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WELCOME

Welcome to the third edition of the Quality Network for Prison Mental Health Services' newsletter. We have received a number of highly interesting articles across a range of topics; many thanks to all those that contributed.

Since the previous edition, the team has been very busy visiting each member service and compiling the individual reports. Thank you to all those that have hosted reviews and to the reviewers that visited them – we hope you have enjoyed the experience.

In March we hosted an event 'Through the Gate Mental Healthcare' exploring the support provided to people transitioning between custody and the community. We had a number of engaging keynote speakers, including Liz Smith and Keith McInnis from HM Inspectorate for Prisons and Probation, Governor Tom Wheatley from HMP Nottingham, and Hattie Moyes and Katie Smithsbury from RAPT. We also had a variety of good practice workshops, including one from Dr Abu Shafi (see image) and the Network's patient representative on his lived experiences.



In addition, we have almost finished developing standards for 24 hour mental healthcare in prisons. We had around 45 people attend a standards consultation event in April 2017 and we are now working our way through the feedback. We will be publishing the standards at the Annual Forum on 6 July 2017.

Finally, recruitment of member services to Cycle 3 of the Network is now open. Please visit the website to find all of the relevant forms and information. We hope you can join us! Also, please keep an eye out for further initiatives over the coming year – further information on our events and training can be found inside.

Dr Huw Stone, Dr Steffan Davies and Megan Georgiou

Novel Psychoactive Substances in Prisons: Current Challenges and Future Perspectives

The rapid and an unexpected diffusion of hundreds of novel psychoactive substances (NPS) has become a major challenge for drug control regimes and national legislations. Advertised on the internet as “legal and safer” alternatives to illicit and recreational drugs, they appear in ever more sophisticated chemical forms and have widespread and unknown long-term effects on users.

Simultaneously, within the prison service, the number of suicides, murders, and attacks on staff related to NPS have also worryingly increased. In 2016, 35,000 cases of self-harm in prisons were reported in England and Wales. This is a 27% increase from the previous year. Of people detained in police custody, 16.2% reported current suicidal thoughts of whom 86.2% reported a history of self-harm or suicide attempts. According to the most recent review of health in the criminal justice system, there are, on average, 600 incidents of self-harm and one suicide every week within the prison service in the UK. This is considerably higher than in the general UK population, with 6% of prisoner stating they have previously attempted suicide. The annual number of attacks on staff has reached almost 5,000, up a third on the previous year.

The interest around these new substances is quickly growing because the number of deaths with a strong (albeit not proven causal) association to NPS was up to 58 between June 2013/January 2016, from 19 reported between 2012/2014. NPS are

becoming extensively used among the prison population because they are relatively affordable and hard to detect by conventional on-site testing. They are often used as a coping strategy to long hours and days in prison life; to struggle against boredom, relieve pain, fight the withdrawal symptoms from other substances and avoid conventional drug testing methods. In fact it has been estimated that among adults with mental health problems serving community sentences, 72% also resulted positive for either an alcohol or drug problem. Drug dependence within the prison population is 45% in comparison to 5.2% within the general population.



In March 2015, project NEPTUNE was developed to improve clinical practice in managing harm resulting from club drugs and NPS use. It divides NPS into ten categories: Synthetic Cannabinoids, Depressants, Dissociative, Nitrous Oxide, Amphetamine-type, Methamphetamine, Synthetic Cathinones, Ecstasy-like Drugs, Stimulants and Hallucinogens; the current evidence indicates that the majority of NPS circulating in the prison system are Synthetic Cannabinoids. These drugs can produce cannabis-like effects, but are often more potent because they are made up of dried, shredded plant material sprayed with strong chemical additives.

The Prisons and Probation Ombudsman (PPO) reported four major risks associated

with NPS use in prisons: (1) Short and long term physical health effects, (2) mental health effects linked to unpredictable behaviour, self-harm and suicide, (3) behaviour problems such as violent or aggressive behaviour, and (4) risk of bullying or debt associated with dealing. In fact, the use of these substances can be dangerous to both physical and mental health. Episodes of violence, aggressiveness and self-harm were reported as well as a series of issues related to the access of the NPS in prison settings. Trading in these substances can lead to debt, violence and intimidation. While it is difficult to establish whether taking NPS was a direct causal factor in self-inflicted deaths, the debt and bullying associated with trading drugs can increase a prisoner's vulnerability and the psychological effects can have a profound influence on mood and mental stability.

The spread of NPS is a global challenge, it requires great awareness and a multidisciplinary approach to the problem, the PPO report proposed this five-point learning approach:

1. Supply needs to be reduced, trafficking in NPS needs to be tackled by effective local drug supply and violence reduction strategies;
 2. Staff awareness needs to be increased, prison staff need better information about NPS, and how to spot that a prisoner is taking them;
 3. Governors need to address the bullying and debt associated with NPS robustly;
 4. Drug treatment services need to address NPS use and offer appropriate monitoring and treatment; and
 5. Demand for NPS among prisoners needs to be reduced, with prisons and healthcare providers ensuring that there are engaging education programmes for prisoners outlining the risks of using NPS
- are still a largely unknown topic. It has been estimated that at least two new

NPS drugs emerge each week.

To face this ever-changing phenomenon it is fundamental to engage with experts working on NPS and carry out more studies to inform action and suitable prevention strategies. In this sense we suggest a survey among inmates evaluating the availability, the level of risks, mental health status and aggressiveness (as well as their attitudes toward NPS). At the same time, validated and standardised tests to scientifically detect the presence of substances in prisoners' bodies are also required. By matching surveys and test responses we could have a more accurate idea about the spread of NPS in jails.

Beyond policy improvement it is also important to underline how drug users represent a large and fragile proportion of the prison populations and imprisonment may be viewed as a chance to provide treatment for their addiction, leading to their better health and also reducing risks to the community on their release. It seems crucial to improve drug-related assistance, including better access to drug-related prevention, treatment, harm reduction and rehabilitation services, of a standard that is comparable to the services provided in the community.

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IAPT in Prison: The PWP Role Within a Prison Integrated Mental Health Team

Almost 2 years since the initial implementation of IAPT services within the North-East prisons, this article provides an insight into working as a PWP within the prison service. It focuses on the challenges, the successes and the scope for the future.

Challenge	Success	Outcome
To establish a primary care IAPT service and implement this into an already established mental health team.	A solution-focused approach was demonstrated by the team which facilitated the initial development of the service and there remains a commitment to ongoing service improvement with the overall aim of streamlining the delivery of stepped care (as recommended by NICE, 2011).	Primary care IAPT services were successfully integrated into prison mental health teams.
Many patients have had previous poor experiences of mental health services in the community due to exclusion criteria which can create a barrier to engaging with mental health services in prison.	PWPs are often the first point of mental health contact for individuals with mild-moderate anxiety and depression. Therefore PWPs are responsible for establishing expectations and boundaries and employing therapeutic skills to encourage engagement.	Patients who were initially reluctant to engage have completed treatment with positive outcomes.
Within the North-East prison cluster there are male establishments (Category A-D), a young offenders institute (YOI) and a female establishment (all categories) and the needs of the patients within these establishments vary greatly (e.g. young offenders are a different stage of development than adult offenders).	PWPs use clinical supervision to consider issues which may be relevant to patients within different establishments and to care plan for this accordingly.	The Rethink IAPT service has been rolled out successfully within all 7 North-East prisons despite the different characteristics of patients within these establishments.

<p>Given the prevalence of co-morbidities/complexities it can be a challenge to adhere to the 7 key PWP interventions:</p> <ul style="list-style-type: none"> - Behavioural Activation - Cognitive Restructuring - Exposure Therapy - Managing Panic - Medication Management - Sleep Hygiene - Problem Solving. 	<p>PWPs adapt the use of behavioural activation with the restrictions surrounding the prison regime in mind (e.g. prisoners can only access the gym at allocated days/times).</p> <p>Additionally sleep hygiene interventions are adapted to take into account static and dynamic factors including cell sharing and substance misuse.</p> <p>PWPs use regular clinical/case management supervision to prevent therapeutic drift.</p>	<p>The 7 key PWP interventions (recommended by Richards, Chellingsworth, Hope, Turpin & Whyte, 2010) are successfully adapted and implemented with patients within the prison population.</p>
<p>Delivering interventions within a prison environment:</p> <ul style="list-style-type: none"> - Time limitations due to prison regime - Logistics such as prisoner movement and employment - Limited therapy space/resources. 	<p>The teams solution-focused approach means that we are continually looking for opportunities to engage with the prison service and have established dedicated rooms for group sessions.</p> <p>PWPs have contributed to mental health awareness training delivered to prison staff and other organisations to promote knowledge of the services delivered and to promote commitment to the mental health of prison population.</p>	<p>The team is able to have regular therapeutic contact with prisoners however there are instances where this is not possible due to prison regime issues/lack of dedicated therapy space.</p>
<p>There is an increased level of risk associated with working with offenders in custody; including risk to self, risk to others, risk from others/vulnerabilities, substance misuse and higher rates of violence and aggression.</p>	<p>Whilst PWPs do not complete therapeutic interventions with patients who are at risk of suicide or significant deliberate self-harm, we are required to complete risk assessments and monitor risk throughout the treatment process to ensure the safety of our patients and others.</p> <p>PWPs liaise closely with TEWV clinical lead nurses and access weekly caseload management supervision to ensure risk is appropriately assessed and monitored (in line with national IAPT recommendations; Richards et al., 2010).</p>	<p>PWPs use a holistic approach to risk assessment (including assessing presenting problem and precipitating, perpetuating, predisposing and protective factors).</p> <p>PWPs attend MDT meetings daily to discuss patients' care and any associated risk issues.</p>

<p>Learning difficulties/disabilities are prevalent within the prison population.</p> <p>Rack (2005) screened prisoners in eight prisons in Yorkshire and Humberside and found that 40% – 50% of prisoners have equal to or below the level of literacy and numeracy expected of an 11-year old.</p>	<p>Within group clinical supervision sessions PWP's have actively adapted resources for use within the prison population such as (pictorial representations) and including prison specific examples.</p> <p>PWP's also seek support from clinical lead nurses who specialise in learning disabilities for advice on adapting interventions.</p>	<p>As PWP's we acknowledge that there is no "one size fits all" approach and during assessment and treatment, patients' developmental and intellectual capabilities are taken into consideration.</p>
<p>PWP's within prison are required to work with a range of co-morbidities/complexities:</p> <ul style="list-style-type: none"> -Substance misuse -Diverse socioeconomic backgrounds -Dual diagnosis -History of trauma -Personality disorders -Social problems. 	<p>PWP's engage in joint working with:</p> <ul style="list-style-type: none"> - TEWV secondary care clinical lead nurses - Higher assistant psychologists - Drug and alcohol recovery teams (DART) - Family support service - Rethink resettlement service. 	<p>Patients who would usually be excluded from community IAPT services due to secondary diagnoses or co-morbidities/complexities are able to engage successfully with primary care interventions within the prison.</p>

Scope for the future

As current integrated working practices have proved successful, we hope in the future to further develop this. This may include co-facilitation of group sessions with DART teams to meet the needs of patients with identified dual diagnoses.

As PWP's we are working closely with our Rethink resettlement officer to organise service user forums; these forums will provide opportunities for patients who currently have, or have previously had, involvement with mental health services to help shape the future of service provision. As a team, we are patient-focused and the introduction of these forums seems like a logical next step to ensure that we are successfully meeting patient expectations and needs.

We would be keen to improve links with local community IAPT services to promote engagement with these services once our patients leave custody. Often patients who would be eligible to access IAPT services within custody are faced with barriers to engagement within the community (e.g. not meeting community IAPT criteria due to co-morbidities). However as previously highlighted, we have had successful outcomes with clients with a range of co-morbidities and would be keen to share our practice of working with offenders.

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

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An Abstract Day in the Life of a Prison Nurse

07:50, arrive at the gate, belt, check, chain, check, keys, check, radio, check, phone locked away, check. Greeted by a full bag search, sniffed by a dog, dog walks away happy, phew. Lose count of how many gates to get to healthcare, fitbit checked 1000 steps.

Settle down for handover, breakfast, black coffee and banana...sorted. Tasks allocated – great, special sick. Offenders on the move, 1st patient in, has a cold, wants antibiotics and bed rest for 1 week, next patient has flat feet...*this is supposed to be an emergency clinic!* The morning follows a similar pattern, 20 year backache, piles, run out of burn and wants NRT *sigh*.

12pm offenders locked up, forced to have lunch. Lunch done, handover done, tasks allocated, I'm in reception. "general alarm segregation all staff required" go to seg, men in white suits applying vapour rub under their noses...dirty protest...my beef

madras for dinner later doesn't seem as appealing now. Shields ready, jack hammer ready, 3 tries and the door is smashed, offender relocated safely, job done.

Go to reception, 5 newbies, all born in the early 90s, happy days fit and healthy. Get some funny looks trying to google translate Chlamydia into urdu...its **کلیمانڈیا** in case you're wondering! Receptions done, now back for evening treatments.

Get shouted at for not allowing pregabalin in possession get told "Nie jestem dzieckiem" My polish isn't great! Treatments done. "Hotel1 receiving code blue M wing 3's landing" .

Grab the emergency bag, lock what feels like a million gates, 3 flights of stairs later, ambulance not required...diagnosis... heartburn!!! "hotel 1 leaving the net" radio away, keys away, fitbit checked 15,000 steps...a quiet day overall.

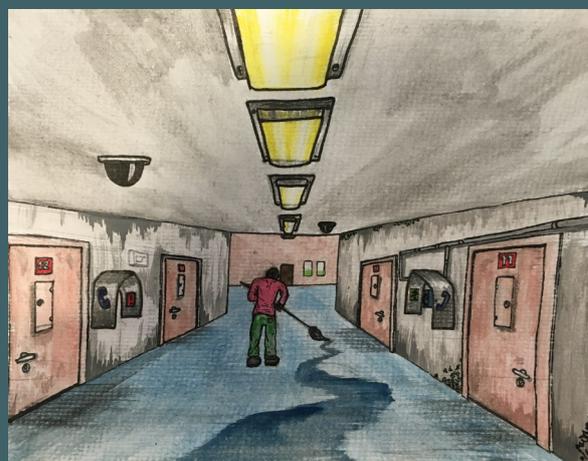
Sam Whiskin
Operational Manager
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Patient Artwork

The Prison Network is looking for artwork produced by patients of prison mental health services to use on our reports and publications.

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.

Image: Anthony Walsh



Pets as Therapy

The offender mental health teams are pleased to announce new members, Cooper and Spud.

Working in partnership with Rethink Mental Illness, a new service has been introduced to the seven North East prisons. Primarily, Rethink Mental Illness provides a step 2 IAPT and resettlement service in the prison, however, in collaboration with TEWV, innovations and service improvements are constantly being sought. Pets as Therapy (PAT), was identified during consultation within the prison. Research published by Pets as Therapy (www.petsastherapy.org) shows demonstrated benefits from pet therapy programmes include: a reduction in stress, a boost in self-esteem, improved mood, and better communication skills. A wide range of mental health conditions are now treated through pet therapy programmes. Interactions with animals are considered to offer benefits to patients suffering from post-traumatic stress disorder and challenging psychiatric disorders. Vulnerable prisoners have also benefitted from animal therapy programmes, including a group of troubled female prisoners in Northern Ireland, where improvements in behaviour and emotional wellbeing were noted as a result of the project. Animal therapy is also used extensively to treat depression. Petting an animal is

believed to cause the release of endorphins ('feel-good' neurotransmitters) which can have an extremely positive impact in patients dealing with depressive disorders. As such, Rethink Mental Illness, in partnership with TEWV, hope that the introduction of a PAT dog will enhance our existing service and ultimately improve the mental health of the service users we work with. Initially the project will be piloted in HMP Holme House, with Linda Cummings bringing Cooper and Spud into the team.



**Carolyn Houghton, Senior Psychological Wellbeing Practitioner
Rethink Mental Illness &
Richard Hand, Service Manager
Tees, Esk and Wear Valleys NHS
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Join the **Email Discussion Group** to network with colleagues in the field of prison mental health.

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

Service User Narrative

The following brief is a service user narrative provided by an inmate on B wing. The narrative illustrates his perceived view of his experience of life on the wing. All details contained in the brief are his personal observations; opinions and perceptions of life on the wing. The information for this feedback document has been gathered anecdotally via service user engagements and compiled by Trevor Urch, on behalf of the BSMHFT HMP Birmingham the Inside Recovery Service.

The fact that new psychoactive substances have taken hold of the whole prison estate has put a fog on the visibility of all four landings, of every wing in every prison across the country. Since my return to custody, my experience with controlled drugs (i.e. methadone) has changed drastically. The regime was a lot stricter before and the drug of choice (illegal drugs) would usually be cannabis or heroin.

Queuing up now to get controlled drugs is quite different. The nurses will make a snap decision on the look of you on turning up to the hatch. If you are deemed under the influence of another substance other than your prescribed medication (methadone or subutex) you will be held back for 24 hours. Even though I know prisoners (lads) that if this is the case it will lead them directly to a handful of guys. Guys that they can subsequently buy their dose of methadone or subutex from that would, under normal circumstances be given to them at the hatch. As this can give those who divert their dose an added incentive to turn up at the hatch before they smoke their mamba.

As I have previously stated the 24-hour break does not really work as you can always get controlled drugs on the wing if you are stopped at the hatch. The lads are left to their own devices, and as a prisoner who only smokes tobacco, it saddens me as

a lot of my friends are now in a zombie state and are very vulnerable due to mamba. Various names are used for mamba (man down) and also (powder). A white crystal substance also known as monkey dust is currently knocking the lads for six. Many are having mamba attacks on a frequent basis, it is very scary. I am witnessing five or six attacks a day and it is horrible. The powers that be have allowed B wing to run as a free for all and most of the lads are constantly off their heads.

Deals are done openly in front of officers and attacks go unpunished as eyes and heads are purposely turned the other way. I believe someone will be killed or die very soon on this wing.

I think a stricter regime would help keep us lads in line a little more. Regular MDT's for mamba with strict punishments (i.e. basic) plus zero tolerance would deter and set examples for any other lads thinking of following suit.

I agree with the 24-hour till sober process. I think it is a great deterrent even though a lot of the lads will still buy or get their hands on the exact dosage from elsewhere if necessary. I also think the officers could at least pretend that they care as they deal with prisoner queries. More involvement with those in recovery and lived experience would be inspirational and more helpful than anything.

Yours, B wing inmate.

Trevor Urch
Recovery & Service User Involvement
Manager
HMP Birmingham
Birmingham and Solihull Mental Health
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Developing a Perinatal Mental Health Pathway within a Female Prison

Introduction

There is a well-established and very valid view that prison is not always the most suitable placement for mentally-ill offenders (Bradley, 2009). Furthermore, it has been suggested by some that a prison environment, by its very construct, is actually more conducive to ill mental health, irrespective of the quality of the mental health provision (Prison Reform Trust, 2017). Similarly, The Corston Report (Corston, 2007) identified that there was a significant amount of women being sent to prison to serve sentences which were disproportionate in view of their crime, a strategy which was, arguably, unrealistic in the attempt to address the underlying concerns which led to their offending behaviours – poor mental/physical health, high levels of vulnerability, disrupted and troubled childhoods, traumatic past histories, as well as, a plethora of social and housing problems. The impact that frequent periods of incarceration had upon many women's lives was of specific concern, particularly upon their maternal and familial health.

The perinatal period, that is, from conception to 12 months post birth, is an extremely vulnerable period in a women's life (Howard et al, 2014). Up to one in five women are affected by mental health problems in the perinatal period; however, unfortunately, only 50% of these women are diagnosed, with appropriate treatment therefore delayed (Royal College of General Practitioners, 2017). Without appropriate treatment, the negative impact

of mental health problems during the perinatal period can be huge and can have long-lasting consequences on not only women, but their families too. However, when problems are diagnosed early and treatment offered promptly, these effects can be mitigated, leading to better outcomes and increased safety for mother and child (Royal College of General Practitioners, 2016). It has long been recognised that childbirth increases the incidence of mental health disorders in women (Royal College of Psychiatrists, 2015). Guidance from the Royal College of Psychiatrists, NICE and many other national/international sources, however, does not specifically consider the mental health needs of women within the perinatal period in prison.

What We Did

Our initiative is a new and innovative cross-agency approach which ensures the timely recognition of mental health needs and the prompt arrangement of suitable interventions in a prison setting, for a vulnerable group of women in the perinatal period. We, as a mental health service, have worked in conjunction with our partners in primary care, midwifery and the prison service to develop a pathway with very little guidance, limited resources and no extra funding. Upon review of the published literature there was a minimal amount available which related to our population – we utilised that which was available to develop a new and innovative pathway. Our pathway ensures that all women in the perinatal period are recognised and listened to, with their needs collaboratively addressed, thus maximising safety and improving outcomes for mother and baby. Since the inception of the pathway in May 2016 we have been able to identify and meet the needs of lots more women, many of whom may have been missed previously. We work with a large number of females, the vast majority of whom are extremely troubled and from

disadvantaged backgrounds. All of these women are vulnerable and may require timely access to help and support in the shape of a mental health intervention. The perinatal period can exacerbate this need for help and support. Women who are currently pregnant or who have given birth in the past 12 months need specialist care and assessment made available to them at what is a very risky period in a women's life. We recognise the potential for a concentration in risk for this population of women. Our predominantly nurse-led initiative sets out to meet this need by working in collaboration with our healthcare and prison service partners, as well as the women themselves, in order to hasten the identification of need, accelerate action, reduce risk and improve safety.

Wider Active Support

It brings me sadness to state that this initiative was brought about as the result of an unfortunate death in custody involving a young lady who had recently given birth. However, whilst we recognise the significance of this event, we have worked tirelessly to ensure that lessons have been learnt and that we minimise the chances of this occurring again in future. The whole perinatal pathway in HMP/YOI Low Newton is reliant upon the collaboration, motivation, flexibility and teamwork of lots of agencies, including the mental health team, midwifery, healthcare staff and the prison service, as well as the women themselves. However, the mental health component is a new and innovative piece of work, which is predominantly nurse-led and dependent upon the dedication and creativity of our team of nurses, both within the mental health team and the primary care team. We have broken new ground to develop a pathway from nothing – no additional funding or resources, no specialist training, no prison specific national/local guidance or no well-publicised examples of prison related best practice. We have increased our workload, we have re-doubled our already

very committed efforts, and we have also put the issue of perinatal mental health in female prisons on the local/regional agenda. This has become the expected practice in a short space of time. We achieved that together.

The initiative began with the realisation that we could and should do more for this population of women. The recognition of need was evident from all stakeholders. We understood the importance of making these resources available and we knew that this had to be implemented quickly. The healthcare elements of the pathway, be these physical and mental, were nurse-led from the beginning and remain so now. We discussed the issue of perinatal healthcare at the various forums both inside the prison, but also in our respective organisations. We wanted the recognition and commitment of service management – which we received in abundance. The next step involved a lot of joint-working, testing and evaluating, development and change. We started with an unwavering desire to make this work, partly because of the previous failings. With the impact that our changes have had, we now know that we must make this work, this is imperative.

Outcomes and Conclusion

In the relatively short space of time since the inception of our initiative we have been able to reach a population of women who, quite simply, would have been missed prior to launch. If we view this in the most extreme perspective, given the origins of our initiative especially, then these are women who may have suffered and possibly acted in an unsafe manner.

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

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Psycho-educational Workshops at HMP Elmley

HMP Elmley is a busy local male prison housing approximately 1200 offenders, including young offenders, foreign nationals, remand and vulnerable prisoners. The prison receives around 300 prisoners through reception each month, with an average sentence of 63 months.



The Bradley Report Review (2009) highlighted prison suicide rates in England and Wales were 114 per 100,000 compared to 8.3 per 100,000 in the general population. It showed 30% of offenders had self-injurious behaviour during custody, 78% of male remand and 64% of male sentenced offenders had a personality disorder. Originally, mental health in-reach teams (MHIRT) were commissioned to support severe and enduring mental illness (SMI) but it was identified they were supporting a higher number of primary care cases. It identified remand prisoners had increased rates of mental disorder compared to sentenced prisoners. At HMP Elmley most offenders are on remand due to it being a local prison. Therefore, it could be argued more support is needed for this vulnerable population. The report highlighted offenders would benefit from robust models of primary mental health services, developed by an appropriately skilled workforce.

HMP Elmley MHIRT designed and implemented a workshop programme based on these recommendations. From the Bradley Report, a need was identified and consideration was given to the transient population. As a vast majority of male offenders have a personality disorder, a specific 'Understanding Personality' workshop was developed to meet the population's needs. One offender explains, *"the course is very informative and helpful"*.

The MHIRT run distinct two-hour workshops with 10 prisoners invited. Eight workshops are offered and prisoners complete as many as they wish. The workshops are: Bereavement and Other Loss, Coping Skills, Mood Management, Mindfulness, Mental Health Awareness, Paranoia, Understanding Personality and Dealing With and Managing Trauma. Workshops are underpinned by cognitive behavioural therapy and advocate discussion with and between prisoners relating to their experiences and current coping strategies. Peer support is encouraged within groups, particularly with a mix of new and established participants. One offender's perspective on the workshop was, *"various techniques that make your time in here slightly easier to cope with that you can also carry with you outside of prison"*.

Workshops are open to all and no criterion needs to be met for a prisoner to attend. For example, they do not need to have a diagnosed mental health condition or be in custody for a set time. If prisoners are referred before being seen by a member of the MHIRT, facilitators conduct an assessment to gather more information about emotional and/or behaviour problems, explain how workshops run and give them a chance to ask questions. Prisoners have reported meeting facilitators prior to attending workshops reduces anxiety and they feel more comfortable attending. This relational element is important in engaging offenders and introducing them to change. An offender

describes the workshops as "a new way to look at things".

Working in prison means facilitators can face some issues. Difficulties in running workshops include operational issues, lockdowns and inability of prisoners to get from their cell to where the workshop is held. The team have worked with the prison to overcome these issues and are pleased to report increased number of workshops running each quarter and having the full support of the prison service.

Psychometrics are administered at the start of sessions, giving facilitators the opportunity to quickly assess prisoners' current levels of distress. Prisoners also complete evaluation forms to give facilitators information on which to reflect and subsequently improve workshops. Evaluation forms are generally positive with regard to workshop material and facilitator effectiveness. Safer Custody reported feedback they had from the workshops: "The men really value the workshops and are

disappointed if they ever can't run".

Due to the evident success of the workshop programme, the team will continue regular running of the workshops, keeping waiting lists to a minimum and helping to reduce prisoners' distress.

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

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HMP Belmarsh Inpatient Unit

In April 2015, Oxleas NHS Foundation Trust took over the healthcare at HMP Belmarsh. It was a new challenge for Oxleas to rebuild an active service within the prison setting, particularly in inpatients working in partnership with the prison service. It came of course at a difficult time with low morale both within the health service and prison service. However, all have persevered with some very positive outcomes.

The inpatient unit at HMP Belmarsh is a 33-bedded unit which provides input to both general health and mental health patients. At any given time, its occupancy is at 90%. Approximately 20% physical health and 70% mental health patients. However, we expect

anything to come through from a patient with TB to a trauma case, to an acutely psychotic patient, all are cared for.

We of course face the challenging role of caring for that ageing population also. A 24-hour service is provided by GPs to meet the primary healthcare needs of the group. In addition, there is in post a consultant forensic psychiatrist, an associate specialist and a specialist registrar has joined the team recently.

We have been fortunate to retain staff and we have an established ward manager, two charge nurses and a full nursing team. All officers and healthcare team are working together in partnership, with staff morale good and low sickness and good retention.

In 2016, we had over 400 admissions on a year basis to healthcare. In addition, there

were 40 transfers from the unit to mental health secure services, predominantly to Broadmoor Hospital and medium security.

However, our prison officers are challenged at many times by the management of a difficult category A prisoner, some of the most serious and high profile cases in the country. The officers have to provide a high officer unlock and at times an intensive medical input will be needed. On the other hand, the officers then are looking after the local challenging remand patients, minor offenders who present other needs.

The inpatient unit has become an active hub within the prison and liaises outwardly to the inreach team, the IAPT team, the addiction services, complex care team and other prison departments.

It has been productive together. We have met the challenging quality NHS indicators,

we are prescribing within NICE guidelines. We are meeting the CPA regulations of Care Programme Approach and furthermore the officers take enormous pride in their work and they see the healthcare as a dedicated area where they develop their own specialty skills as prison officers.

Many of the officers have taken the opportunity to undertake any mental health training offered by Oxleas NHS Trust. So onward, forward we go marching together in a happy partnership at a difficult time of austerity.

"We are what we repeatedly do. Excellence is then not an act but a habit".
Aristotle BC

Mental Health In-patient Team
HMP Belmarsh
Oxleas NHS Foundation

Self-harm and Self-Inflicted Death Project

Following the recent rise in prisoner self-harm and self-inflicted death, the Ministry of Justice funded a project aimed at addressing the issue that was carried out by Tees, Esk and Wear Valleys NHS Foundation Trust in 2016.

Four initiatives aimed at reducing prisoner self-harm and self-inflicted death were trialled at HMP Frankland and HMYOI Deerbolt. The initiatives were developed to enable prison staff to respond more effectively to cases of potential self-harm and self-inflicted death.

The project initiatives detailed below:

Staff development through analysis of mental health team input into the ACCT process designed to support better participation and information sharing

between the prison and mental health teams.

Staff development activities to enhance mental health awareness and training for front line prison staff.

Development and evaluation of the use of therapeutically informed in-cell activities, including BOB boxes (Big Orange Box) and prescribed relaxation.

Development of a trauma informed service model suitable for implementation in male prisons.

The findings from the project indicated that mental health team input in ACCT processes are generally satisfactory for all members involved. However, it is felt that there is scope for improvement and a guide for effective practice for the ACCT process was developed for mental health teams (MHTs).

A further finding was that prisoners and prison staff believe BOB boxes are helpful in managing prisoner distress, prison staff were confident in their knowledge of the BOB box

and its resources, but not all were confident in the process of distributing the resources from the BOB boxes. Therefore, levels of awareness of the BOB boxes and how to use them could be increased. There are several discrepancies in feedback about the frequency of BOB Box use, suggestive of a need to tighten up the feedback/monitoring process. Prescribed relaxation appeared to be useful in reducing anxiety and depression for some (but not all) prisoners who practised it, however, no qualitative data was gathered on their experience of this. As such, it is difficult to identify what works, for whom, in what circumstances.

The trauma informed service awareness training sessions were useful, particularly the second shorter session, which trainees felt improved their understanding of the principles and practical implications of a trauma informed service. Trainees would welcome a trauma informed service at the prison. Therefore all aims of the project were largely met and suggest that each of its component parts could assist prisons to more effectively manage self-inflicted death and self-harm. However, longer-term and larger-scale rollout and research is needed to properly understand the value of the component parts of this project. Changes to implementation management and monitoring would also be beneficial.

As a result of this project Tees, Esk and Wear Valleys NHS Foundation Trust has implemented the roll out of some of these initiatives to the 7 prisons it covers.



BOB boxes are storage boxes containing: drawing and art activities, 'tumbling tower' blocks, colour pencil pack, stress balls, pastel art pack, yoga/relaxation pack, playing cards pack, paper crafts/origami pack, rubix cube, CD player, relaxation/wellbeing CDs, audio book (CD).

Charlitta Strinati, Higher Assistant Psychologist, Richard Hand, Service Manager & Lisa Taylor, Head of Service Tees, Esk and Wear Valleys NHS Foundation Trust

Training at HMP Maidstone

Ian Bryant has a background prior to coming into the NHS of being in the armed forces and has been providing training to Oxleas NHS staff and other services within the prison who are coming in to contact with veterans and their families.

What Ian had noted at HMP Maidstone was that there was a steady increase of foreign

national prisoners who had served in their own countries equivalent to the old national service. Ian felt that there was a need within the service for some training in this area. Ian's training has broken down in to four modules:

- First port of call training a soldier. This part provides insight in to how military personnel are trained and how the training inductor can change the soldier's belief system in thinking. Military training also changes a soldier's normal stress response of flight or fight and on why some ex-service

personnel transition to civilian life can be extremely difficult.

- The second module is collaborated on: Understanding Veterans. This module provides insight into why some ex-military personnel struggle finding it difficult to engage with healthcare professionals and services due to their belief system caused by their training and military service. This module also provides a veteran viewer with possible barriers they might come across when working with veterans.
- The third module: Veterans Mental Health. This module provides insight into veteran's mental health which is the same as the general public. However, particularly emphasis on this module is on PTSD symptoms and the helpful or unhelpful coping strategies have adopted due to their PTSD.
- The fourth module: Armed Forces Covenant. This module provides information

on how ex-service personnel should not be disadvantaged just on military service. It highlights the government's obligations for priority treatment for veterans by the NHS and it provides a snap shot of the possible number of veterans living in the Kent area and the restructuring of the regular and army reserves.

This has been a very insightful set of modules and very well received by Oxleas NHS staff as a training package.

Rachel Daly, Consultant Forensic Psychiatrist & Ian Bryant, Senior Mental Health Practitioner
HMP Maidstone
Oxleas NHS Foundation

News

A look at recent news and developments in mental health and the criminal justice system.

For regular communication, join the **email discussion group** by emailing the word 'join' to prisonnetwork@rcpsych.ac.uk.

NHS Five Year Forward View

This document reviews the progress made since the launch of the NHS Five Year Forward View in October 2014 and sets out a series of practical and realistic steps for the NHS to deliver a better, more joined-up and more responsive NHS in England.

www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/

NHS
NEXT STEPS ON THE
NHS FIVE YEAR FORWARD VIEW

March 2017

Female prisoner deaths rising and prisons must take action says Ombudsman in new bulletin

Prison staff must take action to prevent further prison suicides among women, after 12 took their own lives in 2016, said Prisons and Probation Ombudsman (PPO) Nigel Newcomen.

www.ppo.gov.uk/wp-content/uploads/2017/03/PPO-Learning-Lessons-Bulletin_Self-inflicted-deaths-among-female-prisoners_WEB.pdf#view=FitH



Self-inflicted deaths among female prisoners

Foreword

This bulletin was prompted by the recent dramatic and depressing rise in self-inflicted deaths of women in prison. It looks at 19 investigations between 2013 and 2016 of instances where women took their own lives. This small sample cannot explain the apparently rising toll of despair, but the bulletin does identify a number of important areas of learning. This learning focuses on improving suicide and self-harm prevention procedures, better assessment and management of risk, addressing mental health issues, combating bullying and ensuring timely emergency responses.

sustained action. While we often identify examples of excellent and compassionate care by individual staff, and also recognise that prisons have been under enormous strain in recent years, there can be no excuse for not implementing essential safety arrangements that could ensure vulnerable women in prison are better protected.

It is to be hoped that delivering safer outcomes for women (and men) in prison will be at the heart of the Government's new prison reform agenda, and that this bulletin can assist with this and help reverse the unacceptable and tragic rise in self-inflicted deaths.

I have to add I find it disheartening that many of the lessons we identify repeat those in previous publications from my office. This suggests it is not a lack of knowledge that is the issue, but a lack of concerted and

Nigel Newcomen CBE
Prisons and Probation
Ombudsman

NICE National Institute for Health and Care Excellence



NICE Guideline 66: Mental health of adults in contact with the criminal justice system

Mental health of adults in contact with the criminal justice system

NICE guideline
Published: 21 March 2017
nice.org.uk/guidance/ng66

This guideline covers assessing, diagnosing and managing mental health problems in adults (aged 18 and over) who are in contact with the criminal justice system. It aims to improve mental health and wellbeing in this population by establishing principles for assessment and management, and promoting more coordinated care planning and service organisation across the criminal justice system.

www.nice.org.uk/guidance/ng66

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House of Lords
House of Commons
Joint Committee on Human Rights

Mental Health and Deaths in Prison: Interim Report

Seventh Report of Session 2016–17

Report, together with formal minutes relating to the report

Ordered by the House of Lords to be printed 26 April 2017

Ordered by the House of Commons to be printed 26 April 2017

Mental Health and Deaths in Prison: Interim Report

Joint Committee on Human Rights have written their seventh report of session 2016-2017 on mental health and deaths in prisons.

www.publications.parliament.uk/pa/jt201617/jtselect/jtrights/893/893.pdf

Upcoming Events at the Quality Network

QNPMHS Annual Forum, 6 July 2017

This will be an interactive event for our member services, packed with presentations and workshops. It is an opportunity for professionals from all disciplines to meet and discuss key service development issues to prison mental health services and to learn and share ideas about the future of services.

This is a free event for Quality Network member services and lunch will be provided. Non-members can attend at a cost of £40.

Reviewer Training 2017

Participants will gain practical and theoretical knowledge of all aspects of a peer-review visit and what it entails to be a reviewer on the day. The training involves presentations, seminar discussions and role-play scenarios. We have planned for the training to take place over three dates at different locations to suit your geographical location.

18 September and 24 October: The Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB.

11 October: Copthorne Hotel, Birmingham, Paradise Circus, Birmingham, B3 3HJ.

This is a free event for Quality Network member services and lunch will be provided.

Mental Health in Prisons: Screening, Assessment and Identification, 13 November 2017

This event is an opportunity for professionals from all disciplines to contribute to discussions being held on screening, assessment and identification tools being utilised for mental health in prisons.

This is a free event for Quality Network member services and lunch will be provided. Non-members can attend at a cost of £40.

For further information on event locations and booking enquiries, please visit gnpmhs.co.uk or email prisonnetwork@rcpsych.ac.uk.

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

Her Majesty's Prison & Probation Service

www.gov.uk/government/organisations/her-majestys-prison-and-probation-service

Howard League for Penal Reform

www.howardleague.org/

HM Inspectorate of Prisons

www.justiceinspectores.gov.uk/hmiprison/

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/

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

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