forum 2016

Thursday 7 July 2016

10.30am - 4.30pm

*Royal College of Psychiatrists,
21 Prescot St, London, E1 8BB.*



An interactive event, packed with presentations and workshops. The Annual Forum is an opportunity for professionals from all disciplines to meet and discuss key service development issues to prison mental health services. The forum is a great opportunity to learn and share ideas about the future of services.

The event is **free to attend for member services** of the Quality Network for Prison Mental Health Services. For non-members, places are chargeable at £40.

If you would like to attend, please email the following details to Megan Georgiou at prisonnetwork@rcpsych.ac.uk

Name

Job Title

Name of Prison

Name of Trust/Organisation

Email Address

Payment Details (for non-member services only)

All materials, lunch and refreshments are included. This event is eligible for 6 CPD hours subject to your peer group approval.

Prison Mental Health Standards Expert Consultation Group 30 June 2016, 10am-2pm.

Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB.

The group will consider any revisions to the specialist standards after the first year of implementation and will include individuals from those involved in the pilot year of the Network, key stakeholders and experts within the field of prison mental health.

If you are interested in attending, please email megan.georgiou@rcpsych.ac.uk

The Prison Network

The Prison Network was very pleased to publish standards for prison mental health services in June 2015, supported by a foreword from Lord Bradley. The development of the standards was led by Dr Huw Stone and Dr Steffan Davies, and were consulted on widely by key stakeholders, including individuals working in mental health and criminal justice settings. The standards appear alongside specialist core standards for community services, developed by the British Standards Institution (2015) as part of a wider project organised by the Royal College of Psychiatrists' Centre for Quality Improvement. The standards have been designed to help services engage in a process of quality improvement and service development.

This work has formed the foundation of a quality improvement programme for prison mental health services whereby members can evaluate their practices as part of a self-review and peer-review process. Eighteen prison mental health services are partaking in the pilot year of the Network, with services from across the UK and Ireland. The aggregated data and key themes from this initial phase will be published at the end of the first year, as part of a public report and forum. Further information about attending the Annual Forum can be found within this newsletter.

In terms of developing the Network, we have been liaising with various health and justice bodies over the past six months in order to establish a well-informed and robust constitution for our member services. This has largely been to discuss how we can work together with key stakeholders to the benefit of prison mental health services and their patients, for instance we have met with patient involvement charities to see how we can further embed the patient voice and experience into our work. Furthermore, we

were very excited to find that we have been referenced in the Prison and Probation Ombudsman's report on prisoner mental health and a consultation paper published by the Welsh Government. We would like to expand our membership for the second cycle and recruitment will begin in May 2016.

Late last year, we trained individuals from all of our member services in how to lead a peer-review and we hosted a welcome event solely for our members, including presentations from the Care Quality Commission and NHS England. A couple of workshops also took place, exploring how we can further involve patients and the prison establishment in our work, and looking at what more the Quality Network can do to support prison mental health services.

All of the pilot year services have now completed the self-review process and the peer-reviews will finish in May. It has been extremely interesting to see the difference between services, observing the excellent work taking place and also learning of the main challenges being faced. I have enjoyed meeting each of the teams and it has been so positive to see the shared passion for change and quality improvement within prison mental health.

Finally, I would like to thank all of the members that have completed the review process for their hard work in both organising and running their peer-review days. You have all been so welcoming and it has been positive to hear that you are finding the process useful.

Megan Georgiou
Deputy Programme Manager
Quality Network for Prison Mental
Health Services

Useful links

Care Quality Commission

www.cqc.org.uk/

Centre for Crime and Justice Studies

www.crimeandjustice.org.uk/

Centre for Mental Health

www.centreformentalhealth.org.uk/

Department of Health

www.gov.uk/government/organisations/department-of-health

GOV.UK Prison and Probation

www.gov.uk/browse/justice/prisons-probation

Howard League for Penal Reform

www.howardleague.org/

HM Inspectorate of Prisons

www.justiceinspectorates.gov.uk/hmiprisons/

Institute of Psychiatry

www.kcl.ac.uk/ioppn/index.aspx

Ministry of Justice

www.justice.gov.uk/

National Institute for Health and Care Excellence

www.nice.org.uk/

National Offender Management Service

www.gov.uk/government/organisations/national-offender-management-service

NHS England

www.england.nhs.uk/

Offender Health Research Network

www.ohrn.nhs.uk/

Prisons and Probation Ombudsman

www.ppo.gov.uk/

Prison Officers' Association

www.poauk.org.uk/index.php?aid=2

Prison Reform Trust

www.prisonreformtrust.org.uk/

Revolving Doors

www.revolving-doors.org.uk/home/

Royal College of Psychiatrists' Centre for Quality Improvement

www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement.aspx

See Think Act (2nd Edition)

For information and materials on relational security in secure settings, please visit:

www.rcpsych.ac.uk/sta

We also have modified versions for prison settings, please email megan.georgiou@rcpsych.ac.uk to request copies.

User Voice

www.uservoice.org/

World Health Organisation Prisons and Health

www.euro.who.int/en/health-topics/health-determinants/prisons-and-health

Contact the Network

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