PRISON CCQI
QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for 24 Hour Mental Healthcare in Prisons

Quality Network for Prison Mental Health Services

Editors: Megan Georgiou, Francesca Coll, Dr Huw Stone and Dr Steffan Davies

Publication Number: CCQI268

Date: July 2017

This publication is available at: www.qnpmhs.co.uk

Any enquiries relating to this publication should be sent to us at:
prisonnetwork@rcpsych.ac.uk

Artwork displayed on the front cover of the report:

Evolution
HM Prison Shotts
Pierce Brunt Highly Commended Award for Painting

Image Courtesy of the Koestler Trust

Contents

Foreword 4

Introduction 5

Standards for 24 Hour Mental Healthcare in Prisons 6

Admission and Assessment 7

Case Management and Treatment 7

Referral, Discharge and Transfer 8

Patient Experience 8

Patient Safety 8

Environment 9

Workforce Capacity and Capability 9

Governance 10

Appendix 1: Literature Review 11

Appendix 2: References 19

Appendix 3: Acknowledgements 22

Appendix 4: QNPMHS Project Contact Details and Information 24

Foreword

Welcome to the first edition of the standards for 24 hour mental healthcare in prisons. These standards have been developed by the Quality Network for Prison Mental Health Services and form part of a wider initiative dedicated to improving prison mental health services across the UK and Ireland. Following a highly successful consultation event in April 2017, the below set of standards were developed and agreed upon. Mental health professionals, service managers and senior clinicians, commissioners and patient representatives have shaped the standards through ongoing consultation.

The increasingly high demand for secure beds, within both the NHS and independent sector, has resulted in significant pressures on prisons to manage mentally ill people from within their establishments. There is an emphasis on ensuring that patients receiving care, within the realms of both physical and mental health, experience the same standard of care and delivery as they would in the community. These standards act as a framework for reviewing, monitoring, planning and ultimately improving the provision of care nationally.

These standards provide an additional element of reflection and measurability to the published standards for prison mental health services. I hope this measure will provide a focused tool for improving the quality of your services and that you find them a useful addition when putting them to practice as part of next cycle's review process.

Dr Huw Stone
Consultant Forensic Psychiatrist
Surrey and Borders Partnership NHS Foundation Trust
Co-chair Quality Network for Prison Mental Health Services

Introduction

The Quality Network for Prison Mental Health Services (QNPMHS) was established in 2015 and exists to support prison mental health teams to improve the quality of the service they provide. The Network operates alongside approximately 25 other quality improvement networks, accreditation programmes and audit projects delivered by the Royal College of Psychiatrists' Centre for Quality Improvement.

Our purpose is to provide the tools and support for quality improvement in the form of an annual review cycle. Through self and peer-review mechanisms, the Network reports on service performance and encourages year-on-year improvement. Services also have the opportunity to benchmark their practices against other similar services through our annual reporting of key themes and trends from the aggregated data. There is an action planning element which sees services measure their progression alongside the standards and shares the responsibility of quality improvement across teams, senior management and the prison itself. The ethos of quality improvement encourages the sharing of best practice, networking with peers, and access to current and relevant information.

The Network is advised by a group of professionals who represent key interests and areas of expertise in the field of mental health, as well as patient representatives who have experience of using these services. The group is co-chaired by Dr Huw Stone and Dr Steffan Davies.

Standards

The standards for 24 hour mental healthcare in prisons provide a framework for specialised quality improvement for services with inpatient provisions or enhanced care facilities. The first edition of the standards has been published following a successful consultation event, which saw a number of professionals and patient representatives come together to revise and agree upon the final set. A review of key literature into inpatient care within prisons was conducted and informs the standards (appendix 1).

All criteria are rated as type 1, 2 or 3:

> **Type 1:** Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence based care and treatment.
>
> **Type 2:** Expected standards that all services should meet.
>
> **Type 3:** Desirable standards that high performing services should meet.

NB: Each standard is numbered and with the letter 'i' to differentiate it from the core standards for prison mental health services[1].

[1] www.qnpmhs.co.uk

Standards for 24 Hour Mental Healthcare in Prisons

Admission and Assessment		
No.	**Standard**	**Type**
i1	There is an agreed operational policy which includes the following areas: • admission and discharge criteria; • admission decision making, including out of hours; • leadership of the unit, including clinical and discipline; • the clinical model of the service, including therapeutic activities and prescription/administration of medicines; • the process by which other prisons may refer to the unit when it operates as a regional resource; • the process for liaising with families; • follow-up arrangements.	1
i2	Patients have a comprehensive assessment which is started within 4 hours and completed within 48 working hours. This involves the multi-disciplinary team and includes the patient. An immediate care plan is completed which includes: • mental health and medication; • physical health needs; • risk assessment, including risk of suicide.	1
i3	The purpose of the admission is explained to the patient and an assessment of their capacity to consent to admission, care and treatment is completed within 24 hours of admission.	1
Case Management and Treatment		
i4	Managers and practitioners have agreed weekly clinical review meetings that comply with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	1
i5	Activities are provided seven days a week. *Guidance: This can include occupational therapy, art/creative therapies, non-therapeutic activities and in cell activities.*	1
i6	Each patient receives a pre-arranged one-hour session at least once a week with their key worker (or equivalent) to discuss progress, care plans and concerns.	2
i7	Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.	1

Referral, Discharge and Transfer		
i8	Discharge planning begins at the first review and outcomes for discharge are agreed.	1
i9	There are protocols agreed with the prison to enable patients to access accident and emergency services.	1
Patient Experience		
i10	Every patient is engaged in active conversation at least twice a day by a staff member. *Guidance: This is an opportunity for patients to discuss any issues or difficulties they are experiencing.*	1
i11	There is a weekly minuted community meeting that is attended by patients and staff members. *Guidance: This is an opportunity for patients to share experiences, to highlight issues on the unit and to review the quality and provision of activities with staff members. The meeting should be facilitated by a professional who has an understanding of group dynamics.*	3
Patient Safety		
i12	Risk assessments and management plans are updated according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.	1
i13	Patients are able to access safe outdoor space every day and should be encouraged and supported to do so.	1
i14	Patients have their medications reviewed at least weekly. Medication reviews include: • assessment of therapeutic response; • safety; • side effects, with a clear care plan to manage them when they occur; • adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	1

i15	The team keeps medications in a secure place, in line with the organisation's medicine management policy.	1
i16	There is a clear policy agreed with the prison concerning the management of violence and aggression within the unit. This includes: • the roles of discipline staff and healthcare staff; • the use of restraint; reviews following episodes of restraint in the unit; • audits of restraint.	1
i17	There is a clear policy regarding the use of rapid tranquilisation within the unit, which includes the issue of consent.	1
Environment		
i18	An audit of environmental risk, including ligature risks, is conducted annually and a risk management strategy is agreed with the prison. *Guidance: Any problems are recorded and reported to prison senior management personnel.*	1
i19	Emergency medical resuscitation equipment (crash bag), as required by Trust/organisation guidelines, is available within 3 minutes and is maintained and checked weekly and after each use.	1
Workforce Capacity and Capability		
i20	The team has access to a specialist pharmacist and/or pharmacy technician to support their prescription of medication.	2
i21	There are agreed minimum staffing levels that include at least one qualified nurse present on all shifts.	1
i22	The unit is staffed by permanent staff members, and bank and agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need. *Guidance: The use of agency staff is monitored on a monthly basis. An overdependence on bank and agency staff members results in action being taken.*	2
i23	Arrangements are in place to ensure that a doctor is available at all times to attend the unit, including out of hours.	1

Governance		
i24	The operation of the unit is explicitly included in the commissioning specification from NHS England.	2

Appendix 1: Literature Review

Megan Georgiou and Dr Syed Ali

A comprehensive review of literature has been undertaken in order to inform the development of specialist standards for 24 hour mental healthcare in prison settings. The purpose of the review is to establish context and a rationale for developing good practice standards in this area.

The development of these standards forms part of a wider project dedicated to improving prison mental health services in the UK and Ireland. In 2015, the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) published a set of specialist standards for prison mental health services, incorporating CCQI standards for community mental health services (RCPsych, 2015; 2016). The expression of interest in these standards was so great that a dedicated quality network for these types of services was piloted in order to support services to improve the quality of care they provide. The Quality Network for Prison Mental Health Services (QNPMHS) was launched in 2015, with 18 prison mental health teams participating in the pilot phase. Following the first year of implementation, the standards were revised to take into account recent developments in the field, and also to account for feedback from member services. Now closing the second cycle, the Network engages 42 services in the review process.

Member services engage in an annual process whereby they conduct a self-review of their practice using the published standards as a framework. The commentary and evidence provided is assessed by a visiting peer-review team, which consists of mental health professionals from other prison teams and a representative of the Network. A review summary is presented to the service; this outlines areas of challenge and provides recommendations for improvement, whilst also celebrating the successes of the team. At the end of the review cycle, an annual report aggregates the data and presents on the identified key trends and themes across the Network. The report also functions as a benchmarking tool to allow services to compare their standards against other similar services, and presents the opportunity to share good practice and learning. In addition, member services benefit from a range of initiatives; this includes special interest days (most recently on managing dual diagnosis and new psychoactive substances in prisons, and on through the gate mental healthcare), an annual forum, the publication of regular newsletters, and the moderation of an email discussion group.

The development of standards for 24 hour mental healthcare in prisons is being undertaken in response to member services identifying that further attention is required for those needing a mental health bed whilst being accommodated in a prison setting, for instance a prison inpatient or enhanced care facility.

This evaluation will build on the review conducted for the development of standards for prison mental health services published in 2015 (RCPsych) and it

will be structured into three sections. The first section will explore the current picture of the prison estate in order to provide context to the discussion. Second, a review of the existing literature on 24 hour mental healthcare in prisons will be undertaken. Finally, the review will focus attention on health in the criminal justice system and the developments that have been observed over the past couple of years.

The current picture in prisons across England and Wales

Before exploring the literature, this section will provide a brief context of the current picture in the penal estate across England and Wales.

In June 2017, the prison population was recorded at 85,293, nearly twice what it was in the early 1990s (GOV.UK, 2017). The UK has the highest rate of imprisonment in Western Europe and sentence lengths in the Crown Court have increased by 30 per cent over a period of ten years (Prison Reform Trust, 2016). As a result, overcrowding is mounting pressure on an already overstretched system. HM Chief Inspector of Prisons for England and Wales remarked on further challenges, commenting that prisons "have become unacceptably violent and dangerous places", citing the prevalence of new psychoactive substances (NPS) as exacerbating issues relating to debt, bullying, self-harm and violence (HMI Prisons, 2016: 8). Deaths in custody are also at the highest number on record with 324 deaths in the year to September 2016. One-third of these deaths were self-inflicted (Prison Reform Trust, 2016).

People in prison suffer from multiple and complex health issues at rates far greater than those in the general population (Public Health England, 2016). A study of psychiatric morbidity in prisons across England and Wales indicated that the prevalence of poor mental health in prisons is high. It found that 90 per cent of people in prison aged over 16 years suffered from a mental illness, addiction or personality disorder, and 70 per cent had two or more of these issues (Singleton *et al*,. 1998). These figures, although published almost two decades ago, are alarming and highlight the need for transformation in providing healthcare to the prison population.

Table 1: Percentage of mental health problems of the prison population vs. the general population

Disorder	**Men**	**Women**	**General Population**
Psychosis	15	25	4
Personality disorders	62	57	-
Anxiety and depression	23	49	16
Attempted suicide (at some point in their lives)	21	46	6
Drug dependency	45		5.2
Alcohol dependency	30		11.5
Before entering prison:			

Emotional wellbeing or mental health issues	35	58	N/A
Previous psychiatric admission	10	30	N/A

Source: Public Health England Health and Justice Annual Review 2015/16 (2016)

The dramatic rise of suicide and self-harm in prisons in England and Wales is a significant concern. A report jointly published by the Centre for Mental Health and the Howard League for Penal Reform announced that more than 100 people lost their lives through suicide in 2016. The suicide rate in prisons is around 10 times higher than in the general population. They attribute the rising number of prison suicides to cuts in staffing and budgets, too much time in cells, a punitive regime and overcrowding. It also comments on the increased levels of violence and deterioration in safety (Stubbs and Durcan, 2016).

In late 2016, a much welcomed Prison Safety and Reform White Paper was published by the Ministry of Justice, setting proposals to address the current levels of violence and safety issues in prisons. The paper places prison governors at the centre of the changes, giving them greater control and room for innovation. It states that governors will be held more accountable by introducing performance monitoring, highlighting the successes and failures of each establishment. It also suggests that staff will have greater resources, authority and tools needed to progress and achieve prison reform. Changes in these areas are welcomed, in addition to a reduction of overcrowding and an increase in staffing numbers. However, due to the ever-changing political landscape, it is not confirmed that these much needed reforms will be implemented.

24 hour mental healthcare in prisons

In developing standards for 24 hour mental healthcare in prisons, we are emphasising the importance of people in prison receiving the same standard and delivery of care as they would access in the community. This principle of 'equivalence of care' was first introduced into prison health policy in 1990 (Home Office, 1990, 1991; Wilson, 2004) and has been further acknowledged over the years in various government policy and research (RCPsych, 2015). Within prison settings, the arbitrary standard is set as similar to services within the community, however it was noted that although some parallels could be built between outpatient and primary care services, such equivalence was lacking in relation to hospital wings within prisons (Wilson, 2004). Standardising practice against a well-defined framework which is available, accessible, acceptable, and of good quality (AAAQ) has the potential to transform prison mental healthcare (Exworthy *et al*., 2012). These new standards, incorporating good practice from community and inpatient settings, will serve as that framework by encouraging greater consistency nationally. The need for improvement of mental health services within prisons has attracted significant attention in the last two decades, with mental healthcare now being provided by the NHS and the introduction of prison in-reach teams to ensure a high quality mental health

service is delivered. However, there has been somewhat limited focus on 24 hour mental healthcare within this setting.

In the early 1990s, a high prevalence of psychiatric illness and high suicide rates among prisoners was highlighted as adding pressure on psychiatric services in prisons. It was also acknowledged that the provisions of services for offenders with personality disorder and/or sexually deviant behaviours was limited outside the prison system (Gunn *et al.*, 1991). Therefore a need for an increase in medium secure beds to offer treatment for mentally disordered offenders was suggested, indicating that treatment equivalent to hospitals could not be provided on prison healthcare wings (Gunn *et al*., 1991; Needham-Bennett and Cumming, 1995).

Around a decade later, the results of a year's programme of semi-structured inspections of inpatient care of mentally ill people in prisons was published (Reed and Lyne, 2000). The study reviewed 13 prisons and found that the number of beds within prison healthcare varied from 3 to 75 beds. Practices in prisons varied, however the quality of services provided was considered unsatisfactory and was below the standards within NHS services more widely. A lack of professionals, including qualified doctors and nursing staff, were of significant concern. The absence of a multidisciplinary approach in managing mentally disordered offenders in prison was striking. For instance, out of the prisons evaluated, only one had an occupational therapist in post and only two had a clinical psychologist. Access to nursing staff at night was particularly poor with no set standards or guidance for staffing levels. The size and structure of the facilities in old prisons was somewhat unfit for purpose, and newer built prisons had a reasonable structural design but the number of beds used for healthcare purposes was quite low. The authors concluded that the quality of services for mentally ill prisoners fell below the standards in the NHS, therapy offered to prisoners was limited and limited number of staff had appropriate training to deal with mentally disordered offenders (Reed and Lyne, 2000).

Similarly, in 2002, the Council of Europe highlighted the need for adequately equipped and staffed hospital facilities for mentally ill prisoners inside or outside prisons (Wilson, 2004). Wilson explored the purpose of prison healthcare wings and branded them a 'limbo' between prisons and hospitals. However, he acknowledged improvements in the identification of severe mental illness with the introduction of prison in-reach teams. The need for an increase in secure psychiatric beds or for a major change of prison healthcare wings was emphasised. Furthermore, Wilson acknowledged that primary care and outpatient clinics within prisons could be considered equivalent to the community, but a framework for the treatment of inmates with mental illness on prison healthcare wings was far from equivalent to the care offered in psychiatric hospitals. A lack of a legal framework to administer medication to a non-complaint and/or incapacitous patient was considered as one of the main issues.

Extending the use of the Mental Health Act Code of Practice for the purpose of treatment in prison healthcare wings was explored in a study by Earthrowl and colleagues in 2003. Through developing a policy, it suggested increasing the flexibility of treatment under common law to prisoners with mental disorders who lack treatment decision-making capacity during the interim period where they await transfer to a psychiatric hospital. It concluded that, in the best interests of the prisoner, case law allows more extensive treatment to be provided, beyond emergency situations.

Furthermore, in attempting to reduce the use of seclusion and to improve the care of vulnerable and mentally ill prisoners, a study was conducted of a 10 bedded high support unit (HSU) within in an Irish prison (Giblin *et al*., 2012). The unit opened in 2010 and after a year of operation it was reported that with staff training, close supervision and monitoring, the rates and duration of seclusion was reduced. Staff members were of the view that patients with acutely disturbed behaviours can be managed safely within prisons without being placed in segregation and seclusion for long periods. They identified that a multi-agency and collaborative approach between healthcare and prison staff was beneficial. For instance, joint training of staff improved the confidence in managing such acutely disturbed prisoners within the prison. Most notably, the initiative ensured greater access to mental health services, ensuring equivalence of care for prisoners compared to what they would accessed in the community (Giblin *et al*., 2012).

Similar themes were identified in a qualitative survey in a nurse-led prison hospital wing providing care and treatment for both physical and mental health for male prisoners in Southern England (Foster *et al*., 2013). The working pattern of nursing staff members were broadly defined as "caring", involving tasks such as medication and/or liaison with a visiting psychiatrist, and duties of officers were graded as "security". The prisoners were aware of the difference in roles of staff on this unit, and therefore discussed health related issues with nursing staff and legal matters with officers. It is noteworthy that the unit received criticism previously but later was considered as having good practice (HMIP, 2006; cited in Foster *et al*., 2013). Their key finding was the tension between care and control (therapy and security) and that cooperation, coordination, and collaboration is important for the two groups to work together (Foster *et al*., 2013).

The OHRN published a report in 2015, commissioned by NHS England, specifically looking at prison-based healthcare beds in the East of England, the East Midlands and the West Midlands. It was a mixed method study exploring the purpose of in-patient beds, barriers and facilitators of high quality care, links between in-patient care and secondary services, and the management of suicide and self-harm risk using constant watch procedures. They proposed closing all in-patients units and developing a hybrid model of assertive care on normal location supported by specialist in-patient units. The review supports the development of a specialised gold standard service that focusses on admission

due to health problems. It emphasises that a decision for admission should be based on clinical need made by senior clinicians and that the prisoner-patients should be reviewed and monitored regularly.

In addition, the use of a mental health assessment unit (MHAU) in a female prison in the South East of England was explored by Hales *et al.* (2016). They looked at the admissions over a 32 month period and concluded that the unit was used outside its strict remit. The majority of admissions (68%) fulfilled the national protocol criteria (to hold women pending transfer to hospital or in crisis) for MHAU admissions. In terms of pathways, 28% of admissions led to transfer to hospital and 31% of admissions led to transfer to normal location on a prison wing. 32% of admissions were not related to self-harm/suicidality or awaiting transfer to hospital due to major mental disorder.

Each of the above evaluations demonstrate that there are shortfalls in the current provision of 24 hour mental healthcare. It is promising to see that some programmes have generated positive outcomes; it will be interesting to see whether the implementation of standards for 24 hour mental healthcare contribute to the developments in this area of practice.

The increasing attention of mental healthcare in prisons

Over the past two years, the provision of mental healthcare in custody has received mounting attention, particularly in light of the impact of wider challenges on those incarcerated.

A progressive step forward has been delivered by NHS England in their strategic direction for health services in the justice system over the next four years. It outlines how health and care services throughout the criminal justice system need to evolve, and supports the recommendations set out in the Five Year Forward View for Mental Health, the Crisis Care Concordat and the Government's Shaw Review (2016). In partnership with Public Health England, a complete and integrated health and justice pathway for those involved with the criminal justice system is being developed. The pathway is broken down into three elements: care not custody, care in custody, and care after custody. This includes: expanding liaison and diversion schemes nationwide to divert people with mental health issues away from custody and offering a community-based alternative; improving mental health services in prisons; and providing continuity of care for those being released into the community. The mental health work programme is focusing on five areas, including: suicide and self-harm prevention; developing new commissioning models based on more integrated health and justice pathways; and the prevention of deaths in custody (Public Health England, 2016).

The Prisons and Probation Ombudsman has also made a significant contribution to the conversation in this area, branding the mental health of people in prison as "one of the most prevalent and challenging issues in prisons" (2016: 3). A thematic review into prisoner mental health recognises the association of mental health with high rates of suicide and self-harm. It outlines the need for

improvements in identification and awareness of mental health issues, as well as a prompt, well-planned and effective response to delivering care and treatment. The report provides a much needed review of the standard of mental healthcare received by people in prison, and offers a number of 'lessons' based on independent investigations into deaths of people who died in prisons between 2012 and 2014 (Prisons and Probation Ombudsman, 2016).

Furthermore, the Centre for Mental Health conducted a consultation to determine how the mental health of the prison population can be improved, reviewing the interface between the criminal justice system and mental health services by gathering the experiences of over 200 people with personal or professional knowledge (2016). The report, commissioned by the Department of Health and the Ministry of Justice, found a number of key themes emerged across the criminal justice pathway. Among the findings, the provision of psychological therapies was highlighted as being low and improvements were needed in primary mental healthcare. Recommendations included: clinical commissioning groups (CCGs) need to lead in commissioning services for people leaving custody in their local areas; all criminal justice professionals should receive mandatory mental health awareness training; and an operating model for prison mental healthcare should be introduced to bring consistent, evidence-based and connected services to those in custody.

Most recently, the National Institute for Health and Care Excellence (NICE) published long awaited guidance on assessing, diagnosing and managing mental health problems in adults who are in contact with the criminal justice system (NG66, 2017). It aims to improve mental health and wellbeing by promoting more coordinated care planning and service organisation. NICE also published a dedicated guideline for the physical health of people in prison in late 2016 (NG57, 2016).

Conclusion

The higher prevalence of mental health issues within the prison population indicates that a greater service should be expected within these settings, ensuring equivalence of care compared to the access that would be received in the community. The high demand for secure beds within the NHS and the independent sector has resulted in mentally ill prisoners requiring admission to hospital having to wait for long periods of time for transfer, in order to receive treatment. An improved and greater resourced provision within prisons would ensure that people in prison are receiving appropriate care and that the pressure on the system is alleviated. Developing standards for 24 hour mental healthcare within prisons is a way forward in providing services with a framework to work against, and ensuring consistency nationally. The standards take account of the existing literature and encompass the views and opinions of mental health practitioners, service managers, commissioners and patient representatives. In conjunction with the current standards for prison mental health services, it is

hoped that these tools will better support those providing and using these services.

Appendix 2: References

Centre for Mental Health (2016) *Mental Health and Criminal Justice*, London: Centre for Mental Health.

Earthrowl, M., O'Grady, J., and Birmingham, L. (2003) 'Providing treatment to prisoners with mental disorders: development of a policy: Selective literature review and expert consultation exercise', *British Journal of Psychiatry*. 182:299-302.

Exworthy, T,. Samele, C,. Urquiq, N., and Forrester, A. (2012) 'Asserting prisoners' right to health: progressing beyond equivalence', *Psychiatric Services,* 63(3): 270-5.

Foster, J., Bell, L., and Jayasinghe, N. (2013) 'Care control and collaborative working in a prison hospital', *Journal of Interprofessional Care,* 1-7.

Giblin, Y., Kelly, A., Kelly, E., Kennedy, HG., Mohan, D. (2012) 'Reducing the use of seclusion for mental disorder in a prison: implementing a high support unit in a prison using participant action research', *International Journal of Mental Health Systems,* 6:2.

GOV.UK (2017) *Population bulletin: weekly 2 June 2017*, Prison Population Figures: 2017, available online at: https://www.gov.uk/government/statistics/prison-population-figures-2017

GOV.UK (2016) *Prison Safety and Reform White Paper*, available online at: https://www.gov.uk/government/publications/prison-safety-and-reform

Gunn, J., Maden, A., and Swinton, M. (1991) 'Treatment needs of prisoners with psychiatric disorders', *British Medical Journal*, 303: 338-41.

Hales, H., Somers, N., Reeves, C., and Bartlett, A. (2016) 'Characteristics of women in a prison mental health assessment unit in England and Wales', *Criminal Behaviour and Mental Health,* 26: 136-152.

HMI Prisons (2016) HM Chief Inspector of Prisons for England and Wales Annual Report 2015–16, London: HMI Prisons.

Home Office (1990) Report of an Efficiency Scrutiny of the Prison Medical Service, London: Home Office.

Home Office (1991) Custody, Care and Justice: The Way Ahead for the Prison Service in England and Wales (Cm 1647), London: HMSO.

National Institute for Health and Care Excellence (2016) Physical health of people in prison [NG57], available at: https://www.nice.org.uk/guidance/ng57

National Institute for Health and Care Excellence (2017) Mental health of adults in contact with the criminal justice system [NG66], available online at: https://www.nice.org.uk/guidance/ng66

NHS England (2016) *Strategic direction for health services in the justice system: 2016-2020*, available at: https://www.england.nhs.uk/wp-content/uploads/2016/10/hlth-justice-directions-v11.pdf

Offender Health Research Network (2015) *A review of prison-based healthcare beds in the East of England, East and West Midlands*, Manchester: OHRN.

Prison Reform Trust (2016) *Bromley Briefings Prison Factfile*, London: Prison Reform Trust.

Prisons and Probation Ombudsman (2016), *Learning from PPO Investigations: Prisoner Mental Health*, available online at: http://www.ppo.gov.uk/wpcontent/uploads/2016/01/PPO-thematic-prisoners-mental-health-web-final.pdf

Public Health England (2016) *Health and Justice Annual Report*, available online at: https://www.gov.uk/government/publications/prison-health-health-and-justice-annual-report

Reed, J.L., and Lyne, M. (2000) 'Inpatient care of mentally ill people in prison: results of a year's programme of semi-structured inspections', *British Medical Journal,* 320: 1032-34.

Royal College of Psychiatrists (2015) *Standards for Inpatient-Based Mental Health Services.* Available online at: http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/corestandardsproject.aspx

Royal College of Psychiatrists (2015) *Standards for Prison Mental Health Services*, available online at: http://www.rcpsych.ac.uk/pdf/Standards%20for%20Prison%20Mental%20Health%20Services%20Publication.pdf

Royal College of Psychiatrists (2016) *Standards for Prison Mental Health Services (Second Edition)*, available online at: http://www.rcpsych.ac.uk/pdf/2nd%20Edition%20Standards%20for%20Prison%20Mental%20Health%20Services%20Publication.pdf

Samele, C., Forrester, A., Urquiq, N., and Hopkin, G. (2016) 'Key successes and challenges in providing mental health care in an urban male remand prison: a qualitative study', *Social Psychiatry Epidemiology*, 51:589-596.

Singleton, N., Meltzer, H., Gatward, R., Coid, J. and Deasy, D. (1998) Psychiatric Morbidity Among Prisoners: Summary Report, London: Office for National Statistics.

Stubbs, J. and Durcan, G. (2017) *Preventing prison suicides: staff perspectives*, London: Centre for Mental Health.

Wilson, S. (2004) 'The principle of equivalence and the future of mental health care in prisons', *British Journal of Psychiatry*, 184: 5-7.

Appendix 3: Acknowledgements

The Quality Network for Prison Mental Health Services is extremely grateful to the following people for their time and expert advice in the development of these standards:

- Tracey Abberline, Oxleas NHS Foundation Trust
- Otar Abuladze, Medical Department
- Syed Ali, Sussex Partnership NHS Foundation Trust
- Katherine Barlett, Barnet Enfield and Haringey Mental Health NHS Trust
- Annie Bartlett, Central and North West London NHS Foundation Trust
- Luke Birmingham, Care UK
- Matty Caine, Tees, Esk and Wear Valleys NHS Foundation Trust
- Tracy Carlson, Abertawe Bro Morgannwg University Health Board
- Giorgi Chidrashvili, General Inspection Department
- Nana Deisadze, Medical Department
- Dhara Dinakaran, Partnerships in Care
- Murray Dobbie, South London and Maudsley NHS Foundation Trust
- David Ergemlidze, General Inspection Department
- Adrian Feeney, Central and North West London NHS Foundation Trust
- Jan Fooks-Bale, Care Quality Commission
- Vanessa Fowler, NHS England South
- Sree Govindarajula, Barnet, Enfield and Haringey Mental Health NHS Trust
- Kyriakos Gregoriou, Nottinghamshire Healthcare NHS Foundation Trust
- Adeline Hunt, Nottinghamshire Healthcare NHS Foundation Trust
- Eteri Kamarauli, Council of Europe
- Rachel Lovely, Care UK
- Hannah Lukacs, Barnet, Enfield and Haringey Mental Health NHS Trust
- Gary Mendum, Tees, Esk and Wear Valleys NHS Foundation Trust
- Sofio Morgoshia, Republic of Georgia
- Faisal Mudathikundan, Oxleas NHS Foundation Trust
- Deborah Murphy, Barnet, Enfield and Haringey Mental Health NHS Trust
- Sharon Nheta, South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- Ushangi Papuashvili, Republic of Georgia
- Nicholas Penhaligon, Central and North West London NHS Foundation Trust
- Suraj Persand, Oxleas NHS Foundation Trust
- Martin Saberi, CCQI
- Nino Saria, General Inspection Department
- Abu Shafi, Central and North West London NHS Foundation Trust
- Simon Stanley, Prisons and Probation Ombudsman
- Anne Stevens, Cambridge and Peterborough NHS Foundation Trust
- Karen Telfer, Barnet, Enfield and Haringey Mental Health NHS Trust
- Seamus Watson, Public Health England

- Richard Wood, Tees, Esk and Wear Valleys NHS Foundation Trust
- Laura Woods, Sussex Partnership NHS Foundation Trust

Appendix 4: QNPMHS Project Contact Details and Information

Project Team

Megan Georgiou, Programme Manager
Megan.Georgiou@rcpsych.ac.uk
0203 701 2701

Francesca Coll, Deputy Programme Manager
Francesca.Coll@rcpsych.ac.uk
0203 701 2678

Kate Townsend
Kate.Townsend@rcpsych.ac.uk
0203 701 2661

Madhuri Pankhania
Madhuri.Pankhania@rcpsych.ac.uk
0203 701 2672

Address

Quality Network for Prison Mental Health Services
Royal College of Psychiatrists
2nd Floor
21 Prescot Street
London
E1 8BB

Website

www.qnpmhs.co.uk

Email Discussion Group

prisonnetwork@rcpsych.ac.uk

Royal College of Psychiatrists Centre for Quality Improvement
21 Prescot Street • London • E1 8BB

www.rcpsych.ac.uk

COLLEGE CENTRE FOR
QUALITY IMPROVEMENT