PRISON QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES

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This Issue

WELCOME

Welcome to our festive fourth edition of the Quality Network for Prison Mental Health Services' newsletter! We are always blown away by the number and quality of articles received – a huge thank you to all that have contributed.

Since the publication of our last newsletter we have successfully completed the first full year of the Network outside of the pilot phase. It has been a very exciting year; we have reviewed 38 mental health teams, published the third edition of specialist standards and a new set of standards for 24 hour mental healthcare in prisons, released our second annual report, hosted two special interest days and an annual forum, and held a number of training days. We hope you have made the most of the opportunities and we look forward to working with you further in 2018. Thank you to all that have made it a success!

On the provision of mental health in prisons more widely, we were proud to be able to represent our member services at the House of Commons Public Accounts Committee (PAC) in October. The session was called in response to the findings of the National Audit Office (NAO) report on mental health in prisons and our very own Dr Huw Stone gave evidence to advocate for change, along with Dr Andrew Forrester (OHRN), Sarah Hughes (Centre for Mental Health) and Mark Johnson (User Voice). Each witness provided a strong response to the panels questions before representatives from NHS England, MoJ and HMPPS were asked to account for the shortcomings identified in the NAO report. The session lasted just under three hours; we hope that these discussions continue and that we observe some developments in this area. For those that are interested, the full session and transcript is available on the PAC website and a full report is due for publication in December.

And most importantly, we wish you all a very merry festive period and a Happy New Year!

Megan Georgiou, Dr Huw Stone and Dr Steffan Davies

The Health and Wellbeing Model... What is it?

Assessment after assessment! Referral upon referral! What happens next?
Does anything happen next? Who is responsible to make sure something happens next?

A particular problem common to prison health care some may say! Silo working and communication breakdown, everyone assuming/ believing that it is someone else's responsibility, patients yo-yoing backwards and forwards with services losing sight of the specific needs of the patient.

NHS England has decided that it is time to change! To rethink the way in which services operate. To give a consistent approach to addressing individual's needs by streamlining the assessment process and to focus more specifically upon treatment, recovery and stability with coordination of care.

The Health and Wellbeing Model of Care

An integral part of the Health and Wellbeing Model is the single point of entry assessment. At HMP Belmarsh this new model was introduced in June 2017, following many months of planning meetings and sub group focus work. This assessment has replaced the secondary health screen and the focus is to escape the "yes/no tick box" general responses to health questions and to replace this with a more CBT approach to questioning around all aspects of health and wellbeing, which does include mental/psychological wellbeing as well as having a focus too upon risk to self and others. The aim is to draw out from the individual what are their health and wellbeing concerns, what do they think is the problem(s). More detail and more information will hopefully mean that treatment and interventions can be planned and implemented more effectively and in a timely manner.
Those individuals who are identified as having three complex needs or maybe more will have a care coordinator, this being the practitioner undertaking the assessment. This care coordinator role will be responsible for reviewing all referrals made including the plan of care agreed following the assessment.

This does not mean that the care coordinator is responsible for carrying out the specific specialist interventions, they are not expected to become "a jack of all trades" but their role is to ensure that other specialist services have acted upon these referrals. These cases for care coordination will be discussed at a weekly Health and Wellbeing MDT review meeting, to review the actions taken and monitor those actions which remain outstanding and requiring further intervention(s). The MDT review meeting is attended by a core group of regular attendees, representing all areas of health care - GPs, mental health, primary care including our colleagues from Change, Live, Grow, psycho-social substance misuse services, and our "through the gate" service NACRO/Centra.

Discussion around the plan of care, alternative suggestions, clinical opinions, discussions around risk and management of this are very much encouraged. The meeting is organised and chaired by the Health and Wellbeing Coordinator.

Health and Wellbeing Coordinator
This is a role very much in its infancy, following the introduction of the new model in June 2017. The key functions are to oversee the system as a whole, create a project plan and implement this, deliver training, assist with the assessments, review cases identified for care coordination and liaise with care coordinators around those matters requiring action. Supporting staff adapt to a change in systems/practice and the anxiety/resistance this can cause. Organising, chairing and documentation of the MDT review meeting as well as the collection data as required.

Change

The challenges of change are well documented….. anxiety, resistance, avoidance, attitudes and the impact of all of these… and more. How are we to overcome all of these factors?
…try to remain positive, develop and expand. Not losing sight of the purpose and desired outcome!

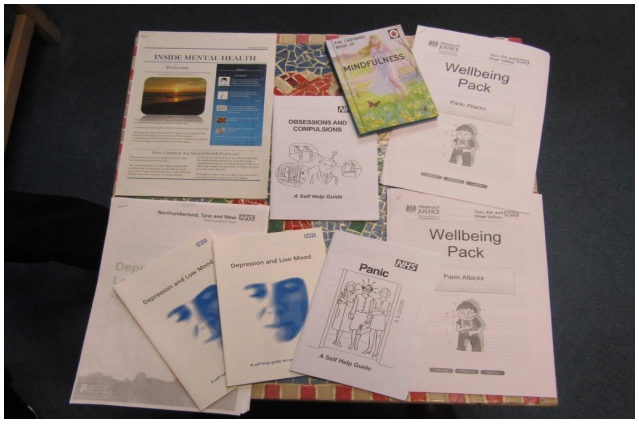
Tracey Abberline
Health and Wellbeing Coordinator
HMP Belmarsh/HMP Isis
Oxleas NHS Foundation Trust

World Mental Health Day – Service Promotion

As an integrated Mental Health Team in HMP Northumberland, we aim to use wider Mental Health events to focus on prisoner mental health and wellbeing, the wellbeing of the wider prison staff team as well as to promote mental health services across the prison site.

Last year, we had great success with a prisoner based activity so this year we wanted to try and incorporate the officer's wellbeing into the event too.

We also want to strengthen recognition and promote the organisations that make up the Integrated Mental Health Team in HMP Northumberland (Tees, Esk and Wear Valley NHS Foundation Trust, Rethink Mental Illness and Middlesbrough and Stockton MIND).



As World Mental Health Day was coming up on 10 October 2017, with a theme of wellbeing at work, we decided to capitalise on this, to promote our services, build links with other agencies in the prison and try to reduce stigma for prisoners and staff alike.

We therefore, sourced funding and resources to support the delivery of:

- Delivering hot chocolate and a mental health information (focus on sleep hygiene) for all residents at HMP Northumberland.
- A cake bake on the 10 October over lunchtime to encourage prison officers to visit the mental health team, improve staff relationships, become more familiar with our role and improve awareness of self-help materials and relevant resources to utilise with residents.
- Promoting work-related stress awareness across the prison site. We intend to display posters promoting WMHD and mental health awareness in staff only area across the prison site.
- Each wing office received a 'survival pack' which included an information pack on managing stress in the workplace, contact details for support

and a thank you letter from the mental health team in recognition of the support the officers give us when we are requesting to see a patient on the wing. The packs also included tea, coffee, a packet of biscuits, popcorn, sweets and branded pens from the mental health providers.

Feedback overall was very positive, with prisoners showing higher engagement with mental health staff and having a positive view of the service.

The staff on the wings were grateful of the packs and the phrase 'Fantastic!' was used by several officers as they opened the sealed box. On delivery of these, it was an opportunity to offer support to the officers, who despite being paid by a separate company are considered as colleagues by the MHT and we would be unable to access our patients and do our jobs without their daily support. Many officers were grateful that we had recognised their stress levels and how mentally challenging their job can be 'wearing us down each day'. Several officers discussed the 'Be in Your Mates Corner' campaign and fed back to us that they often find themselves 'looking after each other', with two staff reporting that they speak to each other more often about 'feeling rough' than they do their wives.

Overall the day was a huge success, raising the awareness of the mental health service and further reducing stigma for both staff and residents around 'talking about stuff'. We reached over 1400 individuals through this event and mental health was a talking point of the prison during that period and we hope it will continue to bring the importance of mental health to the forefront of HMP Northumberland, along with enhancing our integration into the prison as a whole.

Michael Proudlock and Michelle McPake
HMP Northumberland
Tees, Esk and Wear Valley NHS Foundation Trust, Rethink Mental Illness and Middlesbrough and Stockton MIND

Quality Network for Prison Mental Health Services

Annual Report Cycle 2 2016-17

Available online at: www.qnpmhs.co.uk

Reducing Deaths in Custody Project

In September 2015, NHS England organised a roundtable discussion for staff from all professional backgrounds concerned with trying to prevent deaths in London's prisons. They discussed the challenges facing those working within a system facing undeniable pressures and the factors affecting an already vulnerable population, the combination of which were contributing to the records numbers of suicides, episodes of self harm and violent assaults.

From this meeting came a decision to put together a training and development programme aimed at helping staff within the capital's prison network in reducing the number of deaths as well as levels of self harm and violence.

The project began with extended visits, spread over six months, to all of London's prisons and talking to prisoners and over 150 members of staff, at all levels and from all disciplines. From these discussions and my observations, The Reducing Deaths in Custody [RDIC] training programme was put together and circulated to all Heads of Healthcare and Governors.

The programme comprises of a variety of initiatives, including separate three days courses on risk assessment and reception screening, reflective practice sessions, one and two day courses on De-escalation Techniques, and Using CBT Approaches in a Prison Setting and Mental Health Awareness.

A small team are now involved in delivering these courses for officers and healthcare staff. Given pressures within the service and shortages of staff, it has been a challenge to deliver the educational programme as quickly as originally hoped, but so far over a dozen courses have been put on.

The feedback has been uniformly positive from every course in every prison where they've been held. Attendees have reported that they have gained greater knowledge about the subject matter, developed their skills and improved their confidence in their role.

Most particularly, it is the nature of the training itself that they report has made the biggest impact. A number of the courses feature the use of a professional actor, who helps us simulate various scenarios that are based on actual, current case studies.

Staff have reported these sessions allow them to realistically explore not only the issues related to a specific prisoner but, more importantly, the particular skills required to address the challenges they encounter in their everyday work.

The team has also started using two recently made films in the sessions, both of which have been really well received. Along with the simulations, they define the nature of our interactive, skills based training. The first film, set in HMP Thameside, focuses on a man coming in through reception who is potentially suicidal, highlighting current flaws in the reception screening and ACCT processes before demonstrating best practice in the form of a joint assessment by a supervising officer and mental health nurse. The second, filmed at HMP/YOI Isis, explores the detailed assessment of a prisoner who has perpetrated a violent assault on an officer.

Because of the detailed feedback built into each course, and the ongoing dialogue with dialogue governors and clinicians, the programme has already evolved to complement other risk related courses which healthcare staff and officers will have attended. This aims to provide a deeper understanding of mental health problems to non mental health staff and provide a sharper focus on how these affect risk, while looking in greater depth at self harm, suicidal ideas and behaviour, and assessing someone who is violent. The clinical risk training for mental health staff takes an even more advanced specialist, addressing a number of issues that have arisen from deaths in custody reviews from individual

prisons.

The RDIC training is directed at specific groups and their own needs rather than taking a generic 'one size fits all' approach. Even existing CBT practitioners are finding courses like our CBT Awareness useful because it is so closely related to the work they're doing in prisons and the health and wellbeing model.

It is absolutely clear, however, that improving staff performance in the areas of work that will reduce deaths in custody and provide a safer environment for prisoners means giving them the practical skills to do that, as well as the systems and structure that support them in applying them. That is the essential aim of the RDIC project.

Chris Hart
Independent Nurse
Consultant and Leader for the
Reducing Deaths in Custody Project
HMYOI Isis

The Dual Diagnosis Service at HMP Nottingham

The Dual Diagnosis service at HMP Nottingham has now been up and running since August 2017. The team comprises of a senior dual diagnosis RMN, senior dual diagnosis practitioner, and an assistant practitioner, led by the clinical matrons for both substance misuse and mental health.

Dual diagnosis has a higher prevalence within prisons, therefore it made sense to have a specialist team to actively engage with this complex and notoriously vulnerable client group.
Our ethos is based on "the right treatment at the right time", ensuring that dual diagnosis clients are picked up quickly upon admission to prison—this includes identifying if the client has dual diagnosis upon reception screening and referring into the team.

All dual diagnosis clients are assessed within five days of entering HMP Nottingham and a full comprehensive assessment is carried out. Robust risk management plans and care plans are also implemented during assessment.

Pharmacological interventions are also extremely important and all patients requiring medication such as methadone or chlordiazepoxide alcohol detox are identified upon admission and stabilised before any therapeutic interventions are implemented.

Our therapeutic interventions include: Node link mapping, Dialectical behaviour therapy, solution focussed brief therapy, motivational interviewing and group work. Each patient is also supported to create a "wellness toolkit" to enable them to manage periods of stress and anxiety as well as helping to reduce incidents of self-harm. Some examples of what may be contained in a wellness toolkit include distraction techniques such as stress balls, positive reinforcement cards, paper and colouring pencils as well as items to support during crisis flash points such as rubber bands.

We also adopt a holistic approach to our patient's needs, teaching them mindfulness, breathing techniques and progressive muscle relaxation as well as exercises that they can carry out in their cells to aid with relaxation

and sleep.

But what is Dual Diagnosis? Generally, there are four ways of identifying this:

- A primary mental health problem that involves the use of substances—for example a person suffering from Schizophrenia who uses heroin to reduce their symptoms.
- Substance misuse and/or withdrawal, leading to psychotic symptoms or illnesses—for example, the emergence of depression post-detox.
- A psychiatric problem that is worsened by substance misuse—for example a person with an anxiety disorder who uses cannabis to relax.
- Substance misuse and mental health problems that do not appear to be related to one another—for example, an ongoing anxiety problem that is neither worsened or lessened by the use of substances.

Patients identified as falling under the dual diagnosis pathway will be managed by a dual diagnosis worker from point of admission to point of release—this is important as it ensures that patients receive a consistent approach. This is especially beneficial to our patients with a Personality disorder diagnosis to avoid splitting. We ensure that as well as meeting their immediate needs within the prison environment, we adopt a multi-agency approach to their care, linking in with education, resettlement, alcoholics anonymous and narcotics anonymous within the prison as well as probation, housing and external drug and alcohol teams and mental health care teams.

"I am a classic revolving door- in and out of prison on a regular basis and this is my 18th prison sentence in 18 years and I am not proud of that. Previously, I always had both a mental health worker and a substance misuse worker when I came to prison and although they were helpful, I felt that communication wasn't great between the services and I was often going over the same old things with several different people which was annoying to say the least. I think the dual diagnosis service is great—I only see one person so I don't have to explain myself to several different people. They look after my methadone script as well as helping me with my ongoing issues with self-harm that is caused by my personality disorder. I see them regularly and I feel that I have a lot more tools to help me manage my stress and self-harm." Prisoner GM

Andrea Ramsden
Senior Dual Diagnosis Practitioner
HMP Nottingham
Nottinghamshire Healthcare NHS Trust

Providing an Effective Step 2 Service in a Remand Only Jail

HMP Durham has evolved considerably since it first started receiving prisoners almost 200 years ago. In June this year it faced one of its most significant challenges with the switch to a remand only jail. This has resulted in the average stay of an prisoner at the prison dropping significantly, with transfer out of the jail to other prisons occurring within a matter of days or weeks rather than months.

With up to 40 new receptions a day, the churn at the prison has placed significant demands on all the operational services and staff. Meeting the varied needs of prisoners requires focused effort from all the teams and individuals that work at the jail, whether that be education, discipline staff or healthcare. Due to the complexities of the environment, demand and the volume of systems in place, responding to the needs of prisoners often does not happen in a time-sensitive fashion. With the new changes coming into effect, time is now a luxury that we have even less of.

The challenge facing all the teams and personnel within the jail at the present time is how to deliver effective interventions, treatments, education and meaningful care within an increasingly transient community.

Rethink Mental Illness are contracted by Tees, Esk and Wear (TEWV) NHS Trust to provide primary mental health care within the prison. We typically see prisoners with mild-moderate anxiety and/or depression delivering interventions within a step 2, IAPT (Improving Access to Psychological Therapies) model. Historically, we have accomplished this through a fairly routine referral – triage – assessment – treatment process, with the treatment coming in the form of individual or group therapy.

The challenge has been the provision of meaningful input for those referred at the prison, when most prisoners may well have been transferred to another establishment by the time they have worked their way through to the 'treatment' phase of our existing system. We developed a number of new initiatives that would be simple to roll out and would increase the opportunity and availability of information for those suffering with mental health difficulties.

The first initiative was to create a facility on the induction wing, whereby prisoners could quickly access materials and meet members of the team for guidance over any mental health concerns. We developed a range of specific materials, including tailored information on mental health issues faced by a prison population. We decided that a drop-in facility would work best and provided a desk manned by two members of the team during prisoner association. By improving access in this way, we are able to signpost to other services in the prison and reduce the number of inappropriate referrals being triaged and discharged after assessment by the team due to lack of suitability.

We have now rolled out this initiative and the results so far seem promising. Prisoners and staff appear receptive to mental health having a presence on the wing, and informal discussions with prisoners during this time appear meaningful and present a fantastic opportunity for our team to promote advice for maintaining wellbeing whilst being detained in custody. In particular, prisoners appear appreciative of face to face contact as opposed to the traditional paper application process.

For those requiring further input from the primary care team, we have rapid access drop-in groups in which provide basic psycho -education about common mental problems along with some step 2 interventions aimed at reducing distress. Topics covered will include getting a good nights sleep, relaxation techniques, managing worry and tackling low mood. It is hoped by offering such a facility within the prison and by providing some form of early intervention, less severe mental health issues will be resolved before they potentially might escalate.

From a prisoner perspective, it is hoped that these initiatives will place the I.A back into IAPT within the remand setting, as previously, prisoners have vented their frustrations at being placed on waiting lists for treatment and being released or transferred before being seen. A prison environment poses many challenges to prisoner mental health, even for those that are normally resilient within a community setting. Having the opportunity to speak with and receive input from mental health professionals from such an early point can only be a good thing from this perspective. We are hoping that these initiatives have the promise to be rolled out nationally.

Jon Chapman, Sam Hutchins, Alex Morris and Katie McMillan
Psychological Wellbeing Practitioners
Rethink Mental Illness

The Honesty of Politicians

The following poem has been composed by an individual on B wing.

This title I was given by the IMB, about politicians and their honesty
Because I'm from Aston of inner City class, I always keep my eye on what's next to pass.
In growing up quite curious, I always love to know, Who will stay in office and who'll be next to go
Some politicians, I'd say their hearts were clean and want the best for residents in their constituency; others I may wonder nefarious in thought
Self-rise is king, Lie, Steal, or bought a care about people, had never crossed his mind.
His hearts filled with dishonour, his tongue speaks lovely lies. Tis sad, I must reach deep into my soul
People whisper quietly, I'll shout till the truth be told the people we depend on, decisions on our future television interviews, classy suits and humour;
Our prisons stay at bursting point; IPP's all languish over lunch, Prison reform is second to the choice of sandwich. Our leaders strive to see the best. Better transport for the people, better NHS,
Deals under the table, show hurtful disregard. Its tough enough 9 till 5 paying bills, this life is hard
Two wrongs don't make a right I say with sighing breath, there are only a couple of bad ones, there's a million good ones left
So while I live my life at the leader's decisions, I always keep a thought for the honesty of politicians

On behalf of the BSMHFT HMP Birmingham Inside Recovery Service

Reflections from an Assistant Psychologist on Offender Care

Providing mental health assistance in offender care was a defining experience, both professionally and personally. The impact of working in the challenging, yet rewarding reopening of HMP Downview was a journey I will never forget.

HMP Downview was closed in 2013 following a national review of the female prison estate. Then, just three years later, it was hurriedly reopened in order to accommodate the demand caused by the sudden closure of HMP Holloway. During 2016/17, Downview went through a huge transition: a new regime was commenced, modified then re-established; ambitious projects were scheduled then inevitably delayed; new staff were hired; long-serving inmates were returned; comprehensive physical and mental healthcare services were launched; anyone and everyone helped renovate long-since vacated workplaces; systems, policies and procedures were all tweaked to meet requirements. Overall, a community of professionals and prisoners worked as a team, collaborating to turn an empty, non-functioning building into a modern-day prison fit for purpose.

As considerable debate exists around the precise purpose of imprisonment, I began to wonder whether any prison in the women's estate is truly 'fit for purpose'. Whether the aim is to protect the public or to provide

rehabilitation, reform or punishment, it seems something is amiss.

During HMP Downview's transformation, I was continually surprised at the prison population's patience; incarcerated women and caring staff showed considerable appreciation that change takes time and often does not go to plan. Despite some inmates experiencing serious mental health difficulties, and complex emotional and behavioural difficulties, there seemed to be an understanding: 'things are far from perfect, but everyone is trying their best.' Throughout my tenure I truly believe staff did try their best, and as is the case across many public sectors, they viewed the lack of staff, funding, resources and flexibility as additional challenges rather than total roadblocks. Despite all that incredible effort, I couldn't help but wonder whether prisons are fit to manage the needs of modern-day society's complex social dynamics and healthcare requirements.

Are best efforts enough in an archaic system which is both at capacity and failing to deliver the results it promised? Does depriving women of their liberty really help in their reform and therefore reduce crime rates? As far as I could see this system of justice appeared to be designed centuries ago by men, for men. The inability of the current system to provide optimal offender care was astounding. Many women in prison have high levels of mental health needs and histories of abuse, and there have been rises in self-inflicted deaths and self-harm. Any cursory review of the literature highlights the depth of these shortcomings.

I began to wonder if future generations will look back at this period of time in the same way we view asylums from the past: where society believed locking up its citizens would cure their disease of mind, when in fact, history shows us that individual's ailments often significantly worsened. Today, among the general public, rates of psychoses are around 1 in 25, whereas in the prison population this soars to 1 in 4 women

reporting symptoms indicative of psychosis. Women released from prison may return to their families and communities with even more complex mental health needs.

In 2013 over 25% of women in the penal system said they had received treatment for a mental health problem during the previous year. Yet despite this, every year since, less than 1% of community sentences have included any mental health treatment requirement. Even if this was not a legal requirement, and instead additional support and access to local mental health services were provided, this could help reduce the likelihood of sentencing altogether. Not only that, but fundamentally it would help keep families together, resolving the spiralling systemic problems caused by splitting up families and taking children into care. Children in care are more than twice as likely to be cautioned or convicted as their peers. Having worked in children's care homes, young offenders' institutes and latterly the women's estate it has been staggering to witness the cycle of trauma caused through family separation.

It is perhaps unsurprising, therefore, that suicide rates in prison remain significantly higher than the general population. The devastation and tragedy of suicide is enormous. In 2015 there were over 11 times more self-inflicted deaths in custody than the general public. Of these self-inflicted deaths in prison, 70% had already been identified with mental health needs.

Feeling like a tiny cog in a machine that is widely accepted to not be working caused a personal philosophical debate. "48% of women are reconvicted within one year of leaving prison. This rises to 61% for sentences of less than 12 months and to 78% for women who have served more than 11 previous custodial sentences". Hence the moral dilemma: whether to continue working, making any tiny difference I can, or leave, knowing the archaic system and its overarching structures are ultimately failing the very individuals it is supposed to help. Any business has to adapt to its requirements, failure to do so would result in its demise. For instance it is unthinkable that a car manufacturer would produce vehicles where within a year 48% would seriously malfunction, requiring them to be returned to the factory.

I have the upmost honour and respect for the hardworking dedicated professionals working with Her Majesty's Prison Service. Wherever I went I found humour and compassion regardless of circumstances. I will be forever grateful for my experience working with some of the most invisible members of society in complex environments; enabling me to challenge the system on their behalf.

Despite frontline staff's best efforts, the entire machine appears to be breaking. With snap-decisions on prison closures followed by their rushed re-openings, not only does the government's current criminal justice reform strategy appear short-sighted, but the entire approach is simply outdated. The collective impact of this upon individual's and communities' mental health and wellbeing remains unknown. Instead of marginalising and penalising the most desperate and vulnerable in our society, perhaps we should shift to a more compassionate and effective approach, beginning with creative thinking and open-minded reform of a system currently incapable of delivering that very thing: "reform".

I worked within offender care Sep '16 – Sep '17 and have since moved to another position within the NHS, as Clinical Research Assistant in a Community Mental Health Team. This article was prepared in my personal capacity and its opinions expressed are my own and do not reflect the view of any organisation.

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

Chris Millar
Clinical Research Assistant
Aylesbury AMHT
Oxford Health NHS Foundation Trust

Treatment of attention-deficit/ hyperactivity disorder (ADHD) in young adult offenders

Attention-deficit/hyperactivity disorder (ADHD) is a common neurodevelopmental disorder affecting 5% of children and 3% of adults. ADHD is characterised by developmentally inappropriate and impairing levels of inattentive, hyperactive and impulsive behaviours; often accompanied by emotional instability, cognitive deficits, and mental health problems including anxiety, mood, personality and substance use disorders. ADHD is also linked to severe detrimental outcomes including educational and occupational failure, transport accidents with increased mortality, suicidality, and risk of antisocial and criminal behaviour.

Currently diagnosing and treating offenders for ADHD is not common practice within prison mental health services. Yet, it is well established that between 20-30% of prisoners meet diagnostic criteria for ADHD and could benefit from medical and psychological treatments for this condition. We know that a significant group of children with ADHD go onto develop behavioural problems including conduct disorder and antisocial behaviour in adult life. Yet, in many cases, children with ADHD are not given the support and treatment they need. Furthermore, when young people with ADHD enter the criminal justice system, the disorder often goes undiagnosed and untreated.

The impact of treating ADHD on criminal behaviour

Recent studies highlight the importance of diagnosing and treating ADHD within the criminal justice system. Using national registry data from Sweden, a 6-fold higher rate of receiving a criminal conviction was found among men and women diagnosed with ADHD. Further, it was found that during periods of medical treatment for ADHD, there was a 30-40% reduction in criminal convictions. Another study found that on release from prison, there was a 42% reduction in violent re-offending following treatment for ADHD.

These studies establish that during periods of medical treatment for ADHD there is a marked reduction in criminal behaviour, but does not establish that this is a medication effect. It may be that when people are motivated to engage with treatment services, they are less likely to commit crimes. However, it was found that even when tracking individuals who stopped and started medication at different times, crimes were more likely during periods when people were not taking medications for ADHD. Furthermore, these effects on crime were specific to ADHD medications, and not seen with antidepressants which were also commonly prescribed.

The Concerta In Adult ADHD Offenders (CIAO-II) trial

Both the National Institute of Health and Clinical Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) recommend stimulants (methylphenidate or dexamphetamine) for treating ADHD. Despite this, it is uncommon to diagnose or treat ADHD in offenders. One reason is the common occurrence of mental health, neurodevelopmental and psychosocial problems, which might provide a better ... … explanation for impulsive, overactive and inattentive states in young offenders. However, when working at HMP Isis, we found that many patients with severe ADHD were being treated inappropriately with antidepressants or antipsychotics, and remained highly symptomatic or emotionally unstable due to untreated ADHD.

At HMP Isis in Southeast London, we completed an open pilot study of 121

prisoners with ADHD called the Concerta In Adult ADHD Offenders (CIAO-I) trial. We screened almost 2,000 prisoners and found that 20% met ADHD diagnostic criteria. Following diagnosis, we provided psychoeducation, before treatment with Concerta (an extended release formulation of methylphenidate). We titrated to an optimal dose over 4 to 5 weeks with weekly meetings. We found that these meetings were also important for informing patients about ADHD, and advising them on how to manage their symptoms, and behavioural and functional problems in daily life.

Prisoners in the treatment program reported several benefits. They could focus more easily, for example, in work, education or when reading books or writing letters. They felt less restless, making it easier to sit and focus. They reported being less impatient, with improved control over emotional responses (less angry or aggressive outbursts), and better able to stop and think rather than acting impulsively.

These improvements we noted by the independent prison inspectors. In their 2015 report they stated that: "All prisoners were offered screening for ADHD" and that "some prisoners [on the treatment programme] to whom we spoke were experiencing some stability of behaviour for the first time in their lives". They went on to say that "there should be efforts to ensure the continued prescribing of medication and ongoing specialist support for prisoners started on the CIAO trial following their release". This last point is critical. There may be little point in helping prisoners with ADHD if they do not get the support they need on release from prison back into the community.

To understand better the effects of treating ADHD in prisoners, we are now conducting a randomised controlled trial of Concerta In Adult Offenders in prisoners aged 16-25 – the CIAO-II trial. The project underway at HMP & YOI Isis in London and HMPYOI Polmont in Scotland since August 2016, and is funded by the Medical Research Council (MRC) and the National Institute for Health Research (NIHR). The trial teams are working with the prison healthcare teams from Oxleas NHS Foundation Trust and NHS Forth Valley, and trial monitoring by the King's Health Partners Clinical Trials Office Quality Team.

Study participants are randomised to 8-weeks treatment with either Concerta or a placebo. The main questions we will address are: How effective is Concerta in reducing the inattentive and hyperactive/impulsive symptoms of ADHD in this population? What are the effects of using this medication on a wider range of behavioural and functional problems. These include emotional instability, behaviour in the prison, violent attitudes (a measure linked to aggression), educational performance and prison and educational staff reports of behaviour. We hope that our findings will provide the evidence required to deliver cost-effective and safe treatments to adult prisoners with ADHD.

CIAO II Trial Team
Dr Imogen Kretzschmar,
Research Psychiatrist,
Lena Johansson, Trial Manager,
and Professor Philip Asherson, Chief Investigator
King's College London

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 and Service Provider Collaboration to Improve Mental Health Care in Prisons - A Case Study

User Voice is an ex-offender led charity founded in 2009, and is expert at gaining insight into the lives and views of the most marginalised and vulnerable people in and around the Criminal Justice System. User Voice is uniquely able to do this because all the frontline work is delivered by ex-offenders, with 85% of staff having lived experience. This gives them the unique ability to gain the trust of, access to, and insight from people within the Criminal Justice System.

User Voice builds the democratic platforms in prisons and the community that enable collaboration between service users and service providers. As such, they were commissioned in 2015 by NHS England to gather prison residents' feedback and suggestions on how to improve healthcare provisions within a number of prisons in Kent, Surrey, and Sussex. In order to achieve this aim, User Voice adapted their Prison Council Model and utilised their Peer Engagement Team to establish Health Councils in each prison. The facilitation of this Health Council model is enabled by the Health Council Members. Health Council Members are members of the prison population who have been trained and supported by User Voice to engage with the rest of the prison population and gather their views. User Voice and the Health Council Members have gathered over 3,000 surgery feedback forms from within the prison population this year, and enabled the Health Councils to put forward over 55 solution-based proposals in regard to resident's most pressing issues surrounding healthcare provision in prisons.

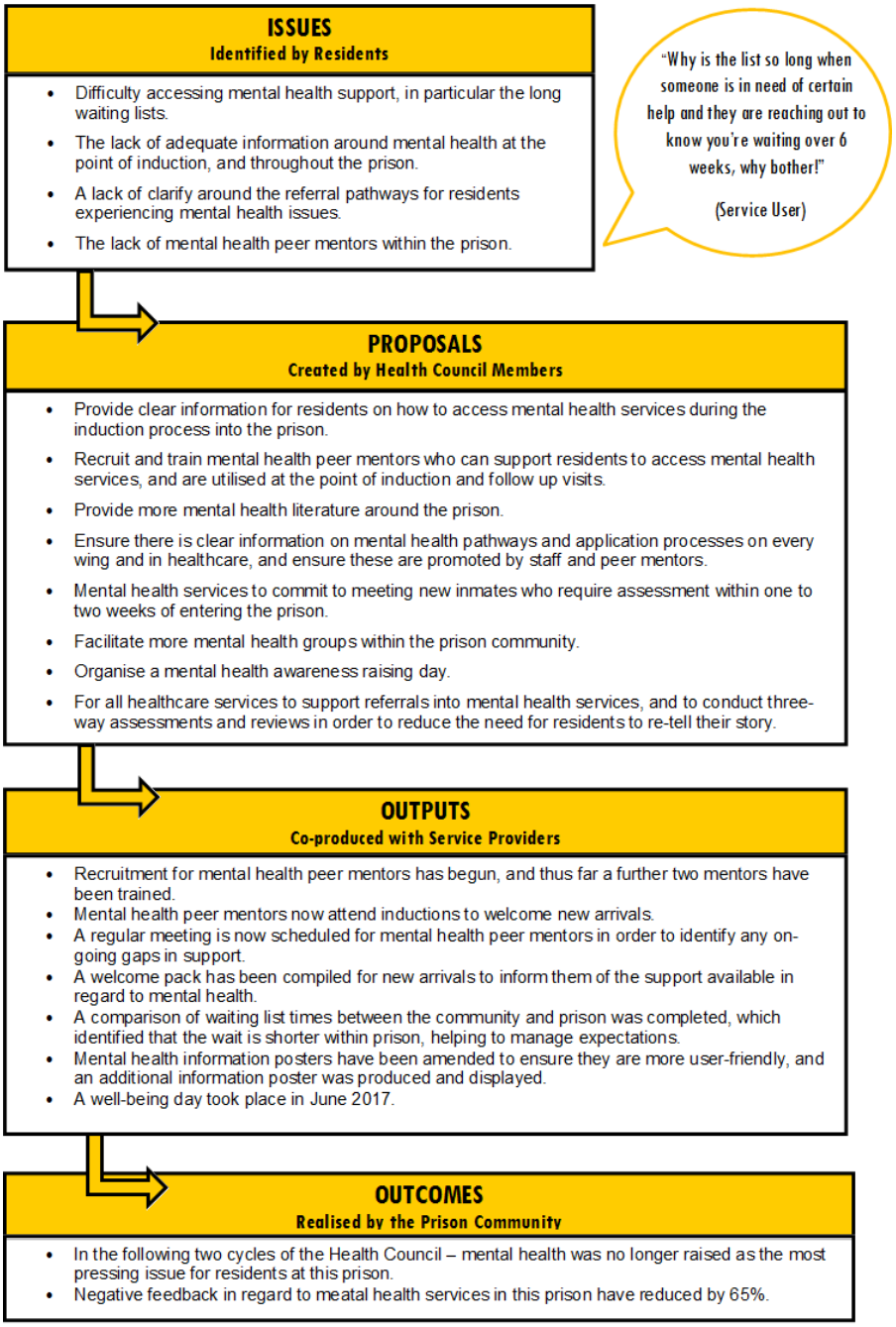
In the lead up to a Health Council meeting in April 2017, at one of the prison sites, Health Council Members canvassed the residents for their views. Health Council Members, with the support of the User Voice Engagement Team, then collated this feedback and identified the priority themes in that period for the residents in that particular prison. The most prominent theme during this cycle of the Health Council related to mental health.

"Why is the [mental health support waiting] list so long when someone is in need of certain help and they are reaching out to know you're waiting over 6 weeks, why bother!" (Service User)

As a result of this feedback, a series of solution-based proposals were taken to the Health Council meeting in April 2017. These proposals included suggestions on how to improve communication about what services are available and how to access them; recruitment of mental health peer mentors and how they could be best utilised; and ensuring the available mental health literature is service user friendly.

The Health Council meeting was attended by the Health Council Members; User Voice; key prison staff; and healthcare providers. As a result of the proposals put forward, significant outputs were achieved, including:

- A recruitment drive for mental health peer mentors.
- Agreement that mental health peer mentors will now attend inductions to welcome new arrivals.
- The implementation of a regular meeting for mental health peer mentors in order to identify any on-going gaps in support.
- A welcome pack for new arrivals to inform them of the support available in regard to mental health.
- A comparison of waiting list times between the community and prison to help manage expectations.



- A review of mental health information posters to ensure they are more user-friendly.
- Facilitation of a well-being day.

Following the work completed by the Health Council, mental health was not raised as the most pressing issue for residents in the prison during the following cycles of the Health Council model. Thus highlighting the potential outcomes for improving mental health support in prison when utilising the Health Council model and meaningful service user engagement.

Annie Poland, Research and Evaluation Team Member
User Voice

Use of CBT-I for Insomnia in Prison Setting

Insomnia is a serious disabling condition affecting one third of adults in the United Kingdom (Dewa, Kyle, Hassan, Shaw & Senior, 2015) and approximately fifty per-cent of the prison population (Dewa et al., 2015). The cause of insomnia is multi-factorial (Harvey, 2002), however it is believed that a combination of personality factors; early life events; life stressors and psychiatric disorders are all implicated in the onset and maintenance of the disorder (Spielman, Caruso, & Glovinsky, 1987).

Around 90% of the prison population have a mental health disorder, including personality disorders and substance misuse disorders (Bradley Report, 2009). As referenced in the DSM-V (2013), insomnia is a precursor to, and comorbid with, a number of mental health disorders including: anxiety, depression, and post-traumatic stress disorder, all of which are prevalent within the custodial setting (Dewa et al., 2015).

With a higher than normal prevalence of mental health disorders, and the nature of the prison regime, normal sleep-wake patterns may be affected through: interruption; forced contact with others; fear of violence; lack of autonomy (Dewa et al., 2015). Furthermore, the physical environment of the prison is likely to result in further disturbances to sleep-wake regulation: experiencing too much/too little light, excessive noise, and inadequate bedroom set-up (Elger, 2007).

Having worked in the prisons as a Higher Assistant Psychologist for Tees, Esk and Wear Valley NHS Trust for two years, I am all too familiar with the effect that a lack of sleep can have on an offender's ability to engage with the prison regime, and the impact it has on their mental health; however due to more pressing issues (substance misuse, psychiatric disorders) the issue of sleep is often side-stepped and the importance of obtaining and having good sleep practice can be forgotten.

As this is an under-researched area, I decided to conduct research on insomnia in the custodial setting. The aim of the study was to see whether a 60-70 minute session of Cognitive-Behavioural-Therapy for Insomnia (CBT-I) with an accompanying self -help pamphlet was an effective treatment in reducing the symptoms of insomnia in male prisoners.

Thirty Category C male prisoners took part in this study. Several psychometric tests were utilised to assess suitability. Once this was confirmed, participants were asked to complete a sleep diary for 7 days. They then completed the CBT-I intervention, which consisted of: sleep education, sleep hygiene, and sleep restriction. A self-help pamphlet was also issued, which introduced the principles of stimulus control, cognitive control, and the use of guided imagery. Participants were required to complete the sleep diary for a further three weeks, in order to monitor their sleep further.

Results from the research were positive, and highlighted that there was a significant reduction in insomnia related symptoms after completing the 60-70 minute session of CBT-I with the accompanying self-help pamphlet. This research is the first of its kind to assess whether an adapted version of CBT-I is effective in the prison population, where there is limited interventions and resources to aid sleep disturbances. Further research is needed to ascertain whether CBT -I is effective in different populations and prisons, however CBT-I would need to be adapted to each establishment prior to this happening.

My experience of this research was positive; I enjoyed the prospect of analysing an undiscovered area and hopefully informing academia and practice within a public health setting.

Richard Hand
Service Manager Offender Health
Tees, Esk & Wear Valley NHS Foundation Trust

Mental Health Awareness Day in Female Offender Personality Disorder Services in HMP & YOI Low Newton

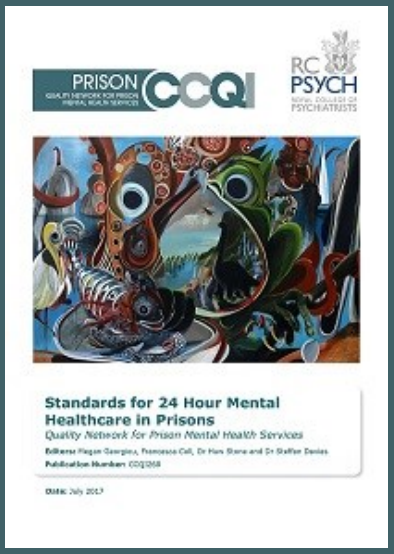
On the 10th October 2017, Tees, Esk and Wear Valleys (TEWV) NHS Foundation Trust and Her Majesty's Prison and Probation Service (HMPPS) supported a number of events within the female Offender Personality Disorder (OPD) Services in HMP & YOI Low Newton. These two services are the Primrose Service and PIPE unit. A number of events were also rolled out across the broader TEWV services and within the prison establishment.

In 2007, the Corston Report (2007) identified "the gap in provision of specialist services for women" (p. 74). The Bradley Report (2009) further reinforced these views and highlighted the importance of appropriately managing mental health and personality disorder with specific groups, including female offenders.

In custody, the Primrose Service in HMP & YOI Low Newton remains the national OPD provision for the treatment of high-risk female offenders with personality disorders. The Primrose Service offers gender-sensitive and individually responsive interventions for each resident in the service.

Interventions offered include the Life Minus Violence – Enhanced (LMV-E; Ireland et al., 2009) intervention; art therapy, schema therapy, EMDR, and an array of other individualised and group interventions.

Psychologically Informed Planned Environments (PIPEs) are specifically designed environments whereby staff members undertake additional training that enables them to increase their psychological understanding of their work (Bainbridge, 2017) and ultimately creates a safe and supportive environment for those who live and work there. Emphasis is not on psychological treatment, but rather "ordinary living" in a setting that is safe and "psychologically informed" (Bolger & Turner, 2013, p. 6). Many of the women whom access the Primrose Service and PIPE unit also present with complex mental health



Standards for 24 Hour Mental Healthcare in Prisons

Available online: www.qnpmhs.co.uk

histories.

The Primrose Service and PIPE residents were extremely enthusiastic in their preparation for Mental Health Awareness Day. They created contributions including artistic pieces of work and poetry. These pieces of work communicate their personal experiences of challenges with their mental health.

One Primrose resident wrote the following poem to communicate her understanding of positive strategies of managing mental health difficulties:

"Hello can you help me
I'm hearing voices constantly
Nurse, nurse please make it go away
Make me normal like you are every day
See most people do not understand
Stigma, stereotyping mental health comes hand in hand
But you can get the correct help by using your voice
Self-advocacy and using it - your voice is your choice
Talking about your mental health is not a bad thing
Proper helpful, you'll be surprised the help talking can bring"
(Primrose resident)

Another resident wrote the following poem focussing on struggles she experiences, but also hope she has for the future:

"Fighting with mental health like Dr Jekyll and Mr Hyde
Nowhere to run, nowhere to hide
Feelings tearing me up inside
Scars on the surface deeper scars beneath
Keep on holding on to the belief things will get better
No matter how long just hold on and be strong"
(Primrose resident)

The services ran a number of activities throughout the 10th October to help residents manage and overcome some of these challenges. The services ran a Tea and Talk session consistent with the Mental Health Foundation strategy. As a component of the Tea and Talk, the structure was also consistent with the CHIME (Connectedness; Hope, Identify; Meaning & Empowerment) model of recovery.

Sleep hygiene sessions introduced the importance of sleep on mental health. The sleep hygiene sessions also included an aromatherapy component with input from a resident who has experience with aromatherapy. Exercise classes also emphasised the positive links between exercise and positive mental health.

The services also ran a "Fake Away" session where the residents used recipes similar to take-away food, but with a healthy focus.

The OPD services are committed to promote positive well-being as a central component of the service ethos. The activities on 10th October 2017 were an opportunity to celebrate the ethos. Another resident wrote the following poem which emphasises the importance of this support in the journey to positive mental health:

"Early one morning I opened the door,
The world seemed so different than before,
colours that met me so fresh and blinding,
Now the joys in life finally finding.
For many a year that door has stayed shut,
round and round I've been stuck in a rut,
Living life stuck in the dark, all the colour bleached out, my life was so stark.
Now I've opened the door, reached for the sun, I'm so happy, life finally begun, I'll always make sure
The door is flung open wide, plenty of room to let light inside"
(PIPE resident)

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

Annette McKeown, Ellen Harvey & Jessica Moules
Tees, Esk & Wear Valleys NHS Foundation Trust

Supporting Veterans in Prison: The (NHS) Veterans' Mental Health TIL Prison In-reach Service, London & South East

The (NHS) Veterans' Mental Health TIL Prison In-reach Service London & South East, (previously known as The London Veterans' Service) has been operating in HMP Wandsworth since June 2015, and in HMP/YOI Isis, HMP Thameside and HMP Brixton since October 2016. It is partly funded by NHS England and partly by The Armed Forces Covenant. We are currently in the process of extending our service to HMP Belmarsh. The service is currently made up of two Clinical Nurse Specialists (RMNs) who are based in the prisons.

The aim of the prison in-reach service is to identify and work with veterans who have served in the British Armed Forces or Reserves within each of the four prisons, and support them through-the-gate and in the community.

Background

The service was established to help address the unmet needs of veterans who enter the criminal justice system (CJS), and is heavily guided by the recommendations made in Phillips's (2014) Former Members of the Armed Forces and the Criminal Justice System review, and the From Gate to Gate (2016) report. The present number of veterans entering prisons in England and Wales is estimated to range between 3.5% and 7%, rising to as high as 13% amongst High Security and Category B prisons. Veterans make up the largest single occupational group in prison (DASA, 2010), and are more likely to serve longer sentences than the general prisoner population. It is known that veteran prisoners can often have complex mental health needs which are often missed by professionals (Murrison, 2010), and a large number will have issues with substance misuse, unemployment, and homelessness.

Service model

A sophisticated referral pathway has been set up in each of the four prisons. All prisoners are now asked whether they have served in the Armed Forces or Reserve in their first and second day healthcare screening assessment, and referrals are sent to our service via the SystmOne electronic patient database. Through regular veteran awareness training carried out by the Clinical Nurse Specialists (CNS) to prison staff, we now also receive referrals from the wide range of professionals within the prisons and also though the Prisoner Veteran Rep roles that we have developed. As it is well documented that veterans in the CJS do not always feel comfortable to declare that they are ex-service personnel, often due to fears about reprisals or because they do not see the point in sharing this information, the CNSs raise awareness of the benefits of engaging with the service and have set up self-referral pathways.

Once a referral is received, the CNS sees the prisoner within 48 hours, an initial screening is carried out and their reported service is verified through our links with the Ministry of Defence. For those whose ex-military service is confirmed, the CNS carries out a comprehensive and holistic assessment (including mental health, social, substance misuse, family, and physical health needs). A care plan is then jointly created to help address their needs, and may include plans for onward referrals to specialist services within the prison, 1:1 CBT informed sessions with the CNS, behavioural activation support, being linked in with veteran charities who we can arrange to see the Veteran whist in prison, or support for their families. Care-coordinating and joint working with other service providers is a key role of the CNS, to help improve access for

veterans. The CNS works closely with offending management and probation services to help ease their transition through -the-gate, and the CNS aims to meet with veterans within their first week of release.

The Veterans' Mental Health TIL Prison In-reach service is currently piloting innovative approaches to change which are transdiagnostic. We have three partner organisations that provide input to the veterans engaged in our service whilst in prison: The Warrior Programme's motivation and training course; Creating freedom drama therapy group; Creative Change art therapy group.

Since the service launched 2 years ago, there have been a total of 268 referrals across the four prisons, 158 of which were confirmed Ex British Armed Force veterans (the remaining were either fabricators or foreign national veterans who served for countries outside of the UK). The service has been successful in improving the channels for identification of veterans in the four prisons, which is particularly important as nationally we know that identification of veterans who enter the CJS is relatively poor (Phillips, 2014).

Evaluation

At present, there is not much evidence out there on the needs and experiences of veterans in the UK CJS, or on the impact of veteran specific services in prisons. The data gathered in the Veterans' Mental Health TIL Prison In-Reach service aims to improve what we know about the number of veterans entering the prisons where we operate, their profile, the type of offences committed, and their mental health and wellbeing needs. For each veteran seen, we invite them to complete measures regarding mental health (e.g. PHQ-9, GAD-7, PDS, PCL-5), substance misuse, anger, work and social adjustment, and a patient satisfaction questionnaire. The measures are given to them at first contact,

again after one month, and then at 3 monthly points following this. Following feedback from some veteran prisoners, we are currently reviewing the number of measures used and considering alternative measures that may feel more relevant to the prisoner population.

For those who have completed the measures over the past 2 years, we have gathered some insightful data which has shown a decline in reported symptoms of depression, anxiety, and anger following input from our Veteran's service. However, reported symptoms or difficulties can increase again later down the line if their situation changes, which is not unusual for the prisoner population who may still be in the process of being sentenced. Qualitative data is also gathered— veterans are invited to be interviewed by an external researcher about their experience of engaging with the service. This data has shown that many of their needs have been met in relation to support with housing e.g. providing veteran charity accommodation, referrals to health and social services, providing 1:1 therapeutic sessions, and organising support for their families e.g. assistance with visiting them in prison if experiencing difficulties or linking family members in with veteran support charities in the community.

What next?

One of the challenges that we have faced in the service is the high turnover of prisoners who are in the partly remand prisons that we work in (HMP Thameside and HMP Wandsworth), where follow-up appointments may not always be physically possible. We are currently developing the service to accommodate for the high turnover in these types of prisons, and work to establish the best way to offer this group of Veteran prisoners the most beneficial type of support within the limited timeframe.

As with the rest of the prisoner population, we have found that getting a hold of Veteran prisoners once released from prison can be challenging. At present, we are working with other service providers who offer resettlement support through-the-gate to joint work those veterans who may face barriers to engaging with our service in the community. For those veterans who are transferred to other prisons (e.g. D-Cat) prior to release, we link them in with the local Veteran charities and the Veteran In Custody Support Officer where present. We continue to gather data for the evaluation of the service, which we hope will help to improve what we know about veterans who enter prisons and shed more light on the type of in-reach service that best meets their needs.

Raquel Williams (RMN)
Clinical Nurse Specialist
(NHS) Veterans' Mental Health TIL
Prison In-reach Service
London & South East
Camden & Islington
NHS Foundation 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 next annual report which will be published summer 2018.

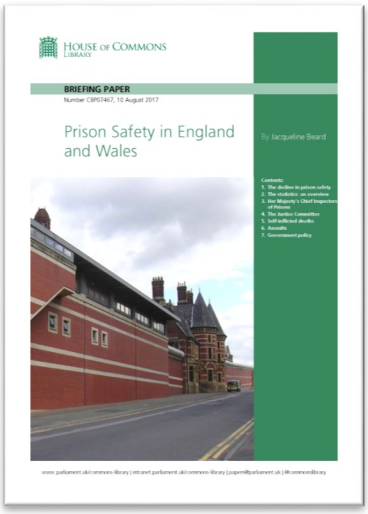
If any of the individuals you work with would be interested in submitting a piece of artwork for consideration, please email it to prisonnetwork@rcpsych.ac.uk.

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**.

Health and Justice mental health services: safer use of mental health medicines

This paper provides a background to prescribing and mental health medicines in secure environments with some common principles that apply throughout the medicines optimisation pathway, and more detailed information within the pathway to support safer practice. www.england.nhs.uk/wp-content/uploads/2017/10/health-and-justice-safer-use-of-mental-health-medicines.pdf

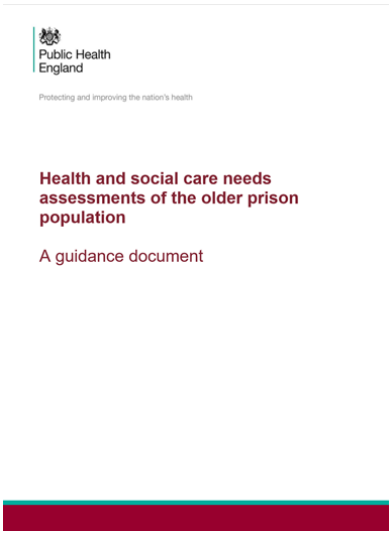


Prison Safety in England and Wales

From 2012 there has been a decline in prison safety. The Justice Committee has described a rapid and ongoing deterioration. Chief Inspectors of Prisons, the Prison and Probation Ombudsman and interested organisations have expressed concern. The Government has acknowledged the decline and committed to additional funding to recruit more staff. A white paper, Prison Safety and Reform, was published in November 2016 and included measures to address the use of new psychoactive substances, mobile phones and drones. http://researchbriefings.parliament.uk/ResearchBriefing/Summary CBP-7467#fullreport

Health and social care needs assessments of the older prison population

This document aims to provide guidance to those commissioning or undertaking Health and Social Care Needs Assessments of the older prison population. www.gov.uk/government/uploads/system/uploads/attachment_data/file/662677/Health_and_social_care_needs_assessments_of_the_older_prison_population.pdf



Upcoming Events at the Quality Network

Improving the Care and Treatment for People with an Intellectual and/or Developmental Disability in Prison, 15 March 2018

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, 21 March 2018

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.

Further dates for 2018 will be announced in due course. Please visit our website or email prisonnetwork@rcpsych.ac.uk for more information.

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

Save the Date: QNPMHS 3rd Annual Forum, 03 July 2018

Join us for the Quality Network's 3rd Annual Forum in 2018. This event is an opportunity for professionals from all disciplines to contribute to discussions being held on the latest news surrounding 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 qnpmhs.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.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/

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

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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Follow us: **@rcpsych** and **@ccqi_** and use **#qnpmhs** for up-to-date information

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