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WELCOME

Welcome to the fifth edition of the Quality Network for Prison Mental Health Services' newsletter. We received several articles and some patient artwork, we hope you enjoy reading the contributions.

We are almost at the end of the cycle with only a couple of visits left. We have really enjoyed seeing you all and learning about your services. It is incredible what is achieved by each of your teams and some of the projects going on are outstanding! We are looking forward to sharing these in our annual report later this year. We also welcomed Paul Rees, RCPsych Chief Executive, to our peer-review visit at HMP Pentonville; he really enjoyed the experience and commented that the Barnet, Enfield and Haringey team "were determined to deliver excellent patient care in very difficult circumstances".

In March, we hosted a dedicated special interest day on improving the care and treatment of people with an intellectual and/or developmental disability in prison. We heard from: Jenny Talbot OBE, Prison Reform Trust; Clare Hughes and colleagues, National Autistic Society; and Lilian Dougan,



Scottish Prison Service, and Amanda Kirby, University of South Wales. We also heard from colleagues in member services that have developed specific pathways and practices in this area. If you missed the event, the presentations are available on our website.

Our next event is the QNPMHS 3rd Annual Forum on 3 July 2018. The day is jam-packed with presentations, from key stakeholders, member services and patient representatives, and will cover care for older prisoners, prison safety and gender identity. We look forward to seeing you there!

Megan Georgiou, Dr Huw Stone and Dr Steffan Davies

Using Computers - Screening for Learning Difficulties and Disabilities

There is increasing recognition that up to 30% of people in prisons have one or more learning difficulties and/or disabilities (LDD) (Coates review in 2017; No One Knows, 2007). This includes ADHD where international studies have demonstrated that up to two-thirds of young offenders and half of the adult prison population screen positively for childhood ADHD, and many continue to be symptomatic with rates reported at 14% in adult male offenders and 10% in adult female offenders. With these numbers, the need for a pragmatic solution for screening is necessary, but more than a tick box exercise and considering the 'whole person'.

Despite wide spread, increasing use and acceptance of World Health Organisation's 'International Classification of Functioning of Disability and Health' (2001) to deliver person centred care, there are still silos of service delivery. The fact that ADHD, ASD, Developmental Language Disorder, Dyslexia, DCD and Dyscalculia often co-occur is sometimes forgotten despite it being common (see below). There remains some talk about IQ scores for determining services. A shift away from single test approaches to a more bio-psychosocial

approach is required. Terminology relating to learning difficulties/developmental disorders/disabilities is also inconsistently used.

Developmental Co-ordination Disorder (DCD) - despite affecting around 3% of the population - is hardly mentioned (Dyspraxia sometimes is).

What can a computer system offer?

The means of delivery so that:

- Take a person centred approach;
- It is consistent and robust - so it can be used in induction with large numbers of individuals;
- Be instantly scored with guidance for staff and offender which is practical and meaningful to both;
- Accessible in design and delivery, especially with so many people having literacy difficulties;
- Translatable into different languages - for around the 10% of people where English isn't their first language;
- Potential to consider a differential diagnosis e.g. asks about conditions such as Traumatic Brain Injury that may mimic ADHD traits;

		Proportion with secondary diagnosis of (%)					
		ASD	ADHD	DCD	DLD	Dyscalculia	Dyslexia
Primary diagnosis	ASD		3-78	25-53	21		14
	ADHD	6		18-53		7-18	18-45
	DCD/ Dyspraxia	6	19-53				
	DLD	4-8	26	30-71		62	48-87
	Dyscalculia		39	25			26-48
	Dyslexia		18-50	15-25		39-48	

- Supports non specialist staff by providing guidance and staff training resources on LDD.

Do-IT Profiler offers all of the above as an innovative and accessible screening and assessment system being used in more than 20 prisons in the UK, developed by Professor Amanda Kirby and Dr Ian Smythe, both having worked in the field of developmental disorders for more than 25 years.

Scottish Prison Services is mid-trial with three prisons and creating the pathways from screening to next steps. Information gets passed to halls, education and to the Learning Disability Nurses if there are 'flags', indicating an offender may have a learning disability or difficulty. In Wales, the tools have been embedded in the prison induction process and, information, for example in one prison is passed to health care services where there are ADHD traits. User experience is important and a recent independent review asked the offenders how helpful the information they got from the tool and 75% reported good or very good.

Over the ten years of development, the system has evolved to be able to deliver additional modules relating to literacy, numeracy, education and employability skills. More recently a 'mental health report' flagging current and past risk factors has been developed for one prison, linking mainstream prison more closely to healthcare services. Tools and resources for offenders include practical support for wellbeing in a range of accessible formats including information on debt management, disclosure, sleep and keeping fit. The adaptability of the system means that

additional screening tools can be added (as long as no intellectual property is infringed!).

The Do-IT Profiler system sits on a management information platform allowing data to be analysed instantly and a detailed understanding of the level of co-occurrence between different learning difficulties/ developmental disorders and the association between this and other factors. The predictive analytics tools, more recently developed, are starting to examine the cumulative adversity e.g. bullying and exclusion in school and attempts at suicide in the present time. With increasing usage, big data sets are accruing with more than 20,000 completions. This allows for detailed analyses and comparisons e.g. YOI v Male v Female estates. Interestingly, differences are emerging which could aid future service design. The system is also used in other settings such as in Youth Offending Teams, NEETS (Not in Education, Employment, Training Settings), as well as in a Secure Training Centre. However, modules provided are age appropriate and guidance is different because of the context. The Prison Officer Association is using the 'Workplace+' version of the tools for screening and supporting their members for Dyslexia and Neurodiversity. A suite of modules for those with Autism Spectrum Disorder is being used with a number of Autism bodies including North East Autism Society.

For more information, see www.doitprofiler.com or email amandak@doitprofiler.com

Professor Amanda Kirby
University of South Wales

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

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

Inside Recovery: 'All in it Together, Fixing the Prison Community'

The following article has been provided by an HMP Birmingham inmate. This individual has been extremely proactive in the development of a range of healthcare initiatives in the prison. Initiatives especially aimed at providing enhanced support for those experiencing mental ill health in the prison. He cites attendance at a two-day Adult Mental Health First Aid training programme as the catalyst for his involvement. This article has previously received recognition by winning a prize in a Prison Reform Trust writing competition in October 2017.

In an emergency, the most useful person in the crowd is the one who knows first aid. Likewise, there is growing opinion that the most purposeful individuals in a prison are the ones who understand mental health first aid. Ten years ago, the internationally recognised education and training programme Mental Health First Aid (MHFA), was introduced to the English population, with the aim of raising mental health awareness amongst the general population. Some would now advocate the implementation of such training within the prison population, where evidently it is most needed.

Amongst other elements, MHFA teaches attendees how to offer and provide initial help, to a person experiencing a mental health issue, and guide them towards appropriate help. Perfect sense you'd think in a society whereby a quarter of us experience at least one diagnosable mental health issue. And yet how many custody officers receive such vital training whilst integral within a segment of society more likely to encounter a much higher ratio than one in four? We are led to believe the Government is committed to lowering recidivism, by trying to win over the hearts and minds of prisoners, with offending behaviour therapy

and vocational education. But what if those minds are elsewhere and they are not in a position to capitalise on these initiatives, until overcoming personal battles with illnesses such as anxiety and depression. Are we doing enough to identify the ones amongst us, struggling to cope, for whom the negative aspects of prison can be multiplied. More importantly, are we quick to act, before unscrupulous others take advantage and manipulate the affected into undesirable activities that compound their problems.

Typical everyday mental health crises within prison walls include suicidal thoughts and behaviour, panic attacks and self-harm. This broad subject includes effects (possibly psychotic) from substance abuse, aggressive behaviour and reactions to witnessing traumatic events. Often prisoners are reluctant to declare their temporary loss of mental clarity.

By spotting the warning signs and intervening earlier, everybody within our already challenging environment – benefits. Being mindful enough to listen non-judgementally can help de-stress someone who may otherwise be bottling up tension? At present, 10% of prisoners are recorded as receiving treatment whilst it is believed up to 90% of inmates have questionable mental well-being. Seemingly the stigma around mental health hinders sufferers from discussing their problems, and therefore seeking adequate treatment and much needed support.

An innovation at HMP Birmingham sees MHFA trained prisoners steer their peers towards help and coping strategies that lead to a reduction in impaired short term judgement and impulsive actions.

Trained mental health first aiders provide that moment of calm in the eye of the storm so badly needed by prisoners suffering with inner turmoil that inhibits their ability to function normally.

So why not include custodians in this

endeavour? After all we're all in this predicament together.

More consideration for those with poor mental health will be a positive step in fixing the prison community, and building a more mentally healthy society overall.

All observations are based on the experience and perception of the individual engaged in writing this article. This healthcare brief has

been produced by the BSMHFT Inside Recovery Team.

Trevor Urch
Recovery & Service User Involvement Manager
HMP Birmingham
Birmingham and Solihull Mental Health NHS Foundation Trust

Secure Hospital Transfers Within The Greenwich Cluster Prisons

Prevalence of mental health in the prison population is high and has been reported at 15% and 25% for male and female prisoners respectively (Prison Reform Trust 2018). Prisoners of all ages are at higher risk of developing a mental health disorder compared to 5% of the general population (NAO 2017). Some prisoners may have a mental health diagnosis prior to their detention, and some may develop mental health problems during their detention. Mental health problems are often exacerbated by use of illicit drugs such as spice and cannabis (Lader et al 2000).

The role of a Transfer Coordinator plays an integral part in the process of secure transfers. HMP Belmarsh, HMP Thameside, and HMP Isis are some of the busiest prisons in London. My role is to support the doctors together with the mental health team to ensure that a smooth and regular channel of communication is maintained at all times between prisons, hospitals, MOJ and police. Most importantly, I have to ensure that the patients' are safe from the point of

identification for secure transfer, to their arrival at the receiving hospital.

The Transfer Coordinator role was developed when NHS Oxleas took over as Healthcare Service provider for the Greenwich Cluster prisons in 2015. Since the appointment of this role in November 2015, secure transfers has doubled, communications has improved between the prisons, hospitals, MOJ and sometimes with the Metropolitan Police. Here are some of my duties as a transfer coordinator:

My role as a Transfer Co-ordinator is to co-ordinate the care and transfer of patients with mental health problems from prison to NHS/independent inpatient units outside of the prisons and monitor their progress liaising with other healthcare professionals, inputting to case reviews, providing assessments and reports, my post is the single point of contact for these prisoners. I am:

- To provide quality healthcare to offenders in Greenwich prisons
- To provide safe and effective care pathways for all offenders identified for transfer to external NHS or independent in-patient services
- Working alongside the responsible prison clinical team, the post-holder will act as the link between external

providers and the prison teams to ensure a co-ordinated approach to transfer planning, which results in effective and timely transfers in accordance with national time scales (14 days if urgent).

- To maintain accurate and timely transfer activity, information and data on the electronic data tracker system
- To be responsible for timely referrals to external providers
- To be responsible for tracking the progress of all referrals
- To promote timely medical and nursing assessments by external providers
- To maintain close links with the Ministry of Justice to ensure timely transfers

Throughout the duration of an offender stay in external services, the post holder will act as a point of contact to ensure the smooth flow and exchange of information and attend all relevant forums relating to the offender.

My role is complex and it requires a lot of responsibilities, as it is the single point of contact for all secure hospital transfers for both internal (stakeholders) and external parties. There are few unknown that are beyond the control of a Transfer Coordinator; such as hospital bed availability which can sometimes cause delay in transfer. There is no protocol in place for when there is a delay in transfer. Only the prison mental health team plays a pivotal role in maintaining patients' safety and in ensuring that there are good management plans in place until a bed becomes available.

However, maintaining an updated and open communication channel between the prisons and receiving hospitals very often is crucial to the quick solution of the problem and the following bed provision.

Another issue that sometimes occurs is when a bed is available but the prison cannot facilitate the transfer on time. This often results in losing the bed. In such cases my communication with prison governors, especially the security governor, is essential in ensuring that the patient's safe and secure transfer takes place on time without losing the bed. I do sometimes have to highlight to governors factors that need to be taken in consideration, should the patient lose the bed. In most cases it means that the patient will have to wait for another 3 to 4 weeks to get a bed. The most common issues that I come across are the lack of staffing and of the vehicle on that particular day for the transfer.

I have gained a vast and detailed knowledge of Mental Health Act and of the process of securely transferring patients between prisons and hospitals.

At the end, in my opinion the most critical and important factor that determines a safe and smooth transfer is the maintenance of an open channel of communication between each and every party: prisons, hospitals, MOJ, mental health team within prisons, and stakeholders.

Modou Barrow
Greenwich Cluster Transfer Coordinator
HMP Belmarsh, HMP Thameside,
HMP Isis
Oxleas NHS Trust

Follow us on Twitter:

@rcpsych and @ccqi_ and use #qnpmhs for up-to-date information.

HMP Belmarsh Patient Artwork

"I run group activities for patients/prisoners in HMP Belmarsh and HMP Thameside, the activities include: Creative Art, Recovery Star and Hearing Voices group.

Some of the patients are clinically reviewed in the Depression Clinic run by Dr Rachel Daly and Myself."



The artist (S. S.) is presently in HMP Belmarsh and he has said the following about his drawings:

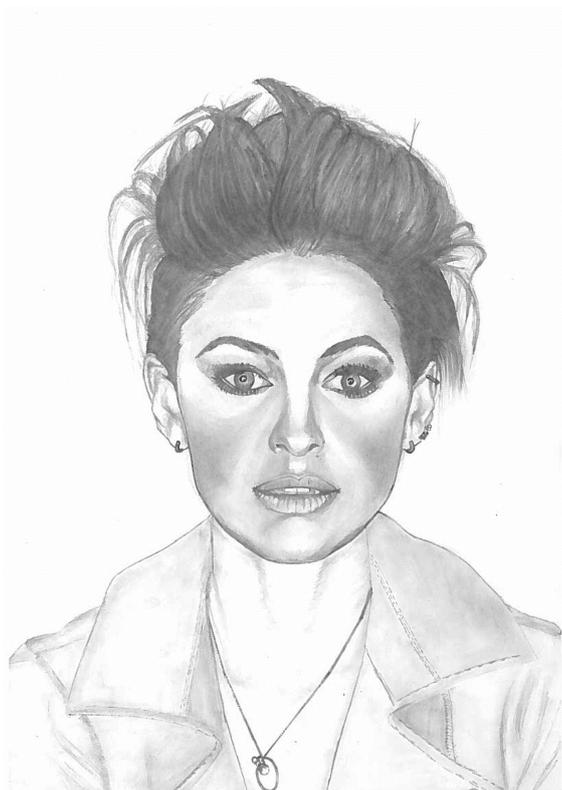
Harry and Meghan:

"Their wedding is coming up and that is why I have decided to draw them, also, Harry supports people with mental health."

Emma Willis:

"I decided to draw her picture because she is popular and pretty."

Dr Faidat Orekan
Resource Centre Clinical Lead
HMPs Belmarsh and Thameside
Oxleas NHS Foundation Trust
Submitted on behalf of a patient at HMP Belmarsh



Patient Artwork

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

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

The Challenges of Ageing Prison Population Nationally and Locally

We recently presented a workshop on the challenges of the aging population in the prison service at the Royal College Annual Forensic conference in Nottingham. There was an interesting debate at this meeting and we noted there are no established national protocols, but lots of good practice in various prisons around the country, including our local prison HMP Belmarsh.

We reviewed the literature and up to date guidelines in the prison service and there is an active programme for redesign of prison service and rehabilitation. The older group is mentioned in this literature but there is no designated benchmarking about designing prisons specifically for this group.

The most helpful document that I found was the Health and Social Care Needs Assessment of the Older Prison Population produced by Public Health England, published in November 2017.

We note the following challenges:

- The number of people who are in prison over the age of 50 has been steadily increasing and is projected to continue for the next five years and beyond.
- Older people in prison have a variety of needs with presence of long term conditions with reduced mobility levels being just one of the major challenges.
- Prison service regimes have not historically been designed around

older prisoners needs and this can be challenging.

Much has been done at looking at the health and wellbeing of this group but further actions are required if we are to give this group of prisoners quality of life equivalent to that of their peers.

Essentially what is felt is required is a proper needs assessment and this needs to be a formal assessment on a prison level in an evidence based way to fully meet the needs of this group.

The prison reconfiguration programme is currently ongoing in England and Wales. In summary, this will involve all prisons being reclassified as primarily for reception, training or resettlement. These three pathways reflect the distinct stages of the journey through the prison system an incarcerated person will take.

Running concurrently with this reconfiguration is the prison rebuild programme. This will provide purpose built placements for at least ten thousand older prisoners. At the same time as these modifications are happening, the number of deaths in prisons has been steadily rising in the last few years. As in the Prison and Probation Ombudsmen reports in year 2007 – Prisons are designed for fit young men, they must adjust to the largely unexpected and unplanned role of the care home and even the hospice.

Her Majesty's Prison and Probation Service have classified people aged 50 or more in prison as older and this is the definition used by other prison systems internationally, however it is not consistent with definitions used elsewhere in health and social care by those aged 60/65 being classified as older.

Numbers

A picture of the national current prison

population:

In December 2017 the total prison population was 84,373.

Age 50 - 59 population 8,638

Age 60 - 69 population 3,243

Over 70 population - 1,641.

Total prison population aged 50 and above - 13,522. In December 2011 the population aged 50 and above was 9,296.

There is strong evidence of the older population of prisoners experiencing a higher burden of physical and mental health problems. Up to 90% have at least one moderate severe cardiac condition and more than 50% have three or more. Various health conditions are worse than those at the same age in the community and worse than their younger peers in prison.

A health assessment is a systematic method of reviewing the health issues facing the population leading to resource allocations that will improve health and reduce inequalities.

So what are the needs of this group?

- Multiple long standing illness including dementia
- Neurological impairment secondary to CVA/TIA
- Substance use including smoking tobacco, alcohol use, opiates and other drugs
- Mental health needs including depression
- Complex medication regimes
- Impaired sensory function including loss of hearing and visual impairment

- Impaired mobility due to cardiac and respiratory disease as well as musculoskeletal illnesses

The other issue is release; what about this older population who are released into the community who are potentially the most institutionalised and may have a break down with community support including less help from family and friends, their needs to seek GP registration in the community and the challenge for the GP's to get access to medical records from those recently released?

The outcome for this group is that mortality rates are almost three times higher than those in the community and also challenges such social care needs.

Locally at HMP Belmarsh we are trying to meet this challenge, we have arranged for a multi-disciplinary meeting where we will try and develop an active protocol about how we go forward to manage aging in our healthcare system which is provided by Oxleas NHS Foundation Trust. We have been addressing areas, we have a palliative care suite in our healthcare inpatient unit, we have a 32-bedded healthcare inpatient unit and we have it divided into two wards and single cells. We have now one ward being used for over 50's which is a six-bedded occupancy, which has been working successfully. However, it involves identifying the right prisoner over 50 who fits in with the ward prison environment.

There are other on-going areas of work within the prison; Oxleas NHS does have a contract with Greenwich council to provide social care. This team currently includes a team leader, one care and support orderly coordinator, six full time social care workers. The staff work across three prisons in South London HMP Belmarsh, HMP Isis and HMP Thameside known as the Greenwich cluster of prisons.

At this time we have those growing older

prisoners, and we have those newly imprisoned with old age needs. It is clear there needs to be a national strategy within the prison setting but also a national strategy by service providers like our own trust on how we progress and manage this older group to give them a quality life which meets their needs within the prison setting.

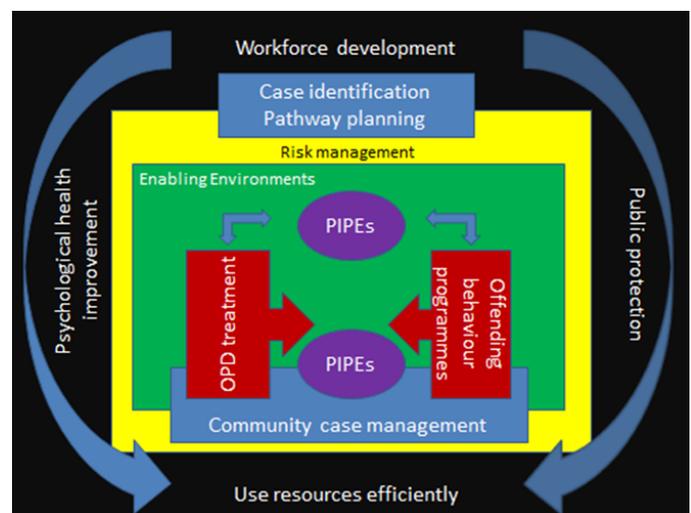
Rachel Daly
Consultant Forensic Psychiatrist
HMP Belmarsh Healthcare
Oxleas NHS Foundation Trust

Faisal Mudathikundan
Associate Specialist in Forensic Psychiatry
HMP Belmarsh/HMP Isis
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The Offender Personality Disorder Programme

The joint NHS and HMPPS Offender Personality Disorder (OPD) strategy was launched in 2011. The new strategy announced the ambitious intention of using the same level of resources that were deployed in the earlier Dangerous & Severe Personality Disorder (DSPD) pilots to provide improved and earlier identification and assessment of offenders who might satisfy a diagnosis of 'personality disorder,' and many more treatment and progression places in prisons, approved premises and in the community. Now seven years into implementation, the OPD programme has identified over 30,000 offenders who are in scope, employs an estimated 2,000 people, and has tripled the number of available treatment places. We are particularly proud of the way that our 'jointness' – in the way the programme is funded, commissioned and delivered jointly by the NHS and HMPPS – is becoming embedded at all levels, and how the pathway is becoming an increasingly well-established part of the health and criminal justice landscape.

The overall aim of the OPD programme is to improve public protection and psychological health. **It is a cross-sector, collaborative, evidence-based, community-to-community pathway approach** that provides motivation and engagement, treatment, and support post-treatment. The key principles underpinning the programme are that offenders who might satisfy a diagnosis of 'personality disorder' (or complex interpersonal problems arising from



psychological, behaviour and emotional difficulties) are a shared responsibility of HMPPS and the NHS, and that planning and delivery is based on a whole systems approach across the criminal justice and health systems.

Treatment and management is psychologically informed and led by psychologically trained staff in HMPPS and the NHS, focusing on relationships and the social context in which people live.

The pathway begins with **Case Identification**. We aim to identify offenders who fit the criteria at the earliest stage after sentence. The criteria for men and women are different due to their different needs, presentations, and behaviour:

Men and women:

- Likely to have a severe 'personality disorder;'
- A clinically justifiable link between the 'personality disorder' and the risk; and
- The case is managed by NPS.

Additional criterion for men only:

At any point during their sentence, assessed as presenting a high likelihood of violent or sexual offence repetition and as presenting a high or very high risk of serious harm to others.

Once individuals have been identified for the pathway, the offender manager works with a health partner to develop a **Pathway Plan** for each offender based on a process of **Case Consultation and Formulation**. This describes a process of specialist advice and discussion between the health partner and the offender manager to consider the offender's psychosocial and criminogenic needs relating to their interpersonal problems.

Depending on the plan for the offender, he or she may engage in suitable HMPPS accredited behaviour programmes, or in **OPD treatment**, which is now available in prison, hospital and community settings. OPD treatment services aim to ensure an improvement in mental and emotional wellbeing, social circumstances, and community ties associated with the reduction in risk of reoffending. They deliver an

evidence-based service within a safe, supportive and respectful environment (quality assured through achievement of the Royal College of Psychiatrists' Enabling Environments award), employing a range of skilled, motivated, supported and multi-disciplinary staff to address offenders' interpersonal difficulties and behaviours.

One example of an OPD treatment service is the **Nexus service for women at HMP & YOI Eastwood Park**. Delivered jointly by the prison and Avon & Wiltshire Mental Health Partnership NHS Trust, Nexus offers a total of 30 treatment places, on a residential, day-care and outreach basis. The therapeutic approach offered is based on an attachment model of care. A phased approach begins with pre-treatment activities (psycho-education, crisis management planning and motivational work), moving to stabilisation, and progressing to trauma-focused work. Another example is the **FIPTS service**. Delivered jointly by South London & Maudsley NHS Foundation Trust and Penrose housing, together with the National Probation Service London Division, this community-based service is primarily focused on intensive risk management, but it also provides group and individual treatment, and for some service users, supported housing. Therapies include psycho-education, Dialectical Behaviour Therapy and the Violence Reduction Programme. The social component of treatment involves assisting with education, vocational or employment opportunities, benefits, and managing service users' physical health.

Psychologically Informed Planned Environments (PIPEs) are probably the best known output of the OPD strategy. PIPEs are not a treatment; they are instead designed to enable offenders to progress through a pathway of intervention, supporting transition and personal development at significant stages of their pathway, either in prison or in approved premises. There are now 23 PIPEs nationally

– 14 in prisons and seven in approved premises.

All available OPD services are summarised in the brochures of OPD Services (one for male services and one for female services), available on request from pd@noms.gsi.gov.uk.

As a developmental programme, we have a strong emphasis on three further areas of work: Firstly, **workforce development**, equipping staff across the offender pathway with the right skills and attitudes to work with this group of high-risk offenders; secondly, **involvement**, taking account of the experiences and perceptions of offenders and staff at the different stages of the pathway; and thirdly **research and evaluation**, with a number of projects underway, including NEON, the national, independent evaluation of the OPD pathway, which will include an assessment of whether the new arrangements offer value for money and is due to report in 2019.

Implementing the OPD strategy has not been without problems. Engagement with this client group can be difficult and there remains a lack of definitive evidence about treatment effectiveness. From a systems perspective, the difficulties are around bringing together two independent



Mural at the PIPE, HMP Swaleside

organisations, HMPPS and the NHS, both with different cultures and systems and both requiring independently and together to embed new ways of delivering services. What unifies them is the client group who require the help and support of both systems together, and the compelling need to deliver more effective public protection.

Sarah Skett
NHS England Joint Head
OPD Programme Team

Laura d’Cruz
HMPPS Senior Co-Commissioning
Manager
OPD Programme Team

The Development and Evaluation of a Prison Clinical Psychological Service

The NHS has resumed responsibility for the provision of mental health services in prisons since 2003, and significant attention has been given to improving mental health care

within prison establishments. Traditionally, there has been a primary focus on forensic psychologists focusing on offending behaviour and risk management in prisons.

However, since the development of standards for in-reach teams and their recommendation for the provision of evidence-based psychological interventions, clinical psychologists are increasingly providing input into prisons.

Within the current remand prison, clinical psychology services were introduced on a permanent basis in 2014. The psychology team consists of one lead clinical psychologist and two assistant psychologists. Given the complex remand nature of the prison with an average stay of just 10 weeks (Bromley Briefings Prison Fact file, 2015), the team were concerned with the successful implementation of clinical psychology services and effective interventions.

Over the last 3 years, the team have worked to design and implement individual and group therapies for prisoners across the establishment. These interventions are primarily CBT focused and short-term due to the nature of the remand prison. Group work consists of 4 sessions on average and individual work is often offered for 6-8 weeks. The therapy group program includes structured CBT sessions, psycho-educational groups and closed specialist groups. Current psycho-educational groups include anxiety management, wellbeing group, mood group and relaxation. Specialist groups include anger management and hearing voices group which is run in collaboration with the charity MIND.

The psychology team are also involved in the provision of training to healthcare colleagues, discipline staff and partner agencies. This aspect to the team's role was introduced with the aim of improving the knowledge and skills of all staff disciplines, particularly in relation to mental health awareness.

To establish the team's success in designing and implementing psychological interventions, two outcome measures were used; the Goal Obtainment Form (GAF) and the Clinical Outcomes in Routine Evaluation –Outcome Measure (CORE-OM). The GAF is an internally developed evaluation tool which allows the prisoner to identify three goals at the outset of an intervention and to provide qualitative feedback at the end. The CORE-OM explores four domains which indicate the

level of psychological distress experienced by the prisoner. These help to provide focus within the therapy and any change in scores can be explored on the completion of intervention. The CORE-OM was used to evaluate individual psychological interventions only as it was considered ineffective in measuring change in standalone, or very short term group sessions.

The data provided by these outcome measures were collated over a 6-month period and analysed in order to establish the current effectiveness of the clinical psychology service. In total 11 CORE-OM's were completed due to high attrition rates in the remand environment. The average number of sessions completed was 3 with number of sessions ranging from 1 to 10. All of the domain scores illustrated an improvement at the end of the intervention and the overall CORE-OM scores that initially demonstrated severe psychological distress at the assessment stage fell within the low level range upon completion of the intervention.

The GAF was completed within both individual and group psychology led interventions. At the time of writing, 169 have been completed by prisoners. Following analysis, the data showed that approximately 70% of prisoners found the interventions extremely helpful, 24% found them somewhat helpful and 6.3% found the intervention unhelpful. Furthermore, 98% stated that they would recommend the therapy to others.

Feedback about the team's input in the provision of teaching has also been collected to aid evaluation of the service provided. Over a 6-month period, the team provided 40 training sessions to various disciplines on a range of topics including mental health awareness, personality disorder and psychosis. 195 feedback forms were analysed. Over 50% of attendees rated the teaching as "excellent". No attendee's rated

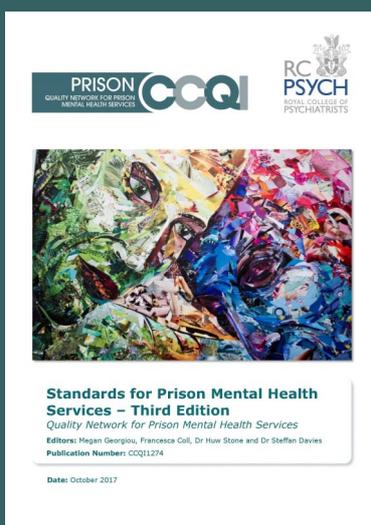
teaching as poor, 35.5% rated it as “good” and 2.5% rated it as “satisfactory”. This data demonstrated that overall, most attendees considered the teaching to be of a high standard.

Given the presence of a number of factors that mean the provision of mental health services is particularly challenging in a prison environment, these initial results are promising and go some way in demonstrating that an effective clinical psychology service is being provided. The team’s focus on continuing to demonstrate outcomes across all interventions will help to further demonstrate the efficacy of the service.

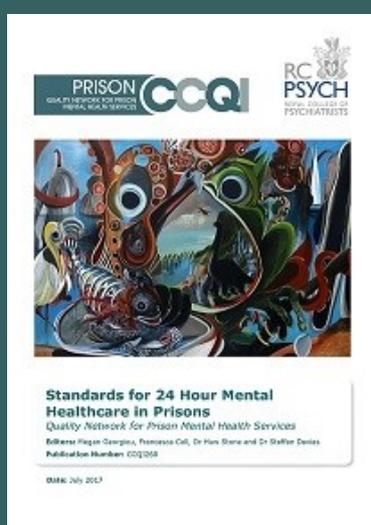
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HMP Pentonville

Sarah Withers
Assistant Psychologist
HMP Pentonville
Barnet, Enfield and Haringey NHS Trust



Standards for Mental Healthcare in Prisons (3rd Edition)



Standards for 24 Hour Mental Healthcare in Prisons

Available online:
www.qnpmhs.co.uk

Getting the most out of your Quality Network review

We're often asked how member services can get the most out of the Network and the review process. We thought we'd share some of the key points with you to help you maximise the benefits and opportunities for your service, your team, yourself, and your patients.

How can you involve your wider team, patients and carers in the review process?

- Take a whole team approach and ensure everyone is aware of the review, what it is, and how they can be involved
- Allocate responsibilities among team members, at self-review and peer-review, to encourage ownership over parts of the process
- Identify patient representatives to raise awareness among their peers and to lead on different areas. This may include: encouraging attendance at meetings, identifying individuals to support the tour of the prison, encouraging newsletter contributions, and/or boosting involvement in Network initiatives

What is the most effective way to approach a review day?

- Inform everyone of the review day and share the timetable in advance
- Assign roles and responsibilities
- Identify any priorities in your service that you wish to discuss with the review team
- Invite everyone to lunch and to network with the reviewing team

Following the review, how could you make the most out of the findings?

- Disseminate the key findings to your

staff team, your patients and partner agencies

- Celebrate the identified areas of achievement
- Develop an action plan in collaboration with all parties and allocate responsibilities
- Have regular meetings to keep track of progress ahead of the next year's review

What would make the process more helpful for your service?

- Be as honest as possible when scoring the standards – this will ensure the report is as helpful as possible in identifying areas for service development
- Hold regular meetings to keep track of progress throughout the self-review period and ahead of the review day
- View the process as supportive when being reviewed and when reviewing others. We're all in this together!
- Maintain good communication with your project link person to ensure the smooth running of the day
- Encourage team members to attend reviewer training and actively participate in review visits
- Promote the benefits to staff members in terms of personal development e.g. learning about other services, developing skills in chairing meetings and delivering feedback, bringing knowledge back to your service to improve your own practices, building your professional network, and CPD opportunities
- Attendance at events and contributing good practice in the form of workshop proposals
- Provide feedback following review visits to help improve the process

Megan Georgiou
Programme Manager
Quality Network for Prison Mental Health Services

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.

Public Health England: Improving the health and wellbeing for women in prison

The official blog of Public Health England.

https://publichealthmatters.blog.gov.uk/2018/03/08/improving-the-health-and-wellbeing-for-women-in-prison/?dm_i=43OD,A5P5,3JEN0F,1420E,1

PRT: Planning services for people with learning disabilities and/or autism who sexually offend

A new report by the Prison Reform Trust and University of Leeds examines sexual offending among people with learning disabilities and/or autism.

http://cotimprovinglives.com/prisons-the-value-of-occupational-therapy/?dm_i=43OD,A5P5,3JEN0F,1420F,1



Royal College of Occupational Therapists - Prisons: The value of occupational therapy

This report illustrates how occupational therapists working with prison services can address high re-offending rates and an increasing prison population living with health conditions.

<http://www.prisonreformtrust.org.uk/Portals/0/Documents/Behaviour%20that%20challenges.pdf>

The independent review of
the Mental Health Act

Interim report



Independent Review of the Mental Health Act: interim report

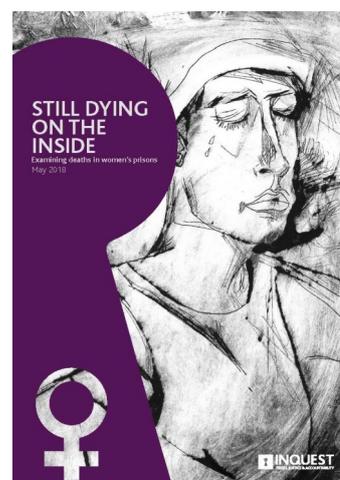
A summary of the review's work so far.

www.gov.uk/government/publications/independent-review-of-the-mental-health-act-interim-report?dm_i=43OD,A5P5,3JEN0F,1420J,1

Still dying on the inside: Examining deaths in women's prisons

This report by Inquest examines the lack of action to prevent deaths in women's prisons

www.inquest.org.uk/still-dying-on-the-inside-report?dm_i=43OD,A5P5,3JEN0F,1420K,1



Mental health in prison

A short guide for prison staff



Mental health in prison: A short guide for prison staff

This guide seeks to help prison staff understand and respond appropriately to the mental health needs of adult prisoners.

www.penalreform.org/resource/mental-health-in-prison-a-short-guide-for/?dm_i=43OD,A5P5,3JEN0F,1420L,1

Join the **Email Discussion Group** to network with colleagues in the field of prison mental health.
Email 'join' to prisonnetwork@rcpsych.ac.uk

Upcoming Events at the Quality Network

Reviewer Training 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. We have planned for the training to take place over three dates at different locations to suit your geographical location.

Available sessions:

- *15 August 2018 (14:00 - 17:00) – Principle Met Hotel, Kings Street, Leeds, West Yorkshire, LS1 2HQ.*
- *25 September 2018 (14:00 - 17:00) – Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB.*
- *25 October 2018 (14:00 - 17:00) – Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB.*

Quality Networks for Prison and Forensic Mental Health Services Prison transfer and remission: Improving practice, 27 November 2018

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

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/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/

www.qnpmhs.co.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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Twitter

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

Royal College of Psychiatrists (CCQI) Quality Network for Prison Mental Health Services

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