PRISON CCQI
QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES

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ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Prison Mental Health Services

Quality Network for Prison Mental Health Services

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Untitled 1, HMP Peterborough, Caro Millington Highly Commended Award for Mixed Media
Image courtesy of the Koestler Trust

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Foreword

The prison population has increased rapidly in the last decade and the high prevalence of mental health problems in both female and male prisoners has been highlighted in many recent reports and in the media. Important developments and improvements in prison mental health services have taken place in the past few years and some of these have been evidenced in The Bradley Report Five Years which independently reviewed progress since The Bradley Report was published in 2009. It is encouraging to see that prison mental health services are taking on board the recommendations made in the report and are committed to improving the provision of care to people with mental health problems in the criminal justice system. It is also encouraging that a more standardised approach to prison mental health services is now in place since NHS England became responsible for prison healthcare. There is still however, a lack of a 'national blueprint' which would support and provide guidance to services to ensure that high quality care is provided to patients in the criminal justice system across the country. In light of this, I am pleased to welcome the standards for prison mental health services which provide the basis for a new, national Quality Network for Prison Mental Health Services. This network will be managed by a team at the Royal College of Psychiatrists' Centre for Quality Improvement with vast experience in running quality improvement programmes in secure settings.

The standards in this document address areas which are key to prison mental healthcare, and by participating in the quality network, teams will have the opportunity to measure their performance against these best practice standards through a model of openness and engagement. The quality network will provide a framework to support prison mental health teams to improve quality through a self and peer-review process and will also facilitate and encourage teams from different services across the country to share good practice and learn from each other.

The Rt Hon Lord Bradley

Developing Quality Standards for Prison Mental Health Services

These standards have been developed by Dr Huw Stone and Dr Steffan Davies and edited by the Quality Network for Forensic Mental Health Services (QNFMHS):

1. Literature Review

A literature review and review of key documents was carried out. It appears in this document with a list of documents referred to in Appendix 1.

2. Standards Development Workshop

The Quality Network for Forensic Mental Health Services held a preliminary consultation workshop as part of the development of standards for prison mental health services. The workshop was attended by over 60 people representative of multidisciplinary teams as well as other key statutory and voluntary sector stakeholders (see Appendix 3).

3. Expert Consultation Group

With attendance from a variety of agencies involved in mental health and criminal justice, a small expert working group met to consult and provide feedback on the draft standards (see Appendix 4).

4. Standards Consultation Event

The Quality Network for Forensic Mental Health Services hosted a standards consultation event on 4 November 2014 for key stakeholders to comment on a draft of the revised standards. The event was attended by over 100 stakeholders including commissioners, senior managers, multidisciplinary team staff, frontline staff, patients, family and friends (see Appendix 5). Following a brief introductory presentation on the process of developing the standards, delegates worked in small groups making verbal and written comments on the standards before feeding back at the end of the day. The delegates were asked to remove the standards no longer required, add further standards and edit existing standards to make them more challenging to achieve.

5. Electronic Consultation

In November 2014, a draft of the standards was sent electronically to all the QNFMHS contacts, including; QNFMHS membership, medium secure (MSU) and low secure (LSU) email discussion groups, delegates of QNFMHS recent events and workshops, NHS England, Commissioners and other relevant agencies. People were asked to remove the standards no longer required, add further standards and edit existing standards.

6. British Standards Institution Development of Core Standards for Community and In-patient Services

In June 2015, the British Standards Institution published core standards to be used alongside the specialist standards of each project within the CCQI. The core standards for community services have been incorporated into this publication and appear together with the specialist standards. All core standards have been marked underneath the standard number in brackets, followed by the letter 'C' and the core standard number as it appears in the core standards for community services publication [e.g. (C3.4)].

Standards for Prison Mental Health Services

No.	Type	Standard
Admission and Assessment		
1	1	As part of the formal prisoner induction process, all prisoners undergo health screening that incorporates a mental health assessment.
2	1	The screening mental health assessment is carried out by a nurse or GP trained in mental health.
3	1	The role of the team in the screening process is clearly defined and in agreement with the prison establishment.
4	1	There are clear referral criteria and defined response times.
5 (C1.4)	1	A clinical member of staff is available to discuss emergency referrals during working hours.
6	1	Urgent assessments are undertaken by the team within 48 hours and routine assessments within 5 days.
7	1	The team assessment uses a standardised format, which includes a relevant previous history, an assessment of mental health, intellectual and developmental disabilities, substance misuse, psychosocial factors, risk to self and others.
8 (C3.4)	2	The assessing professional can easily access notes about the patient (past and current) from primary and secondary care. *Guidance: Notes should be accessed for all patients known to mental health services and where notes are available.*
9 (C4.5)	1	The team discusses the purpose and outcome of the risk assessment with each patient and a management plan is formulated jointly.
10 (C5.1)	1	All patients have a documented diagnosis and a clinical formulation. *Guidance: The formulation includes presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate.*
11 (C1.2)	1	Clear information is made available, in paper and/or electronic format, to patients and healthcare practitioners on: • A simple description of the service and its purpose • Clear referral criteria • How to make a referral, including self-referral if the service allows • Clear clinical pathways describing access and discharge • Main interventions and treatments available • Contact details for service, including emergency and out of hours details
12 (C3.3)	1	Patients are given verbal and/or written information on: • Their rights regarding consent to care and treatment; • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records.

Case Management and Treatment		
13	2	Patients are managed under the Stepped Care Model for People with Common Mental Health Disorders (NICE guidelines 41, 2011).
14 (C7.3)	1	The core team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. *Guidance: Referrals that are urgent or that do not require discussion can be allocated before the meeting.*
15 (C7.4)	1	There is a written care plan for every patient, reflecting their individual needs. *Guidance: The care plan may vary in complexity depending on issues identified and interventions offered.*
16 (C7.5)	1	The practitioner develops the care plan collaboratively with the patient.
17	1	Patients are encouraged and supported to be fully involved in their CPA meeting.
18	1	Patients discuss, negotiate and agree with their care coordinator on who should be invited to their CPA meeting, and a joint decision made on what happens if people are unable to attend.
19	1	Patients will be shown a copy of the final draft report after the CPA meeting and will have the opportunity to add their views at this stage.
20	2	The team has a policy on inter-agency working across criminal justice, social care, physical healthcare and the third sector within limits of patient consent, confidentiality and risk management.
21	2	There are written policies in place for liaison and joint working with substance misuse services and primary care in cases of co-morbidity.
22	2	There are contracted agreements for joint working with offender management units for all patients.
23	2	There are contracted agreements for joint working with primary care to ensure high standards of physical healthcare and mental healthcare for patients with co-morbid physical and mental health problems.
24	1	The team works collaboratively with other health care providers and the prison to manage self harm and suicidal ideation in accordance with NICE guidelines 16 (2004) and 133 (2011).
25	1	The team actively participates with the Assessment, Care in Custody and Teamwork (ACCT) process in managing the risk of self-harm and suicide.
26 (C8.1.2)	1	Patients are offered evidence based pharmacological and psychological interventions and any exceptions are documented in the case notes. *Guidance: The number, type and frequency of psychological interventions offered are informed by the evidence base.*

27 (C8.2.1)	1	When medication is prescribed there are patient specific treatment targets, a review of the risks and benefits, a timescale for response and evidence that the patient has consented.
28 (C9.2.1)	1	Patients who are prescribed mood stabilisers, antipsychotics or stimulants for ADHD are reviewed at the start of treatment (baseline), at 3 months and then annually unless a physical health abnormality arises.
29 (C6.2)	1	The team pro-actively follows up patients who have not attended an appointment/assessment or who are difficult to engage.
30 (C9.1.7)	1	The service has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.
Referral, Discharge and Transfer		
31	1	There is an agreed policy that identifies the role of the team in initiating, facilitating and managing referrals to outside hospitals.
32	1	The process for referral and transfer of patients under Section 47 and Section 48 of the Mental Health Act follows the Good Practice Procedure Guide (DoH, April 2011).
33 (C11.2)	1	The care co-ordinator or equivalent is involved in discharge/transfer planning.
34	1	An identified key worker and/or responsible clinician from the receiving service are invited to discharge planning CPA meetings.
35	1	All patients receive a CPA/Section 117 discharge meeting within 4 weeks of expected discharge.
36	2	Referrals to community mental health services are made for those patients who require continued care and follow-up support following release.
37	1	On discharge from the team, patient information is provided to the receiving primary care or mental healthcare service.
38	2	The team carries out a follow-up interview with the patient and/or the new care co-ordinator/service provider within 14 days of release/transfer from prison. *Guidance: This includes communication in person, via the telephone or in writing.*
Patient Experience		
39	1	The patient is involved in decisions about their care, treatment and discharge planning.

40 (C14.2)	1	Patients are given the opportunity to feed back about their experiences of using the service, and their feedback has been used to improve the service. *Guidance: This might include patient surveys or focus groups*
41 (C16.1)	1	Patients are treated with compassion, dignity and respect. *Guidance: This includes respect of a patient's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.*
42 (C16.2)	1	Patients feel listened to and understood in consultations.
43 (C17.3)	1	The service has access to interpreters.
44 (C17.4)	2	Interpreters have received guidance about mental health matters, including the importance of full and accurate translation.
45 (C18.1)	1	Confidentiality and its limits are explained to the patient at the first assessment, both verbally and in writing.
46 (C18.3)	1	The patient's consent to the sharing of clinical information outside the team is recorded. If this is not obtained the reasons for this are recorded.
Patient Safety		
47	1	The team communicates findings from risk assessments across relevant agencies and care settings, in accordance with patient consent and professional guidance relating to patient confidentiality and risk.
48	1	The patient is given information on the intervention being offered and the risks and benefits are discussed with them.
49 (C13.2)	1	Capacity assessments are performed in accordance with current legislation and codes of practice.
50 (C8.2.4)	1	There are systems in place to monitor and audit the safe use of high risk medication, at least annually and at a service level. *Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines.*
51 (C10.3)	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and young people. This includes escalating concerns if an inadequate response is received to a safeguarding referral.
52	2	The team understands and engages in prison service policies on food refusal capacity assessments.
53	2	The team understands and engages in prison service policies on Security Incident Reporting (SIR).
54	2	There is a joint working policy between the prison, primary care and the team on the control and management of substance misuse and illegal substances.
55	2	The team understands and engages in prison service policies on Multi-agency Public Protection Arrangements (MAPPA).

56	2	There is an agreed policy in place for joint working between the prison and the team on the sharing and monitoring of planned transportation and movement of patients outside of the prison establishment.
57	2	Prison staff are aware of individuals receiving treatment from the team, within the limits of confidentiality and patient consent.
58	3	All prison staff receive mental health awareness training.
Environment		
59	2	The prison and healthcare regimes ensure that patients are able to attend appointments with the team at the scheduled appointment time.
60	1	There are designated rooms for the team to run clinics.
61	1	There are designated rooms for the team to run 1:1 sessions.
62	1	There are designated rooms for the team to run small group sessions.
63	1	All interview rooms are situated close to staffed areas, have an emergency call system, an internal inspection window and the exit should be unimpeded.
64	1	The team has dedicated spaces and meeting rooms for confidential working.
65	1	Each member of the core team has access to a computer directly linked to the electronic patient records system.
66	1	Each member of the core team is issued with a secure prison email account and a desk phone to enable internal movements and communication.
Workforce		
Capacity and Capability		
67	1	The multi-disciplinary team consists of or has access to staff from a number of different professional backgrounds (e.g. general adult and forensic psychiatrists, registered mental health nurses, forensic and clinical psychologists, social workers, occupational therapists, clinical pharmacy).
68	2	The team consists of a range of multi-disciplinary members that enables them to deliver a full range of treatments/therapies appropriate to the patient population.
69	2	The team has access to specialists in intellectual disabilities (ID), autistic spectrum disorder (ASD), neuropsychiatric disorders and cognitive impairment.
70	1	There is a clearly identified clinical lead for the team.
71 (C22.6)	2	There has been a review of the staff and skill mix of the team within the past 12 months, to identify gaps in the team and develop a balanced workforce to meet local need (e.g. numbers and complexity of caseload).
72	2	There are agreed arrangements and processes in place which ensure that the prison healthcare team can access specialist mental health advice out of hours.

73	1	Capacity management plans are in place to ensure continuity of service in the event of leave or sickness.
74	2	There are clear protocols outlining prescribing responsibilities between psychiatrists, GP's and nurse prescribers.
75	1	There are monthly multi-disciplinary team clinical meetings, which are recorded with written minutes.
Training, CPD and Support		
76	1	All permanent staff within the team receive a full local induction before being issued with keys.
77 (C10.1)	1	The team receives training consistent with their roles on risk assessment and risk management. This is refreshed in accordance with local guidelines. This training includes, but is not limited to training on: • Safeguarding vulnerable adults and children; • Assessing and managing suicide risk and self-harm; • Prevention and management of aggression and violence.
78	1	All staff within the team receive prison awareness training and personal protection training.
79 (C26.5)	1	Staff receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines.
80 (C24.1)	1	All staff receive an annual appraisal and personal development planning or equivalent. *Guidance: This contains clear objectives and identifies development needs.*
81	1	All staff within the team receive Continuing Professional Development (CPD) in line with their respective professional body.
82 (C24.2)	1	All clinical staff receive clinical supervision at least once every four weeks or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*
83 (C24.6)	2	All staff receive monthly management supervision.
84 (C25.4)	2	Staff have access to reflective practice groups.
Governance		
85	1	The team is part of the prison clinical governance and quality processes.
86	3	Patients are involved in the governance and development of the team.
87 (C27.1)	2	The team attends business meetings that are held at least monthly.
88 (C27.2)	2	The team reviews its progress against its own plan/strategy, which includes objectives and deadlines in line with the organisation's strategy.

89 (C30.1)	2	A range of local and multi-centre clinical audits is conducted which include the use of evidence based treatments, as a minimum.
90 (C30.3)	2	When staff undertake audits they; • Agree and implement action plans in response to audit reports; • Disseminate information (audit findings, action plan); • Complete the audit cycle.
91 (C31.1)	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.
92 (C31.4)	1	Team staff members and patients who are affected by a serious incident are offered a debrief and post incident support. *Guidance: This may include death, suicide, serious self-harm, compulsory treatment, violent or threatening behaviour*
93 (C31.5)	1	Lessons learned from incidents are shared with the team and disseminated to the wider organisations.
94 (C31.6)	2	Key clinical/service measures and reports are shared between the team and the organisation's or Trust's board, e.g. findings from serious incident investigations, examples of innovative practice.
95 (C20.7)	1	Staff are able to raise any concerns about standards of care, in line with national guidance and local policy.
96	3	The team engages in service relevant research and academic activity.

Appendix

Appendix 1: Literature Review

Dr Huw Stone, Dr Steffan Davies and Megan Georgiou

In order to fully identify the core areas that would need to be addressed when developing standards for prison mental health services, a comprehensive examination of the existing literature must be undertaken. The review of the literature has been condensed into three sections to fully explore the topic. The first section, 'equivalence of care', explores how prison healthcare was first introduced into government policy. It provides an overview of the key reports and publications that came to influence the development and modernisation of prison mental health services. Second, the implementation and the quality of prison mental health services was reviewed, discussing a number of recommendations from a variety of sources that came to drive change within these services, for instance, *Patient or Prisoner?* (Home Office, 1996) and *The Bradley Report* (Department of Health, 2009). Finally, recent developments in prison mental health services are explored and also proposed work due to take place in the next couple of years is discussed.

Before a review of the literature is undertaken, however, it is important to provide a brief context of the current situation in the penal estate across England and Wales. The prison population has increased rapidly over the years from 41,800 prisoners in 1993 to over 85,000 in 2015 (Ministry of Justice, 2013; GOV.UK, 2015). Research suggests that more than 70 per cent of the prison population has two or more mental health disorders and as many as 9 in 10 prisoners have signs of mental illness, alcohol misuse or drug dependence (Singleton et al., 1998). In figures released by the Prison Reform Trust (2015), 46 per cent of women prisoners and 21 per cent of male prisoners were reported as having attempted suicide at some point in their lives, compared to around 6 per cent in the general UK population. These figures illustrate the prevalence of mental health issues throughout the prison population in England and Wales and underline the need for improved prison mental health services.

Primary research into the effectiveness of treatment in the prison system falls behind that of generic mental health services and treatment modalities employed in the community can be difficult to deliver in prison settings. This is due to organisational issues, a lack of resources and the complexity of the population dealt with (Steel et al., 2007).

Whilst prison mental health services have lagged behind community and in-patient services there is currently a fast pace of change, with developments in commissioning, clinical guidelines for mental and physical health by the National Institute for Health and Care Excellence, and the publication of standards for prison mental health services.

Equivalence of Care

> *…prisons are full of people not ill enough for secondary care but too difficult (or too transient) for primary services. It is perhaps in that area that services the prisons with mental health problems are most in need of strengthening.*
>
> (Shaw, 2007)

A principle of 'equivalence of care' for prison health became embedded into government policy from 1990, advocating a vision that prisoners should receive the same standard and delivery of health care as they would were they not in prison (Home Office, 1990, 1991; Wilson, 2004).

This was further considered in the discussion paper, *Patient or Prisoner?,* published by the Home Office in 1996, drawing attention to the provision of health care in prisons and recommending that the National Health Service (NHS) should assume responsibility for the delivery of all health care. It highlighted weaknesses in prison health care services; noting particular shortfalls in the quality of care provided and the links with the NHS, and the professional isolation of prison health care staff (Birmingham, 2003). The paper outlined that the implementation of this recommendation would see consistency of delivery to everyone in the community, whether in or out of prison.

These findings were reinforced by a report published by the Office of National Statistics in 1998, *Psychiatric Morbidity among Prisoners in England and Wales* (Singleton et al., 1998) which was based on the findings from a survey commissioned by the Department of Health to provide information about the prevalence of psychiatric problems amongst prisoners, in order to inform policy decisions about prison mental health services. The survey showed that psychiatric morbidity was far more common amongst prisoners than the general population, with only one prisoner in ten displaying no evidence of any mental disorder (Reed, 2003).

In 1999, it was proposed in the report *The Future Organisation of Prison Health Care* (HM Prison Service and NHS Executive) that the care of mentally ill prisoners should be developed in line with NHS mental health policy and national service frameworks. A joint working group was set up by the Home Secretary and the Secretary of State for Health to review the health of prisoners and make recommendations for its improvement. For the first time, it established the principle that the Prison Service and the NHS should work together in a formal partnership to make the necessary improvements.

Shortly after this report, the Department of Health and HM Prison Service published a landmark document, *Changing the Outlook* (2001), setting out a joint approach in developing and modernising prison mental health services over a three to five year period. It aimed to provide prisoners with "access to the same range and quality of services as are available to the general population through the NHS" and noted that current provisions were "ineffective and inflexible" with prisoners often receiving inappropriate or no treatment for their mental illness

(2001: 5). A number of areas were identified for change, ranging from reducing the number of prisoners located in prison health care and lessening the average length of stay, to providing better integrated and more effective services from the Prison Service and the NHS.

Moreover, the document proposed that funding should be given to Primary Care Trusts (PCTs) specifically to provide in-reach services in prisons. In 2003 it was announced that the responsibility of the provision of healthcare in prisons in England and Wales was to be shifted from the Home Office to the Department of Health, with investment being committed between 2003 and 2006 to mental health in-reach services (Department of Health, 2005).

This move, recognised as a significant development in mental health in-reach services within prisons, was then followed by the publication of the *Offender Mental Health Care Pathway* (Department of Health, 2005). The document was guided by two fundamental aims; firstly that those with acute severe mental illness should not be in prison and secondly, that prisons should be safe places for people suffering with mental health problems, thus preventing suicide. It documented best practice guidance, informing those who directly deliver services and supporting commissioners in decision making practices. The templates for good practice are structured around nine key phases which make up the offender mental health care pathway, including; pre-prison, first night and induction, through-care and pre-release, and prison transfers and aftercare.

Reviews of the Implementation and Quality of Prison Mental Health Services

Following the transfer of prison healthcare in prisons to the Department of Health in 2006, a number of reviews assessing the implementation and effectiveness of these services occurred.

Ten years after the publication of *Patient or Prisoner?* (Home Office, 1996), HM Inspectorate of Prisons published a thematic review of the care and support of prisoners with mental health needs, *The Mental Health of Prisoners* (2007). This review described the conditions and treatment of prisoners with mental health issues and acknowledged that the quality and extent of treatment had improved. The report came to two conclusions; the first was that there were too many gaps in the provision of these services and the second was that the need would always outweigh capacity, unless services for mentally ill people in the community were also improved, so that there was effective treatment for prisoners both before and after their period of imprisonment.

A chapter on mental healthcare in prisons reviewed the primary and secondary care provisions for mental health and the role of GPs, noting significant findings from interviews carried out with staff and patients and an examination of a range of clinical records and files. By way of illustration, it found that staffing of prison mental health teams was mainly provided by mental health nurses with variable access to other professions. Caseloads showed that 58 per cent of patients had

regular appointments with a mental health professional and patients interviewed expressed that non-clinical interventions were the most helpful. With only 23 per cent of prison officers having received mental health training, this was noted as an area for improvement.

A number of recommendations were made as a result of this review, highlighting a need for; greater resources for primary and secondary mental health services, greater access to psychiatrists, increased involvement of prison officers in referrals and care planning, improved access to clinical supervision and professional development, greater involvement of prisoners in their care planning, greater involvement of prison mental health staff in segregation practices and further treatment available for prisoners with personality disorder.

Similarly, the Royal College of Psychiatrists produced a general report, *Prison Psychiatry: Adult Prisons in England and Wales* (2007), making 26 recommendations to improve mental healthcare in prisons. The main recommendations of the report addressed areas such as; the role of the consultant psychiatrist in prison, commissioning mental health services in prison, specialist psychiatric services and training needs for psychiatrists to be able to work effectively. The report also made reference to addiction services, learning disability services, female prisoners and old age psychiatry.

A further review, *From the Inside,* (Sainsbury Centre for Mental Health, 2008) sought to listen to the views of prisoners about their own mental health and their experiences of mental health services in prison. They noted that this was in contrast to most other reviews which had focused on interviews with staff. Interviews were carried out with nearly 100 prisoners and 75 members of staff in 5 prisons in the West Midlands. They found that being in prison can damage a prisoner's mental health and that arrival at the prison can be a particularly stressful experience. They also noted that mental health in-reach teams were making a difference to the prisoners they supported and that their input was valued by those prisoners. The major barriers to change in prison mental health care were identified, for instance a lack of attention to resettlement, and prisoners acknowledged what would help them with their mental health problems, such as better planning for their release and access to psychological therapy. A series of recommendations were made, proposing changes in inter-agency working, mental health awareness training for prison staff and the development of a 'stepped care' approach, to name a few.

Most notably, policies in England and Wales on mental health in the criminal justice system have been driven by The Bradley Report (Department of Health, 2009). This review, focussing on people with mental health problems and learning disabilities, attempted to examine the extent to which offenders could be diverted from prison to other services and sought to make a number of recommendations to the government. Lord Bradley addressed each stage of the prison process, from reception to resettlement, and recognised areas for improvement throughout. Some of the key areas identified were; developing a robust model of primary mental health services, providing awareness training to all prison staff, and ensuring the varying needs of prisoners are catered for, such as those with dual diagnosis or patients leaving prison who are not subject to supervision.

Reinforcing these points further, the Offender Health Research Network (2009) carried out a national evaluation of prison mental health in-reach services. The evaluation had three elements: a national survey of prison in-reach teams, case studies of in-reach teams and a longitudinal cohort study of prison in-reach services. From their findings the Network produced a number of recommendations to inform the commissioning of mental health services in prisons. Arguably one of the most important proposals was that the mental health of prisoners should be the responsibility of the whole prison, promoting a safer custody agenda. Other recommendations included; improvements in training for primary care staff and prison officers, increased investment to ensure appropriate, skilled and timely care, specialist services for prisoners with a sole diagnosis of personality disorder and improved services for those with a dual diagnosis. The report also identified that further research should be carried out into the needs of prisoners with learning disabilities, adjustment disorders and Post Traumatic Stress Disorder and that the needs of prisoners who lack the capacity to consent in taking part in research are considered to ensure they are represented in future work.

Addressing the criminal justice system more widely, *Inside Out* (Policy Exchange, 2009) put forward a case to improve mental healthcare for offenders. When considering prison mental health services, the report recommended that resources should be better integrated in order for healthcare and mental health assessments to be more effective. One area identified as still presenting a challenge for prison mental health services is the underfunding and lack of national guidance available. The report underlines that a robust commissioning provider partnership and an integrated use of resources can lead to a well-funded service.

Taking this into account, the Health and Social Care Act 2012 outlined a new health commissioning landscape in England to take effect from 2013. It recognised that individuals involved in the criminal justice system are often disadvantaged in terms of accessing health services and socially excluded groups can be deemed low priority. As a result it commissioned ten lead Local Area Teams to manage health services for people in prison and other places of detention (TSO, 2012; Marshall, 2013).

Each of the reports and legislative changes explored above provide a promising outlook for the future of prison mental health services. Recent developments and proposed work is outlined below.

Recent Developments in Prison Mental Health Services

Despite the various reviews and developments over the years, prisoners suffering with mental health issues are still a huge concern. In *HM Chief Inspector of Prisons for England and Wales Annual Report 2013-2014* (HMIP, 2014), a number of concerns were raised over the safety and welfare of prisoners. It found that staff had insufficient training to identify prisoners with mental health problems

and the knowledge to refer them for assessment, with primary mental health care services in 25 per cent of prisons identified as being insufficient to meet the demand. Further challenges for services included not being able to transfer patients with serious mental health problems from prison to a hospital within the expected transfer time of 14 days. Most worrying is the rise in deaths in custody since the previous year, with a 67 per cent increase in self-inflicted deaths, and a dramatic increase of 38 per cent in serious assaults involving adult male prisoners.

These statistics are of concern, particularly in light of the findings from an article published in 2013 (Forrester et al.) which investigated the variations in prison mental health services in England and Wales and concluded that prison in-reach teams are unable to offer prisoners care equivalent to that they would receive in the community. It suggests that investment in prison mental health services be prioritised and that there should be a national focus on equity in prisons, with a national development of a framework for inter-prison healthcare service comparison.

Also considering the development of mental health services in the criminal justice system, *The Bradley Report Five Years On* (Centre for Mental Health, 2014) independently reviewed the progress of The Bradley Report (Department of Health, 2009). It is pleasing to see that some of the recommendations have been implemented, with the responsibility for prison healthcare being passed over to NHS England allowing for a more standardised approach to prison mental health services (Centre for Mental Health, 2014). It also noted that prison mental health services were developing a broader focus; however an “absence of a national blueprint” was one of the key challenges faced by services (2014: 5). One key recommendation was that an operating model of prison mental health and learning disability care be developed. Additionally, the report highlighted the importance of supporting prisoners from prison to the community by offering ‘through the gate’ services.

Considering the findings from these recent reports, a proposal from the Care Quality Commission (CQC) that they would be jointly monitoring the care provided in all prisons with HM Inspectorate of Prisons was very much welcomed. The joint inspection framework, due to be published in April 2015, will outline a new approach to regulating health and justice services, providing “a more cohesive joint view of healthcare with secure settings” (CQC, 2014: 5).

Moreover, it is encouraging that the National Institute for Health and Care Excellence (NICE) has launched the development of two sets of clinical guidelines (2014); *Physical Health of People in Prison* and *Mental Health of Adults in Contact with the Criminal Justice System*, both due for publication in November 2016. The scope of the first document, addressing physical health, will focus on improving health and wellbeing in prison targeting areas such as; coordination and communication between healthcare professionals, the use of medication, urgent and emergency management in prison and the continuity of healthcare on admission to prison, transfer or on release to the community (NICE, 2014). The second set of guidelines focussing on adults within the criminal justice system is covering a range of areas, including; identification and assessment of mental

health problems, adapting existing interventions for the criminal justice system, improving the organisation and provision of services for people with mental health problems and providing training to criminal justice professionals and practitioners to provide good quality services (NICE, 2014).

Conclusion

From the literature reviewed, it is clear that the provision of mental health care services in prisons has developed significantly since the early 1990s. There have been various reviews, inspections and policy developments, with further planned in the next few years, however there are still improvements that need to be made. Too few staffing and resources, a lack of joint working, and the complexity of patient needs have been the key challenges identified preventing services from providing quality services to the prison population. It is particularly encouraging to hear reports of new guidelines being developed and joint inspection frameworks which should, in conjunction with the development of standards for prison mental health services, ensure further progression in this area over the next few years. Ultimately, it is evident that further guidance on how prison mental health services should operate is required, ensuring consistency and continuity across the UK.

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Appendix 2: Acknowledgements

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- Dr Steffan Davies, Northamptonshire Healthcare NHS Foundation Trust.
- Sarah Tucker, previous Programme Manager, Quality Network for Forensic Mental Health Services.
- Standards Development Workshop Delegate List 28 November 2013 (see Appendix 3).
- Members of the Standards Development Expert Consultation Group 4 September 2014 (see Appendix 4).
- Members of the Standards Consultation Event 4 November 2014 (see Appendix 5).
- QNFMHS Patient Reviewers and Family & Friends Representatives (see Appendix 6).

Appendix 3: Standards Development Workshop Delegate List

28 November 2013

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Appendix 4: Standards Development Expert Consultation Group

4 September 2014

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Appendix 5: Standards Consultation Event

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Appendix 6: QNFMHS Patient Reviewers and Family & Friends Representatives

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George Cooley	Family & Friends Representative
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Appendix 7: QNFMHS Project Team

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Tiffany Rafferty	Project Worker – MSU

Appendix 8: Glossary

Name	Job Title
ADHD	Attention Deficit Hyperactivity Disorder
CCQI	College Centre for Quality Improvement
CPA	Care Programme Approach
CPD	Continued Professional Development
CQC	Care Quality Commission
DH	Department of Health
GP	General Practitioner
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison Service
LSU	Low Secure Units
MDT	Multi-Disciplinary Team
MOJ	Ministry of Justice
MSU	Medium Secure Unit
NHS	National Healthcare Service
NICE	National Institute for Health and Care Excellence
QNFMHS	Quality Network for Forensic Mental Health Services
QNPMHS	Quality Network for Prison Mental Health Services
RCPSYCH	Royal College of Psychiatrists
TSO	The Stationary Office

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