Quality Network for Prison Mental Health Services
Managing Dual Diagnosis and New Psychoactive Substances in Prisons, 28 November 2016
Summary of Workshop Discussions

Identification

Good practice:

- Mental health/Substance misuse staff sharing the office, joint working – shared responsibility.
- Mental health teams integrated Substance misuse/GP and Primary Care – joint working
- Mental health teams engaging in people at risk
- Drug Testing – Research and Understanding
- Mental health team can build a therapeutic relationship but this can take time.
- Protocol – Medical emergency but only covers immediate risk.
- "SPICE teams" – Physical, MH and Substance abuse. Respond and provide brief interventions.
- All Staff briefing – Call ambulance. On-call GP
- Jobs/education/activities can help –but limited
- Enabling environments
- Understanding/visual reminder of the consequences
- Crisis teams should attend prison/liaise with services
- Staff searches
- Technology – scrambling mobiles

Challenges/barriers:

- Joint working hard
- Not enough staff – prison officers, prison mental health
- Lack of experience – "prisoners running wings"
- Not being able to get the treatment for psychosis
- NSP overshadowing other mental health issues, not being diagnosed
- Resilience to act "it's only spice"
- Issues not reported or communicated to mental health
- Complacency
- Tackle Supply Change
- Full drone attack – 20 drones
- Bullying
- Guinea pigs/testing
- Not bothered about consequences
- No established follow up pathways
- No replacement Therapy
- Advance directives
- Dealers not wanting to leave prison
- Detection

Patient involvement:

- Emotional wellbeing workers
- Key workers
- Patient forum – hard to engage/ get people interested

Quality Network for Prison Mental Health Services
Managing Dual Diagnosis and New Psychoactive Substances in Prisons, 28 November 2016
Summary of Workshop Discussions

Education:

- Officers – SPICE
- Some physical health team don't know realise health problems stemming from NPS
- MH/ Substance abuse officers – emergency physical health
- Use of mental health awareness – Training, support and clarity are needed.

Management

Session 1:

- Good practice? – no right answer
- Risk of death does not act as a deterrent
- People live in the moment
- "Day-trip" to hospital
- Reduction of NPS recently in prisons – increase in cannabis

Challenges:

- Physical environment
- City locations – how do you reduce the supply? Too easy access.
- Mobile phones in prisons.
- Time in cells too excessive.
- Not enough staff
- Need of dedicated teams.
- Agreement and willingness to engage.

Opportunities:-

- Communication – healthcare and prison staff
- Integration e.g. weekly meeting
- Whole system approach – substance misuse, mental health, safer custody
- Patient involvement:-
    - Issue that it is "fun"
    - Ignore dangers despite education
    - Peer support, recovery champions, not doing enough.
- Need for better strategy to manage anxieties from prison life – then tackle NPS and substance misuse
- Wider picture – cultural shift is needed e.g. schools etc.
- Structure and containment in a smaller, calmer environment e.g. mental health services
- Some have chaotic circumstances outside
    - Prison officers more than on outside
- Education
    - Small numbers learned not to use it
    - Prisoners doing training to staff
    - Trial new methods – Engage with commissioners.
- Imprisoning people – need to help vulnerable people – divert from custody.
- Revolving Door

Session 2:

- National Consistency – all dealing with the same issues in the same way – more guidance needed.
- Punishment does not stop the issue – Positives from taking the NPS outweigh these.
- Integrated working
- Quality standards have more of an impact
    - Consider developing standards for management of NPS and measuring the outcomes
- Rapid response
- Employing paramedics to go to callouts
    - Better access for acute issues
- Confidence of treating people without capacity – need clearer guidelines
    - Can we restrain people for health reasons?
- Harm Minimisation (SCRA)
    - Give them cannabis as a substitute? Reduce bullying, reduce trade.
        - BUT legal issues
        - Vaping cannabis oils
        - Too complex – too many different issues to manage.
- People will seek risk-taking behaviours
    - Not solving the situation
- Smoke-free prisons – supply change to tobacco? – will likely make NPS use worse
- Cannabis – pain relief
- Functions – why are people taking it – then consider solutions
    - Extreme boredom
- Test ideas in separate prisons
- Users not sure what they are using and the side effects are unknown – Better education is needed.
- Anxiety and poor coping – want traditional methods of calming that cannabis can give
    - Find medical based controlled substance
- Need to have more people around – give training, helpful regime.

<u>Prevention</u>

Education:

- Both prisoners and staff need more education on how to deal with Spice
- Thoughts about education for prisoners as part of their induction
- Educate the staff on legal highs and Spice in general
- Educate staff on how to deal with it when prisoners are under the influence/or addicted to Spice. Use a more collaborate approach between the staff and the therapy staff.
- Finding/identifying patterns of when people are most vulnerable to Spice, or when coming off Spice. Trying to stop the pattern of people collapsing if we can try to predict the patterns of high use etc.

- One person mentioned an old comic (Peanut Pete) that actually managed to get people off amphetamines. Something similar for Spice?

Therapy:

- Drop in sessions; it was thought that sentence plans are not always the best approach as it becomes a tick-box exercise. Drop in sessions can ensure people who are there are motivated and driven to stop their addiction.
- On top of this there needs to be 1-to-1 follow up sessions, as group work alone can be intimidating.
- Actually getting to the root cause of why the prisoners are taking the drug, making sure to ask them.

Staffing:

- Personal Officer Scheme (this is more effective on longer-term prisoners)
- Continuity of good, well-established and experienced staff. A lot of new staff members are easily intimidated by the prisoners, have less of a connection, and can lack the communication skills needed to get through to the prisoners.
- More mental health awareness training for all staff members, including people dealing with admissions.
- A proactive approach to those in prison known to be dealing the drugs. Making changes such as moving them to a different Unit, or putting them in segregation.
- Training of peer mentors and intro of motivational interviewing.

Other:

- Boredom seems to be the biggest factor of why people take spice, the killing bird syndrome. Being able to introduce more **meaningful** activities, so that the prisoners have a fuller routine. Meaningful activities, more than activities to fill their day, such as giving them opportunities to gain more skills, gain qualifications or transferable skills to enhance their chance at getting a job when released.
- Obviously lack of resources and money were identified as being major factors, and something which isn't easily changeable. This was acknowledged throughout the workshops by everyone.

Collaboration

Session 1:

- Weekly substance misuse meeting for collaboration work.
    - Shared office space works, but usually in a prison logistics means that different areas of prison are used.
- Different disciplines use different healthcare note systems in IT. Drug team have different care notes.
- Confidentiality issues, what can and can't be disclosed as SU.
- "Safe Prescribing" medication getting stopped by GP = NPS.
- It is not a 24 hour healthcare system, so sleeping medication is being taken at 4pm.

- There is not a good collaboration with MHA.
- 7 day services vs. 5 day comprehensive? On-call GP is expensive. Nurse "sits" limited access to SU.
- 14 day aim to transfer to forensic services.
    - Average is really 40 days. Too long that SU doesn't get mental health care.
- Positive aspect – better collaboration between prison and healthcare stakeholders, but this needs to be better.
- Get psych in but then the SU cannot see them – Lockdown.
- Collaborate with SU – "peer-support"
    - Unpaid work at HMP Rochester.

Session 2:

- Nurse cannot see previous full notes, so rely on SU.
    - Why is system one not open? Relying on SU, need the full history. Nursing staff only use information from SU. Usually say not on NPS.
- Need peer groups for NPS, especially for induction.
    - Need for this collaboration as new SU being used as guinea pigs.
- Lack of communication between healthcare and prison officers. Joint Training? Addiction forums for healthcare and prison officers.
- NPS and emergency services – need 3 officers to go if taken NPS, this takes away from numbers.
- Some prisons have 24 hour mental health staff, some have Mon – Fri mental health staff.
- Treating the symptoms and not the issues. High transfer rates and so don't always get to treat.
- Education for SU – Collaboration to take responsibility and look after peers if taken NPS.
    - First aid for patients across board.
- Communication between external charities needs to improve.
- Reoffend to get back into prison to sell NPS.