

REPORT

SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change



From the inside

Experiences of prison mental health care

Graham Durcan

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This research received ethical approval from the local research ethics committee. Research with prisoners is a sensitive area and permission was not sought or granted for using direct quotes. The 'quotes' and case studies that appear in the text are all amalgams of what a number of prisoners have told us and give a typical picture without revealing information about any particular individual.

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This report is dedicated to Deidre Rice: a real champion for improving prison mental health.



Foreword

by Lord Ramsbotham

In October 1998 the Office of National Statistics (ONS) published a report entitled *Psychiatric Morbidity among Prisoners in England and Wales* (Singleton *et al.*, 1998). It was, and remains, a seminal document. It set out, in stark detail, the scale and nature of an extremely serious problem, graphically analysed in Graham Durcan's admirable analysis of the situation in five West Midlands prisons, namely the number of prisoners with mental health problems whose needs are not being fully addressed during their time in custody.

I have to admit that, on being appointed Her Majesty's Chief Inspector of Prisons in December 1995, I had no idea of the size and shape of the problem, because it was not one that received much attention in the national press. Immediately before taking up this post, I had chaired an NHS hospital trust. My excellent Director of Mental Health insisted that I trained as a lay assessor, firstly so that I could contribute something useful to the work of the hospital, and secondly so that I might better understand the impact of drugs on adolescent brains. This was in relation to the increasing evidence of latent problems, such as schizophrenia, being advanced by drug use: the cause of a tragic suicide that took place soon after I took up my post.

I mention this because, during my first prison inspection, of the women's prison HMP Holloway, I became aware not only of the large numbers with mental health problems, but of the total inadequacy of Prison Service health care arrangements. I was amazed to find that the Prison Service was not even part of the NHS, having, since 1947, been allowed to run its own medical affairs. As a result only 10% of all prison doctors were qualified to act as GPs in the community, no documentation passed from GPs to prisons or back again, and psychiatric staff were virtually non-existent. I set about trying to rectify this, and am glad that, in 2003, the NHS became responsible for funding health care in prisons.

I mention this because, at the base of the current situation is the dreadful fact that prison needs have, for years, not figured in NHS budgeting. As a result no additional places in secure accommodation were added to cater for the numbers who really ought to be treated there, rather than in prison. Since 2003 the NHS has tried to improve matters, with individual mental health trusts being contracted to provide services in individual prisons. At last Ministers have begun to realise that prison conditions, particularly being locked in cells for the majority of every 24 hours with nothing to do, is the very worst form of treatment for those suffering from many forms of mental health problem. This merely results in the person affected being made worse, which in turn impacts on communities when they leave prison. Prison health is a public health issue, a fact that is emphasised by the figures in the ONS 1998 report.

Therefore, I was delighted when the Sainsbury Centre for Mental Health, one of the most highly regarded research organisations in the country, decided to turn its attentions to the problem. I say this because it is able to bring to bear experience and analysis of many aspects of mental health treatment and needs around the country, and apply them to prisons, in which the Government is anxious to claim that 'equivalence' is the standard sought. This means that, instead of treating prisons as a unique problem, Graham Durcan and his team were able to compare what they found in the five prisons with current practices in the community and define what changes need to be made to bring them into line.

In other words, he has been able to advise on how prisons might be part of, rather than apart from, common practice. In doing so he has, inevitably, identified gaps in the current situation in prisons, which should give cause for concern to those responsible for filling them, as well as providing practical advice in determining how that might be done.

I could not commend *From the Inside* more highly to all those concerned with the problem. Sadly prisons are, all too often, used as repositories for those who are neglected and rejected by other services in the community. This is not a fit and proper task for prisons and the needs of these neglected people have, until now, been too often ignored. Therefore, because they form such a significant part of current prison populations, their particular needs must be catered for. That is why, in addition to advice on treating more acute conditions, I am delighted to see concentration on such vital issues as staff awareness, the improvement of screening, the development of a 'stepped care' approach to managing needs and greater concentration on the basics of resettlement such as housing.

I hope that, as with the 1998 ONS report, Graham Durcan's Sainsbury Centre report becomes recognised as seminal, and a universal guide book on what must be done as matters of urgency, humanity and public good.



Executive summary

The prison population of England and Wales now exceeds 80,000 and is set to rise to beyond 100,000 within a decade.

The majority of prisoners have mental health problems. Many also have a complex mix of other issues including substance misuse, poverty and a history of abuse.

Few previous attempts have been made to listen to the views of prisoners about their mental health and mental health services in prison. We interviewed 98 prisoners and 75 staff in five West Midlands prisons to find out more about mental health care inside and outside prison.

We found that being in prison may in itself damage mental health: for example because of separation from family, bullying and a lack of someone to trust. Self-harm and worries about children are particularly serious problems for women prisoners.

Prisoners' lives before prison were frequently chaotic. Abuse and homelessness were commonplace. Many had previous contact with mental health services but had not been followed up and had lost touch.

Arrival at a new prison is a stressful process. Screening for mental health problems is poor yet reception is often the only occasion where this happens for many prisoners.

Having something to do is vital for prisoners. For those with mental health problems, a lack of meaningful daytime activity and limited opportunities for exercise are major concerns.

Prison health care departments offer very limited support for prisoners' mental health. Nursing staff with mental health training rarely practise those skills.

Mental health inreach teams, however, are making a difference to the prisoners they support. Prisoners in contact with inreach services told us they were more confident about their future and thought they were less likely to re-offend because of the practical help the team offered.

The major barriers to change in prison mental health care are:

- Custom and practice prevent staff working flexibly or using their skills appropriately with prisoners;
- Inflexible appointment systems;
- A lack of understanding between different services within the prison;
- A lack of attention to resettlement.

Prisoners with mental health problems told us what they felt they needed:

- 'Someone to talk to' about their feelings and problems;
- Better planning for their release;
- 'Something to do' during the day: meaningful activity, including work and exercise;
- Help in a crisis;
- Access to psychological therapy and advice about medication.

We recommend:

1. Integration between agencies working in prisons on health, mental health, substance use and resettlement.
2. Investment in mental health awareness training for all prison staff.
3. Better care for prisoners with 'mild to moderate' mental health problems, including a new 'primary mental health practitioner' role.
4. A major rethink of mental health screening.
5. The development of a 'stepped care' approach to manage mental health according to the severity of a prisoner's needs.
6. Intensive outreach to prison wings to replace inappropriate use of prison health care beds for people in a mental health crisis.
7. A greater priority given to resettlement, focusing on the 'basics' of housing, employment and drugs.
8. Research to understand the impact of psychological trauma on prisoners and the development of services to support them.
9. Listening to prisoners' own views about the support they get and how it could be improved.



Introduction

England and Wales together have the highest imprisonment rate in Western Europe. The population in our prisons exceeded 80,000 in 2007 (NOMS, 2007a) and has remained above this level ever since (e.g. Ministry of Justice / NOMS, 2008). It is expected to rise beyond 100,000 by 2014 (Carter, 2007). The majority of these prisoners need support for their mental health and experience high levels of mental distress.

The Government has acknowledged the need to improve mental health care in prisons and by April 2006 responsibility for prison health care was fully transferred from HM Prison Service to the NHS. *Changing the Outlook* (DH & HMPS, 2001) stated that, “prisoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS”. This introduced the aim of ‘equivalence’ to prison mental health care. It recommended the introduction of specialist mental health inreach teams to work with those prisoners who have ‘severe and enduring mental illness’ and that mental health provision in prisons should reflect what was being developed in the community. However, it made no mention of care for those with common health problems who would be supported by primary care in the community.

In the summer of 2006 the Sainsbury Centre for Mental Health conducted a review of five prisons in the West Midlands to assess the provision of and need for mental health care. Each of the prisons was served by a well-established mental health inreach team. The review included interviews with 173 people who were either imprisoned in, worked in, managed, commissioned or provided services for the five prisons. Additional information was drawn from statistical data, audits of case notes and in the region of 150 hours of observing the daily routines within the five establishments.

This report primarily draws from the interviews and in particular from the conversations the Sainsbury Centre team had with 98 prisoners drawn from all five establishments. These interviews sought details of the prisoners’ lives up to that point, including their history of offending, life in prison, use of mental health services and the problems they experienced both inside and outside prison. We also asked for their views on how a mental health service in a prison could meet their needs. For most, this was the first time they had been asked to share their experiences, concerns and views.

The prisoners interviewed included both males and females between 15 to 60 years. Some prisoners were remanded, others sentenced and some were facing lengthy sentences. They included people with histories of severe and enduring mental illness and others with more moderate mental health difficulties. Some were experiencing marked mental health problems at the time of the interview. But regardless of their mental wellbeing, their age, sentence status or gender, there was remarkable consistency about the nature of their needs and their experiences.

The five prisons were:

- A male young offenders institute (YOI) and juvenile unit serving sentenced and remanded young adults (18-21 years) and juveniles (15-17 years) with a total population of around 500;

- A semi-open women's resettlement prison with a small young offenders' unit and a total population of approximately 300;
 - A contracted-out category B male training prison and its separate therapeutic community with a population over 800;
 - Two male category C training prisons, each with over 600 inmates. One devotes half of its beds to *'vulnerable' prisoners'.
- * A 'vulnerable' prisoner is one who would be vulnerable to abuse, exploitation and / or violent assault, if housed with the general prisoner population. Most commonly these are sexual offenders, those who have committed crimes against children, but also can include former police and prison officers, those with learning difficulty / disability, prisoners with marked mental illness and some offenders with personality disorders. These prisoners tend to be housed separately from the general prison population in a separate wing and movements from this wing will generally be coordinated to avoid contact with other prisoners.

The total population of the five prisons was almost 3,000 prisoners. The different categories of men's prisons currently in operation in England and Wales are shown in Box 1. Prisons for juveniles and women are not categorised in the same way but also vary in their purpose and security level.

Box 1: Prison types and categories

Local prisons are for unconvicted and short-term prisoners.

High security (formerly known as 'dispersal') prisons are for high security prisoners.

Training prisons are for long-term prisoners who do not need the highest security.

Open prisons are for prisoners not believed to be a risk to the public or in danger of escaping.

Category A: prisoners whose escape would be highly dangerous to the public, police or security of the State and for whom the aim must be to make escape impossible.

Category B: prisoners who do not need the highest conditions of security but for whom escape must be made very difficult.

Category C: prisoners who cannot be trusted in open conditions but who do not have the ability or resources to make a determined escape attempt.

Category D: prisoners who can reasonably be trusted to serve their sentences in open conditions.

Taken from the *Liberty Guide to Human Rights*

(<http://www.yourrights.org.uk/your-rights/chapters/the-rights-of-prisoners/classification-and-categorisation/classification-categorisation-and-allocation.shtml>)

Interviews with prisoners and staff

The interviews took place over 300 hours. Around half this time was spent interviewing prisoners, all identified as having mental health problems but not all receiving any help with these.

It was intended that up to 20 prisoners from each prison (i.e. up to 100 in total) would be interviewed and that these would be a mix of those who had common mental health problems and severe / enduring mental health problems. In the event 98 interviews took place, 60 adult males (over the age of 21), 19 women and 19 young men and in each establishment around half were on mental health inreach team caseloads.

We also interviewed a range of other individuals through one-to-one and some group interviews. These included:

- Local primary care trust (PCT) commissioners;
- Senior and operational NHS trust managers;
- Senior local authority managers;
- Senior prison management and staff from each establishment (governors, health care managers, chaplains and other key prison staff including those who work in the residential and work / education areas of the prisons);
- Health care practitioners, including senior clinicians, nursing staff and primary care practitioners;
- Mental health staff working in prisons including: inreach team managers / leaders and staff, psychologists and psychiatrists;
- Non-statutory sector providers in the establishments.

Approximately 75 people took part in these interviews. It did not prove possible to include carers in this exercise.

The Sainsbury Centre guaranteed anonymity to all those it interviewed, providing that this did not contravene the law, individual safety or security. Additionally, we agreed with the local research ethics committee that we would not use any direct quotes from prisoners. This was to protect vulnerable individuals and to ensure that no individual prisoner could be identified from the material in this report.

Non-participant observation

Observation had not been intended originally as one of the formal data collection methods. However, the research team had considerable opportunity to observe the day-to-day activities, running and management of all of the health care departments and to a lesser degree other parts of the prison such as segregation units and ordinary residential locations (prison wings). So early in the exercise, the research team began taking detailed notes of their observations.

Documentary review and audit

We reviewed a variety of local documentation, including policies, protocols, tools, service level agreements and previous audits, needs assessments, evaluation and research.

The audit included a retrospective review of case notes and service activity statistics as well as a review of a sample of reception screenings from each prison, primary care consultations and detailed profiles of mental health inreach teams and primary mental health care (prison nurse) caseloads. (Reception is the part of the prison where all prisoner arrivals at the prison are processed before being placed on a prison wing.)



The prison population

Prisoners both in the UK and worldwide have always had disproportionate levels of ill health. Infectious disease and mental illness have usually been the most prominent (Stern, 2001).

The most exhaustive study of the prevalence of mental illness in England and Wales was that conducted by the Office of National Statistics (ONS) in 1997 (Singleton *et al.*, 1998). This study is now a decade old and since then the population of our prisons has grown considerably. Several new prisons have been built and more are being planned. However, it remains our best guide to the prevalence of mental ill health in prisons. It was conducted across all of the then 131 English and Welsh prisons (there are now 143) and used clinical interviews with a sample of 3,142 male and female prisoners. The results are shown in Table 1. It shows that most prisoners have either a mental health problem (including serious mental illness and more moderate problems), a personality disorder or a substance misuse problem, and seven out of ten have more than one of the above problems.

Table 1: Mental illness among prisoners and the general population

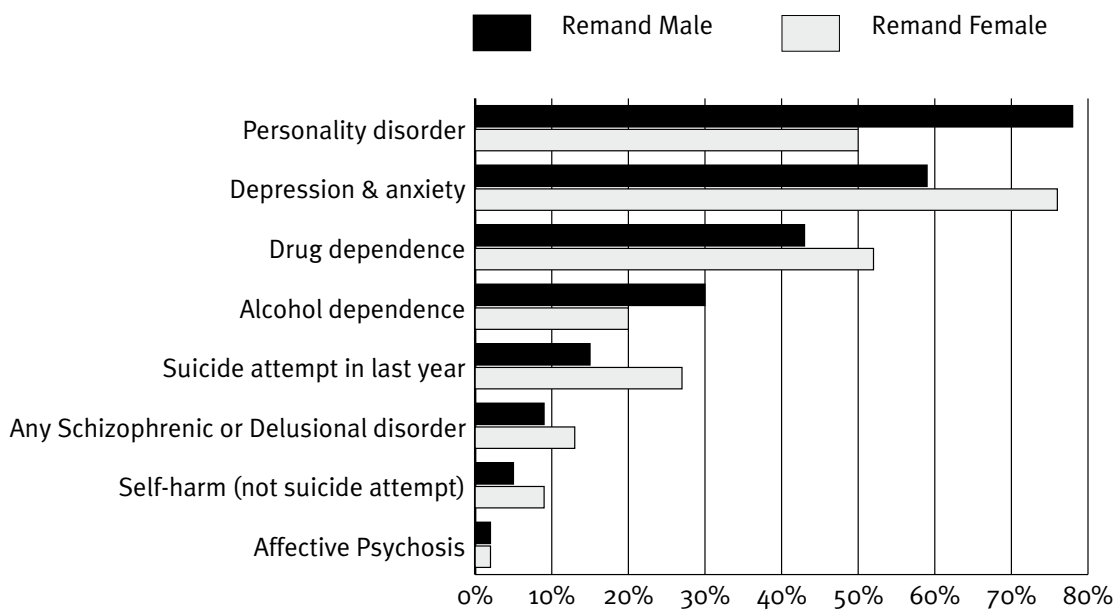
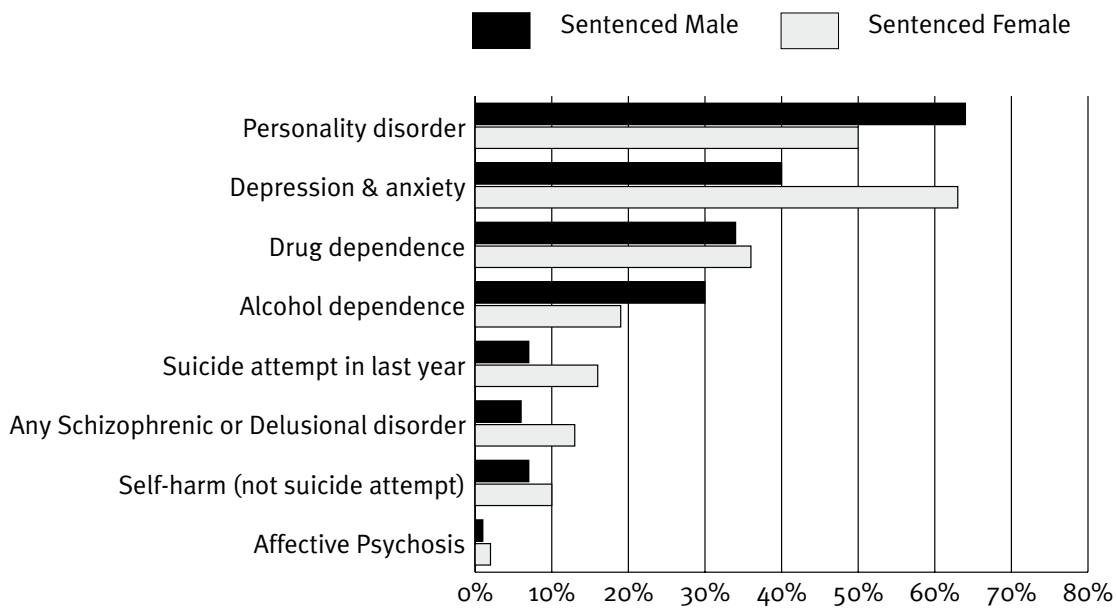
	Prisoners	General population
Schizophrenia and delusional disorder	8%	0.5%
Personality disorder*	66%	5.3%
Neurotic disorder (e.g. depression)	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%

Source: Singleton *et al.* (1998) Source: Singleton *et al.* (2001)

* Personality disorders are described by psychiatrists as aspects of an individual's personality that develop in a way that makes it difficult for them to live with themselves or other people. They are characterised by unhelpful ways of thinking, feeling and behaving that cause problems, for example in getting on with others or in controlling behaviour. Personality disorders are usually noticeable from childhood or early teens.

Some groups of prisoners, such as young people and women, have an even greater prevalence of mental ill health. There are also differences between types of prisons. Figure 1 shows the rates in sentenced and remanded prisoners for both men and women.

Figure 1: Mental illness among sentenced and remanded prisoners



(Adapted from Brooker *et al.*, 2002)

Women

Of the 82,602 people in prison on February 29 2008, 4,454 were women (Ministry of Justice / NOMS, 2008). Women represent a small proportion of the overall prison population but in recent years there had been a dramatic increase in their numbers. Rickford (2003) cites a 192% increase in women prisoners between 1993 and 2003, since which time the women prisoner population appears to have stabilised.

Women prisoners are twice as likely as their male counterparts to have received help for a mental / emotional problem in the 12 months prior to imprisonment (Prison Reform Trust, 2000). Women prisoners are a particularly socially excluded group: 40% will have been unemployed for at least five years prior to offence, 61% will have no qualifications whatsoever (Social Exclusion Unit, 2002), and at least one in ten will have significant problems in reading or understanding instructions (Singleton *et al.*, 1998).

Rates of self-harm, attempted and actual suicide are high among women prisoners. Of those remanded, some 44% will have attempted suicide at some point in their life compared to 27% of remanded men (Home Office, 2007a). In 2006, seven out of the 82 suicides were women (Prison Reform Trust, 2007); while 16% of women prisoners self-harm compared to 3% of men (Home Office 2007a).

When Sainsbury Centre researchers visited Holloway prison in 2005 approximately 18% of the women were reported to be self-harming (Durcan & Knowles, 2006). Some women are prolific self-harmers and account for a significant number of all incidents (Home Office, 2007a) and women overall account for 49% of reported incidents (Prison Reform Trust, 2007).

Almost a quarter of sentenced women prisoners are serving a sentence of 12 months or fewer (Ministry of Justice / NOMS, 2008), but during that time their children may be taken into the care of the local authority, and they may lose both their job and their home, increasing the likelihood of re-offending and mental illness.

In the five West Midlands prisons we surveyed, we spoke to 19 women prisoners, all but one of whom were mothers. Most of them prior to imprisonment had been the main and often sole care giver to their children. At the time of the interviews, three of these women were contesting local authorities' proposals to arrange adoption for their children.

They appear to be typical of many women prisoners. Up to 17,000 children are separated from their mothers as a result of imprisonment each year and many will be taken into local authority care (cited in Rickford, 2003).

Due to the smaller number of women prisoners there are fewer women's prisons: just 17 in England and none in Wales. This means that women are more likely to spend their sentences at a considerable distance from home which limits the number of visits they receive and their contact with their families. The average distance from home was 58 miles in September 2006, with a quarter living over 100 miles away from their home (House of Commons, 2007). Approximately half of the women in prison receive no visits from their family (Social Exclusion Unit, 2002) and the problem is greater for women from Black and minority ethnic (BME) communities (HMIP, 2001). North American research suggests a strong link between maintaining family contact and a reduced risk of recidivism (cited in HMIP, 2001).

Prison has a disproportionate impact on women in other ways too. Women are punished within prison for breaches of discipline at a significantly higher rate than men (224 offences per 100 prisoners

compared to 160 per 100 men – CSIP London Development Centre, 2006). There is also some evidence that women with mental health problems are more likely than other women prisoners to be disciplined (O'Brien *et al.*, 2001).

The Women's Offending Reduction Programme (Home Office, 2004) aims to reduce women's re-offending by ensuring that women receive greater support before, during and after custody. The Home Office-commissioned Corston Report recently recommended completely replacing the women's prison estate and creating better alternatives (Home Office, 2007a). The government response accepted many of the report's recommendations but stopped short of pledging to replace the current women's prison estate (Home Office, 2007b).

Young people

Of the 82,602 people in prison at the end of February 2008, 11,894 were under 21 years (Ministry of Justice / NOMS, 2008). Of these, 2,348 were juveniles, i.e. those aged between 15 and 17 years. These figures exclude those in other forms of secure accommodation. A further 457 children were in either secure training centres or secure local authority accommodation.

Most offending is committed by people aged 15 to 21, the most prolific offenders being young adults (Revolving Doors, 2002). It has been estimated that 8,500 crimes are committed each year by young people released from prison and that 70% of young people released from prison will be re-convicted within two years (Howard League, 2005).

The years between 16 and 25 are significant developmentally and mark the period in most young people's lives when independence is developed and the transition to adulthood is made. Prison may be detrimental to this (Barrow Cadbury Trust, 2005).

Young people in prison have an even greater prevalence of poor mental health than adults, with 95% having at least one mental health problem and 80% having more than one (Lader *et al.*, 2000). Few have any qualifications or had worked prior to prison and most experienced traumatic experiences prior to their incarceration (Social Exclusion Unit, 2005; Revolving Doors, 2002). Young adult males are significantly more likely to commit suicide while in prison than when they are in the community (Fazel *et al.*, 2005).

Black and minority ethnic communities

People from Black and minority ethnic (BME) communities represent about 10% of the UK population (Singleton *et al.*, 2001) but in prison this rises to approximately 20% (Rickford & Edgar, 2005). This can be partly explained by the presence of foreign nationals in UK prisons. The rate of diagnosed mental health problems in prison is lower in BME groups than among the white population. This may be due to a number of reasons including the lower rates of referral and recognition (Durcan & Knowles, 2006).



The impact of prison on mental health

There is little in the way of research on the impact of prison on the mental health of those within. While the general consensus (e.g. World Health Organisation & International Red Cross, 2005; Joint House of Commons and House of Lords Committee on Human Rights, 2004) is that the impact will be negative, this will not always be the case. Chitsabesan *et al.* (2006) found that young people in the secure estate (i.e. prisons and other secure accommodation) had better health, including mental health, than the offenders they sampled who were on community sentences. Crucially, though, these apparent gains were lost when they were released.

For some people, prisons introduce order in otherwise chaotic lives. For those with drug addiction, particularly opiate addiction, there is the opportunity for detoxification. Yet many prisoners will be introduced to opiates for the first time in prison and others will continue to misuse substances while in prison. Several of the prisoners we interviewed in the West Midlands reported using opiates for the first time in prison, all becoming major users after this introduction and all reporting that it was relatively easy to attain drugs whilst in prison.

John's story

John was serving a four year sentence when we met him. His earliest release date was due about six months after our interview. Like many other men we spoke to, John, now 42, could not recollect the number of times he had been in prison, just that in most years since he was 18 he had spent at least a few months in prison. John had spent spells in care as a child and had stopped attending school altogether by the time he was 14. John was introduced to drugs by an uncle when he was around 11. Several members of his family, including his mother and various step fathers, had drug and alcohol addictions. John believed he had both alcohol and drug dependence by the time he was 15. Throughout his teenage years he was offending, mainly minor thefts, and was arrested on many occasions, but did not receive his first custodial sentence till he was 18.

Though John had been married and had other partners, each of these relationships had broken down and he had lost all contact with his two children and indeed with all of his family.

John had not had a permanent home in over five years and had lived largely in squats, and slept on friends' floors and sofas, though he had also spent short periods sleeping on the streets. The people he associated with were all involved in substance misuse.

John felt he also had mental health problems, largely depression and anxiety, but had never really received any help for these. John stated he found it difficult to cope 'outside' and although he still used drugs inside prison, he generally used far less. John stated that he had never worked and it was only in prison that he had any experience of following a routine day.

The World Health Organisation and International Red Cross (2005) identify the following factors as contributing to poor mental health among prisoners:

- Overcrowding
- Various forms of violence
- Enforced solitude
- Lack of privacy
- Lack of meaningful activity
- Isolation from social networks
- Insecurity about future prospects (work, relationships, etc)
- Inadequate health services, especially mental health services, in prisons.

We asked prisoners in the West Midlands about the impact of imprisonment and the aspects of the prison environment and day-to-day life which affected them. There was considerable consensus and a great similarity with the WHO's list. Box 2 details the list of factors which were repeated time and time again in the interviews.

Box 2: Factors damaging to mental health identified by West Midlands prisoners

- Bullying (by other inmates);
- Concerns about family etc. – difficulty in communicating with them;
- Having no one they can trust to talk to;
- Having little meaningful activity and the monotony of the regime;
- No privacy;
- Worries and concerns over their release;
- Substance misuse;
- Incompatibility with cell mates;
- Poor diet;
- Limited access to physical activity such as the gym;
- Unresolved past life traumas;
- Difficulty in accessing services, particularly health care and counselling.

Suicide and self-harm

Prisoners and recently released prisoners commit self-harm, suicide and attempted suicide at rates much greater than that of the general population. For example, male prisoners are five times more likely to attempt suicide than their counterparts in the general population.

Research indicates that there are key periods during and after incarceration when the risk of suicide is at its greatest. These are during the first seven days of entering prison (Shaw *et al.*, 2004) and in the days following release; with male offenders recently released having an eight times greater risk than other men, and women having a 36 times greater risk (Pratt *et al.*, 2006). Most of those who take their lives have had a history of mental illness (Shaw *et al.*, 2004).

The number of self-inflicted deaths in prison fell following the introduction of Assessment Care in Custody and Teamwork (ACCT), a system of case management for vulnerable prisoners (particularly those who self-harm or are considered a suicide risk) and mental health awareness training for prison officer staff (see <http://www.justice.gov.uk/news/newsrelease010108a.htm>). At the time of writing, however, there has been a rise in the number of suicides (see <http://www.justice.gov.uk/news/newsrelease010108a.htm>).

The growth of the prison population

Britain has experienced a marked growth in its prison population. Demand for prison is constantly at risk of outstripping the supply of available space. This 'over-crowding' has a major impact on movements within the prison system.

In 2003 / 2004 prison transfers numbered 100,000 in a population of 75,000 (House of Commons, 2005). Assuming that this rate has been maintained the number of transfers could currently be over 109,000 per year. This means that prisoner movement (by reason of transfer and discharge) is just over 8% of the prison population every month. For local remand prisons the percentage would be much higher.

The number of inter-prison transfers averaged 6,238 per month between April 2007 and February 2008 (House of Commons, 2008b). This does not include the transportation of prisoners between court and prison which will itself account for a significant number of movements. GSL, a private sector organisation with a contract for inter-prison transfers and movements to and from courts, reports 670,000 prisoner movements across England and Wales per year (see http://www.gslglobal.com/services/transport_services/prisoner_movements.html).

Pressure on prison places means that a prisoner going to court on one day and being returned to prison that evening will often not be returned to the same establishment. Available space in the prison estate may not be suitable for new prisoners, making it necessary to transfer others.

This movement of prisoners is also reported to disrupt mental health care and is exacerbated by failures in communication within the prison system.

Prison staff we interviewed in the two category C establishments reported another significant consequence of overcrowding. Previously, most people arriving at a Category C prison would have spent at least a few months in the 'local' prisons to which they were first sent from court. These prisons have more extensive health care facilities so prisoners would have had many of their health problems

addressed. During their time in a local prison, their anger at being incarcerated may also have subsided and they may indeed have looked forward to the less restrictive regime of a category C training prison.

However, staff reported that in recent times prisoners arriving at category C establishments had spent less time in local prisons, sometimes only days, and that fewer of their health issues had been resolved. Many more had not been detoxified from their drug addictions. Prison health care staff stated that this placed a strain on their services.

We observed that a significant minority of prisoners arrived with no medical information and quite a few came with incomplete information. This creates the potential for those with a marked need for mental health care to be lost, at least temporarily, in the system. In one case, a Sainsbury Centre researcher identified a prisoner with a significant mental health history and apparent symptoms of psychosis, and had to refer him to the inreach team because neither the team who had worked with him in the previous prison nor the current prison's health care department had done so.

Imprisonment for Public Protection (IPP)

Imprisonment for Public Protection (IPP) is an indeterminate sentence, implemented in April 2005. It provides prisoners with a tariff (the minimum period that they must spend in custody) rather than a fixed release date. An IPP is given following a conviction for a serious offence and a positive test for 'dangerousness'. In 2003, the Government predicted that the arrival of IPP would result in a net increase of around 900 prison places. However, just three years after implementation, there are more than 4,000 prisoners serving IPP (Rutherford, 2008).

Because of the Parole Board's stringent release criteria, and a shortage in prison courses for prisoners to demonstrate a reduced risk, IPP prisoners have contributed significantly to overcrowding. Only 17 who had reached their tariff by January 2008 had been released, out of a total of 535 – a release rate of 3% (House of Commons, 2008a). The average tariff at the time of writing is around 30 months, although the shortest tariff period on record is 28 days. It would therefore seem that in many cases the net has been cast too wide.

Amendments to the forthcoming Criminal Justice and Immigration Bill, and legal challenges by prisoners may result in a requirement for judges to set a minimum tariff of 24 months when issuing an IPP, but it is unclear what impact, if any, this will have on the Government's forecast for 12,500 IPP prisoners by 2014 (Ministry of Justice, 2007).

In spite of various measures designed to reduce the pressure on prison places (e.g. a programme of early release introduced in July 2007) the prison population continues to grow: from 76,932 in 2006 to 81,914 in mid March 2008 (NOMS 2006 & 2008).



Life before prison

Prisoners are almost exclusively drawn from Britain's most deprived communities. Many will have experienced extreme social exclusion and have complex problems. They have poor general and mental health, little in the way of educational attainment and few have any qualifications to take to the work place. Many have addictions and problematic use of substances. Others will have experienced homelessness and disruption in their family lives since childhood. Most of the prisoners we interviewed, particularly young offenders and women, described traumatic events in their past. Figure 2 describes some of the disadvantages that prisoners face.

We wanted to explore this with prisoners to get more understanding of their needs and the particular contexts in which these needs were set. We also wanted to know whether they had previously used, or tried to make contact with, mental health and other services, within and outside of prison, to gauge the extent to which their needs had in the past been met.

We asked all 98 prisoners about their lives prior to their current prison placement. Some prisoners were on lengthy and even life sentences. Their experiences were quite different from those on short sentences. There were differences between adults and young people and differences between the men and women, but some common themes emerged.

Trauma and abuse


Many of the prisoners had lived in deprived areas, had disrupted childhoods related to parental separation, the deaths of significant others, periods in local authority care, disrupted schooling, and either a family or a personal history of substance misuse. It appeared that community mental health services had failed to engage with many of the prisoners in the past.

We carried out an audit of case notes of young prisoners who were inpatients in the enhanced health care unit of the young offenders institute on three separate days. Just over half the young people audited had suffered a bereavement of a significant person in their lives (e.g. a parent, sibling or grandparent) by their mid teens and for several of these there appeared to be an association, at least in time, with these losses and first or increased contact with police and courts.

Most of the prisoners we spoke to reported at least some traumatic experiences. These included physical and sexual abuse in both their child and adult lives and also torture. Few had received any support in living with the impact of trauma and a number of prisoners reported feeling the effect of these experiences throughout their lives. Some described symptoms typical of post traumatic stress disorder such as emotional numbness, difficulties in relationships, anxiety symptoms, and vivid and intrusive thoughts about the past.

For some prisoners drugs and alcohol had become a means of dealing with this psychological trauma, in effect a form of self medication. It is perhaps not surprising then, that four out every five prisoners we interviewed said that their most recent convictions, i.e. the offences that led to their current


Figure 2: The complexity of prisoners' needs

67% 
are unemployed before coming to prison

70% 
will have no employment or placement in training / education on release

51% 
of short-term prisoners have housing problems prior to prison

42% 
of released prisoners have no fixed abode

49% 
of prisoners with mental health problems have no permanent residence on release

65% 
of prisoners have numeracy skills (and 48% have reading skills) at or below the level of an 11 year old

50% 
on release have no GP

67% 
are reconvicted within two years (78% of young offenders)

33% 
of offenders' debt problems worsen in custody

Sources: Social Exclusion Unit, 2002; Niven & Stewart, 2005; Lewis *et al.*, 2003; Williamson, 2006; Revolving Doors Agency, 2002; Social Exclusion Unit, 2002; Cuppleditch & Evans, 2005.

episode of incarceration, were drug or alcohol related, commonly theft to support addiction to drugs, selling drugs and other offences committed under the influence of drugs or alcohol.

Education and employment

The prisoners we interviewed had a range of educational attainments. A small number had higher education qualifications (e.g. Bachelor degrees), one of which had been attained while in prison. At the other end of the scale there were several prisoners who had extremely limited reading and writing skills. However, the majority of those we spoke to said that they had some reading and writing skills, but no qualifications.

A considerable number of prisoners had no significant experience of working while outside prison. Many had stopped regular school attendance several years before the minimum school leaving age. For those prisoners who had experience of work, this was almost exclusively manual labour and in small scale family run businesses (e.g. window cleaning, office cleaning and building), and some of these expected to return to the same businesses upon release.

In contrast, many of the ‘vulnerable’ offenders, many of whom had been convicted of sexual offences, had experienced work and even careers. Although these were an older group of prisoners, most of them had never previously been imprisoned.

The vast majority of prisoners (vulnerable and non vulnerable alike) did not expect to work on leaving prison.

Homelessness

The vast majority of men we spoke to had experienced periods of homelessness in the past. Several had no fixed abode prior to their current period of imprisonment. Some had been living on the streets.

Most of the adult male prisoners we spoke to had experienced multiple periods of incarceration. It was not an uncommon experience according to those we interviewed for prisoners to be released with no accommodation arranged. A few prisoners had slept on the streets on release, though most managed to sleep on friends’ or family floors and sofas. A significant minority of all the prisoners we spoke to had spent at least a few days sleeping on the streets between periods of incarceration. Substance misuse played a part in the lives of many of these prisoners and was often associated (by the prisoner) with their ‘falling out’ of permanent accommodation.

Some prisoners had been accommodated in hostels after leaving prison and there were mixed experiences of these. The prisoners we interviewed were able to tell us which hostels were the most challenging for them in terms of ‘staying off drugs’ as drugs were freely available and actively ‘pushed’ in some.

Kevin and Shane's stories

Kevin was in his late 30s and had been in and out of prison on many occasions since he was about 17. It had been about seven years since Kevin had any form of permanent accommodation, living in temporary accommodation (squats and friends' sofas and floors, with the occasional spell in a hostel, night shelter and on the streets). Kevin used drugs both in and out of prison, but said he used less when 'inside'. Kevin was due for release a few weeks after our interview and while looking forward to this event he was quite pessimistic about 'staying out'. Hostel accommodation had been arranged for him and he was familiar with the hostel having been there before. Kevin said that he had managed for the first time in years to 'come off' drugs during this period of incarceration, but he knew that it would be hard if he was placed in this hostel.

Shane's story was similar. He too had stopped 'using' inside but based on previous experience he felt he knew that within hours of release he would be using drugs. Shane had a wife and children to return to but stated, "I just know I won't make it across the city, I'll find the nearest crack house...and I'll be back on the streets the same night". Shane reported life outside the prison was much more stressful than in it and he felt sure he would "let the family down again...they're better off without me".

Previous contact with mental health services

Many prisoners clearly had mental health needs before coming into prison but often appear to have been let down by community services. Farrell *et al.*, (2006) found that the majority of prisoners with mental health problems were not able to get help from mental health services in the year before coming to prison. Accounts given by prisoners to us for this review suggest that this is very often still the case.

Many of the young people whose medical notes we audited included reports of failed contacts with mental health services, usually detailed psychiatrists' reports for a court summarising their psychiatric history. Typically they had been referred to child and adolescent mental health services (CAMHS) and offered written outpatient appointments to which the young person and / or their family had not responded.

Some CAMHS services send questionnaires to those referred to them and the returned questionnaires help prioritise who they will see and when. There was no apparent recognition that most of these young people come from chaotic backgrounds, and that literacy might be an issue for them and their families. In a previous Sainsbury Centre evaluation, a mental health service user stated:

"When I was really ill I never opened my mail for an entire year...it wasn't that I didn't want help...just that sending a letter was not the right way to get through to me..."

For those young people who had experienced previous episodes of incarceration, there were similar 'failures' in response from community mental health services on their release from prison.

Aaron's story

Aaron was 17 when we met him and had two previous spells in the young offenders institute both of a few months' duration and on remand. Aaron said he had seen CAMHS on and off since he was 10. During his previous stay in prison he had engaged with the inreach team who had referred him to both CAMHS and a young person's substance misuse service for when he was released. The substance misuse service could not see him for two weeks after release and he found the CAMHS appointment was cancelled on arrival at the clinic. Like most of the young people we interviewed, Aaron felt let down (something of a theme in many young offenders' pasts) and chose not to follow-up the CAMHS appointment and did not attend the substance misuse appointment.

Most of the adults we interviewed had similar experiences of services. They had encountered:

- A lack of assertiveness in most community mental health services;
- Poor integration with substance misuse (both inside and outside of prison);
- Limited and often no services for people labelled with personality disorder (both inside and outside prison);
- No services for those whose mental health problems predominantly consisted of depression and anxiety;
- A service response usually only following a crisis and often then only for the duration of that crisis;
- Not meeting the entry criteria for most of the services they sought help from or were referred to ('sub-threshold').

Those with more severe mental health problems, however, reported some recent experience of a more 'assertive' approach from community services. There were examples of mental health workers meeting them on release from prison and meeting with them at home or in other places they frequented, rather than requiring them to attend an appointment at an outpatient clinic. This very likely reflects the recent introduction of crisis resolution and assertive outreach teams who have more assertive engagement approaches.

Women

Most of the women we met were parents and most were the main care giver prior to imprisonment. Only one or two had a partner outside now looking after their children and a few had their parents providing care. Three were currently contesting local authority court cases regarding the adoption of their children.

The women we interviewed on the whole reported committing fewer offences in the past than male prisoners. For most of the women this was their first experience of prison. The exceptions to this included three young women who reported recent histories of prostitution. All three had marked substance misuse issues and had also engaged in thefts to support these habits. Each of these had experienced several periods of incarceration.

About a third of the women reported being convicted with a partner (husband or boyfriend). Most of these women reported that they had been given longer sentences but claimed a lesser part in the offence. The most common convictions among the women were drugs related.

About half of the women had experience of mental health service use outside prison. Their experience on the whole was that mental health services were unhelpful and not able to take account of the complexity of their need. Most of the women did not suffer from a serious mental illness like psychosis, but rather depression and anxiety.

A significant number of the women reported a history of abuse. Mostly this took the form of physical abuse, from parents and partners, but many reported sexual abuse during their childhood years and a small number as adults. The three women who had worked in prostitution all reported long histories of sexual abuse, one reporting this while in local authority care, and all reported having been raped as adults by 'clients', partners or 'pimps'.

Men and young males

The vast majority of men and young males we interviewed had long offending histories, dating back to their early teenage years if not before, with frequent contacts from an early age with the police and other criminal justice agencies. Among the young people we interviewed there was an association at least in time with significant changes in their family circumstances and reported peaks or escalations in their offending. For at least five young people this was the death of a carer. This was also true for the sample of prisoners whose medical notes we read. Deaths of siblings also featured in their narratives. Many of the men we interviewed described very similar losses in their childhood and adolescent years.

Quite a number of the young males we spoke to claimed membership of 'gangs' outside prison and several more had what appeared to be looser connections with gangs. Many had offended in association with other gang members. Some young people reported that much of their substance misuse was related to gang membership and that stopping misuse would be easier if they broke these links. Most thought this unlikely if they were return to their previous neighbourhoods.

The vast majority of men were in prison for crimes related to acquisition (theft) and these were usually linked to substance misuse. Some prisoners had engaged in violent crimes and a small number had committed rapes and sexual assaults.

The majority of men had a previous period of incarceration and while most could list the number of sentences they had served, few could list all of their experiences of incarceration as many had multiple experiences of remand leading ultimately to no sentence or release on bail prior to sentence.



Arrival

Our researchers were able to observe a number of receptions at the prisons. We also spoke to some prisoners on arrival at prison in addition to the 98 we interviewed. The majority of these prisoners were being transferred from other prisons in the same region. In one prison, where we had the opportunity to observe receptions over several days, almost half of prisoners being transferred from other prisons arrived with no medical information and quite a few more arrived with partial information (i.e. with some medical notes missing).

In all of the prisons it was difficult to predict the number of people arriving at each reception. Although the prison health care department will be told how many prisoners will be arriving, often they may not arrive, or more prisoners will arrive than had originally been expected. Reception screening can therefore be a challenge to resource. In local prisons, which receive prisoners from court, the volume of prisoners arriving can be significant and this poses a challenge to the depth at which each prisoner can be screened.

The prison reception health screenings we observed were all brief, lasting a maximum of five minutes. The mental health element of all of these was minimal, and consisted of asking questions about self-harm, service use and substance misuse. At only one prison were any questions asked about current mental health state and even this was very limited.

The young offenders institute, unlike the other prisons in our sample, receives remanded prisoners. It uses the standardised screening tool for all prisons for first receptions (i.e. prisoners arriving newly in prison as opposed to those being transferred from another prison or those returning from court or other external appointment).

Each of the other prisons in our sample used its own screening questionnaire. All of these asked similar questions to the standardised screening tool. None of the prisons were utilising any supplementary questionnaires or rating scales.

Part of the screening process involved a review of medical notes. Yet many prisoners arrived without any notes and others arrived with partial notes. Even for those who did arrive with notes there was very limited time for this process.

For all of the prisons, screening was a largely 'one-off' event, taking place at reception. Many of the prisoners would have experienced at least one previous screening and perhaps several if they had been transferred between establishments before. In spite of this, when we reviewed medical notes we found that it was not uncommon for there to be no indication of mental health problems on previous screening questionnaires, even when it was clear from other sources that there was a history of mental health problems (e.g. letters, histories in notes or psychiatric assessments for courts).

Our researchers were able to take part in some screenings and found that by asking some additional questions, quite a lot could be revealed. Asking these questions did not significantly add to the length of the screening but appeared in these cases to provide additional useful information that might not have been gleaned otherwise. Even with such improvements, however, a one-off screening at reception is never likely to provide an exhaustive picture of newly arrived prisoners' health needs.

Observations at a prison reception

While observing a reception I noticed that a prisoner seemed anxious and appeared to have some concern, but was not indicating any problems in response to the screening questions. During a pause in the screening I stated that I noticed he didn't seem too happy at the present. In response to this the prisoner stated he had a personality disorder and tended to get very anxious over minor physical symptoms and that he often annoyed cell mates with his anxiety. He also revealed that when previously in the establishment he had been placed on the 'vulnerable' prisoners unit (even though the offence for which he was convicted wouldn't have prompted this placement automatically) where he felt he was managed better. A brief consultation with the unit revealed that this had been the case and they were happy to receive him again. (Sainsbury Centre researcher)

Prisoners' experiences of reception

Some of the prisoners we interviewed stated that they did not particularly want to discuss any medical problems, let alone mental health problems, at their reception to a prison. They described screening interviews as rushed and that sometimes the staff (including health care staff) did not appear interested or sympathetic. More often than not the prisoners were tired and hungry, perhaps having spent several hours on prison transport. They just wanted to return to the holding cell, where there might be an opportunity to receive a meal, a drink and for those who smoked (perhaps most), a cigarette.

Prisoners frequently told us that they didn't wish to reveal any vulnerability. They didn't trust prison staff and they did not expect anything to be done to help them. One prison officer working on a prison wing stated:

“There's a lot of bullying in prison and the guys often feel they have to appear 'hard' to stop others picking on them...some of them will just look for weaknesses in others to get some power over them.”

The male prisoners we spoke to all confirmed this. Those placed on units for 'vulnerable' prisoners stated it was less of a problem but that bullying still took place.

A big concern for prisoners arriving at a prison is cell sharing and, in particular, who they will be sharing with. Prisoners with mental health problems talked about feeling they had to conceal their mental health issues as other prisoners might not understand or be tolerant of their problems. Across the five establishments we reviewed there was only limited single cell accommodation.



Life in prison

The majority of prisoners we interviewed were white British adult males, but we also spoke to women prisoners, young adults and juveniles and prisoners from a number of different cultures as well as some from abroad. They told us about their experiences of prison and how they managed their mental health while inside.

Family responsibilities

The women we interviewed were different to the men in a number of respects. For most this was their first time in prison, though some had previous convictions. Most had been the primary parent prior to prison: often they were a single parent.

Imprisonment always means disruption for children and families but especially so for the families of these women. Some women described the anxiety they experienced when they were first remanded to prison and the difficulty of having to make childcare arrangements. In all cases the prisons had been helpful in facilitating this. A preoccupation for these women was the wellbeing of their children.

Three women were contesting adoption cases, i.e. the local authorities in the areas they had come from were pursuing the adoption of their children through the courts. Each of these women was very stressed at the time of interview, and this was exacerbated by the fact that they needed permission to leave prison to attend the court and while this was likely to be granted there was no guarantee.

One or two of the men had children in similar circumstances, but they were not primary parents and did not appear or report to be as affected as the women.

An issue for nearly all of the women was maintaining contact with family. Most were imprisoned at a considerable distance from home, and the prison was located quite some distance from the nearest train station. The women were also concerned about the impact that visits to a prison might have on their children. Most of the women felt they did not have enough contact with their children and some had not seen their children in several months.

We spoke to quite a number of men who had spent many years 'in and out' of prison. Some of these had more than one family. It was not uncommon for male prisoners in their 30s or older to have two or three different families, i.e. partners and former partners with whom they had fathered children. In most cases the men had little or no contact with their children. Younger prisoners commonly stated that not having contact with their children made it easier to bear their time in prison. Older prisoners often stated regrets over their 'lack of involvement' in their children's lives.

It was not uncommon, especially among the men, for their parents and siblings to have 'distanced themselves' from the prisoner. More often than not this was not related directly to their conviction or imprisonment (for a minority it was) but related to a history of strained family relationships dating back to their childhood and / or to substance misuse and the pressures this had placed on their

families. What was apparent from conversations with these men was that they had little in the way of social and supportive networks beyond those which had formed the context of their offending and substance misuse.

Self-harm

Many of the young people in the 24-hour inpatient unit of the young offenders institute (YOI) had histories of self-harm and some were prolific self-harmers. We had the opportunity to talk to some of these young men and boys. Several talked about times when they wanted to commit suicide but also about self-harming to get staff attention or to relieve tension and stress.

For most of these boys self-harming had become a means of dealing with stress. Self-harming resulted in staff taking note of these young people. It increased the likelihood of having a member of staff to talk to and at the very least got them more attention.

These were the lengths to which young people felt the need to go to get adult attention. It was clear from most of their histories that adult attention was usually attained only through such extreme and dysfunctional means. Several of the young men had marked scarring and disfigurement, especially on their arms where they had made numerous cuts.

At least three young prisoners had self-harmed, by their account, as a response to difficulties they experienced in coping with being located on prison wings. Each had been moved to health care as a response to their self-harm. These 'difficulties' largely concerned being bullied and not having enough time with staff to talk.

Several of the men we spoke to had self-harmed and a few had made suicide attempts while in prison. A small number of men reported that self-harming was a means to reduce stress and that this was a long engrained behaviour they would like to change. Those men who talked about their suicide attempts gave a variety of reasons. They included:

- Shortly after receiving a prison sentence and in response to the sentence;
- Feeling very low and 'hopeless about the future';
- Relationship problems with partner;
- 'Bad news from home' (deaths and illness in family);
- Addiction (attempts to address it or not feeling able to);
- A serious mental illness;
- Bullying and debt within the prison.

Self-harming was a common part of the women's narratives, but only one reported having recently self-harmed. Attempts at suicide and self-harm rates are high among women prisoners, but the women in this prison reported that the regime was more relaxed and staff were often available to talk. At least one of the women who was contesting a pending adoption predicted that she would not want to live if the decision went against her; she had previously made suicide attempts.

People from black and minority ethnic communities

We interviewed a total of 23 prisoners from Black and ethnic minority (BME) communities. Most of these were from families with origins in Pakistan or with African or Caribbean origins. People from this latter group tended to have quite serious mental illness, though not all were in contact with an inreach team. Two of the prisoners that we decided during the interviews were not well enough to proceed were also African Caribbean; neither of them had been referred to inreach.

Those African Caribbean men who were in contact with inreach had all at some point in their past been compulsorily treated outside the prison under the Mental Health Act and all but one had been placed in a medium secure unit at some time in their past.

The issues for young prisoners of Asian origin were different to others in that they often centred on their families' and wider communities' attitudes to mental illness. Some reported that mental illness was not really understood or accepted by their families. They told us that seeking help for mental ill health might not be encouraged and that there was some element of shame. At the very least their families would not want other members of the community to know about their mental health problem. Several reported that at least one parent also had a marked mental illness, though seemingly most were not thought to be in contact with a mental health service. These young people felt quite well supported by health and mental health services in the prison.

Foreign prisoners

We met a small number of foreign prisoners. All of the prisons had some foreign prisoners placed with them. Three of the men we met were facing deportation at the end of their sentence. One, a French national, welcomed this as he had never resided in the UK but had been arrested at a UK airport for a drug trafficking offence. Another reported that he was likely to be deported to the country of his origin in Africa, but that his family (wife and children) had residence in France. He was uncertain how he would reunite with them. The third, also of African origin, had lived in the UK for nearly 20 years and his family lived in London. He was contesting the deportation, but reported living with uncertainty and that he suffered anxiety and depression as a result.

The foreign prisoner element of the sample was small, though we did meet some others at prison receptions. A common experience for all of them was isolation; those with family located in other countries had virtually no contact with them and were understandably worried about their wellbeing.

Prison as a stabiliser

Many prisoners reported feeling that their mental wellbeing had deteriorated inside prison. However, some prisoners pointed out that prison 'acted as a stabiliser'. Some of those with problems with substance misuse reported living quite chaotic and unpredictable lives outside prison. Some of these found that prison imposed a welcome order on their lives: they were generally warm, appropriately dressed, had a bed to sleep in, had access to washing materials and regular meals and those in the adult male prisons generally had access to some occupation during the day.

While prisons were reported to be stressful environments, the nature of the stress was different to that experienced outside. Responsibility for much of the management of their lives was removed from them: decisions about the timing of events in their day, about the activities they engaged in and about the food they ate. Being ‘outside’ was, for many prisoners, ‘stressful’.

All but one of the women liked the regime they lived under. Like the men, some had lived what they saw as chaotic lives and had multiple problems with which they wrestled outside. For these women prison imposed some order, but most felt the regime was relaxed and supportive. Their main complaint was limited access to counselling or mental health services, but many felt supported by prison staff and by other prisoners. One prisoner commented that for her and many of her fellow prisoners the prison represented a significant improvement in the quality of their lives. She was not alone in stating that she had some ambivalence about leaving and returning to the ‘outside’.

Substance misuse

At least 80 out of the 98 prisoners we interviewed reported experience of problematic use of substances at some point during their lives. This included alcohol and prescription drugs as well as illicit substances.

Aasif’s story

We met Aasif when he was 17. Like most of the young people and adults we interviewed, he had started offending and had his first contacts with the police in his early teenage years. Aasif described his life and lifestyle as ‘chaotic’.

Several members of his family had substance misuse problems and a sibling introduced him to drugs when he was 10. Aasif believes he had dependence problems from his mid-teenage years, with a variety of substances, including alcohol. He had used opiates both in and out of prison. Aasif stated that he had mental health problems, which he described as depression, stress and anger, for much of his childhood. He had experienced both physical abuse and neglect. He had at several points been referred to mental health services, but did not remember seeing anyone.

All of the prisoners we interviewed, and indeed all of the prison staff, reported that illicit substances were readily available within prison, with the exception of alcohol. Alcohol or ‘hooch’ was occasionally available and some prisoners acknowledged having drunk hooch at some point during a stay in prison. Several of the prisoners were using substances at the time of interview (primarily opiate based drugs) and most of these reported using drugs partially as a continuation of an addiction but also to help them cope with prison life and their mental health problems.

Most prisoners had used some drugs during their stay in prison, but quite a number had reduced their usage or had stopped altogether. One prisoner stated that he found it easy to stop ‘using inside’ but ‘knew’ he would return to problematic substance misuse on release because of the stresses of ‘living on the out’.

Many of our interviews indicated a close association between the dealing of drugs and bullying. Several men stated they had been attacked by other inmates as a result of drug debt, and at least four reported having requested moves to other parts of the prison to move away from those pursuing it. Some prisoners had stopped using to avoid going into more debt with prisoners or groups of prisoners who provided drugs. In one establishment, tobacco trading between prisoners had also led to debt problems and bullying between prisoners.

Prisoners with current and recent histories of addiction stated that there was very little help available in the prison beyond physical detoxification and that they had largely had no one with whom to discuss the underlying reasons for their addiction or what support would be available when they left prison.

Relationships inside prison

For many prisoners with mental health problems, prison appeared to be an especially isolating experience. Concealing their mental health problems (to avoid exposing any vulnerability) meant keeping themselves to themselves. Bullying was an issue in all of the prisons but especially so in the male prisons.

A common theme in the conversations with male prisoners was the need to be seen to be able to look after yourself physically and to be seen as ‘tough’. This did not prevent bullying but was seen as a deterrent: “they won’t go for you first”.

Few prisoners talked about their problems with their cell mates (pad mates). We were told this was due to lack of trust, lack of understanding, fear of exposing vulnerability, or that the cell mates had their own problems.

Violence

Violence in the women’s prison appeared to be quite rare (with the exception of self-inflicted violence such as self-harm), but most male prisoners had witnessed violent incidents. Several prisoners had been subjected to what appeared to be markedly violent assaults. Debt resulting from drug use was the most common reason for this, but other causes related to bullying and continuation of disputes from outside the prison (mostly gang related in the case of YOI prisoners). On wings for vulnerable prisoners, bullying and violence, while not absent, were rarer events and some prisoners had actively sought to be placed on these wings to escape violence.

Three prisoners who had complained about being assaulted found that the staff response was poor and in one case a prisoner reported that he, rather than the perpetrator, was moved to a ‘segregation unit’. In his view it was he who had been punished. Most prisoners were reluctant to complain about bullying or violence as they expected that they would not have their concerns taken seriously without naming the perpetrators. All prisoners reported that ‘grassing’ was a taboo, but most of those we interviewed said they would be willing to name the perpetrators if they felt they would be ‘safe’ afterwards.

All of the prisons had bullying policies in place but the prison officers we spoke to stated it was hard for them to deal with all but the most blatant incidents of physical violence.

Day time occupation

Four of the prisons provided work for the prisoners and all provided education. In addition, all the prisons ran courses aimed at changing prisoner behaviour. These were provided by each prison's forensic psychology department. Quite a number of the prisoners we met had attended an Enhanced Thinking Skills course and most reported finding it useful.

In the YOI the department running this course reported that at the time they were running the adult version of the course which was not ideally suited to their clientele. There was a significant drop out rate. The department had a target for the number of course completers in every year so a significantly greater number of prisoners had to enter the course to achieve this figure due to the drop out rate. The YOI served both young adults and juveniles, with the latter funded by the Youth Justice Board (YJB). The YJB provided most of the funding for prison psychology services and consequently very little was available for the young adults in the prison. None of the prison psychology departments had the resources to offer anything significant in the way of one-to-one work tailored to the individual.

While some adult male prisoners found working in workshops to be enjoyable, the majority found it monotonous. The work consisted largely of assembly tasks. One workshop assembled components for electric lighting. There was no obvious link between the work prisoners did in prison and their later resettlement, i.e. this work did not lead to jobs outside. There may well have been exceptions to this but not among the prisoners we interviewed.

Vulnerable prisoners reported having less choice and access to occupational tasks than other prisoners. In most cases vulnerable prisoners and the mainstream population cannot be mixed as the latter can pose a risk to the former.

Some, but not all, of the prisoners who had marked symptoms of mental illness were placed with the vulnerable prisoner population. Regardless of where they were placed, the prisoners in this group that we talked to were less likely to be working than others and spent more time in their cells. It was not entirely clear why in all cases. While some were clearly too ill, others would, in the opinion of health care staff, have benefited from more activity during the day.

There were marked differences between the men and women we interviewed. This is partially due to differences in regimes. The women were in a semi-open facility and many worked every day in 'real' work settings outside the prison, while almost all of those not allowed outside the prison had jobs within it. All of the women were quite positive about their prison work experience and many felt they were getting new skills.

The women's regime allowed considerable freedom of movement within the prison and also a greater degree of responsibility in terms of getting to and from work places and education. This was also true for the health care department which had no 'holding cells' but rather a conventional waiting room. It was able to run an appointment system.

The men in the two category C prisons experienced a more secure regime and not all worked or were deemed fit for work (largely due to poor mental health). We talked to a number of prisoners who acted as cleaners on prison wings, all of whom enjoyed the role, apparently because of their more trusted status, greater time out of cell and some other 'privileges' that came with the role.

Exercise

Several prisoners felt that exercise was important in maintaining good mental and physical health, but achieving access to the prison gym for more than two or three times a week was difficult in some of the prisons. At times of staff shortage (which were not infrequent) even this might be difficult.

Vulnerable prisoners reported having less access than others. One prisoner reported that at his previous prison the GP had ‘prescribed’ gym instead of medication. He had initially been sceptical but found that his ‘mood’ improved and that exercise replaced the need he had previously felt for anti-depressants. But the GP in his current prison did not share this view.

We were surprised by how many prisoners, including those with marked mental illness, saw the gym as a real highlight of their day. One prison officer told us that outside prison most prisoners had no access to such facilities and had no ideas of the benefits:

“They start to use the gym out of boredom at first...most find out then that they get a lot out of it...I wish we could get more to go.”

Diet

The quality of food available to prisoners varied considerably across the prisons and even within prisons on different days. Prisoners from minority communities had the most difficulty in getting their needs met. The prisoners we interviewed were divided roughly 50:50 on the quality of the food. Half complained that there was limited choice and that food was poorly prepared. The other half were satisfied and generally felt better fed inside than when outside.

Three of the men we spoke to ‘made the connection’ between nutrition and wellbeing including mental wellbeing: “if you feed yourself shit you’re going to feel like shit”. Prison staff we spoke to did not make this connection directly but some did associate well-prepared food with good morale among prisoners.

Buildings

The prisons varied in age. The oldest dated back to the late 18th century and arguably had the greatest noise levels. The prison with the lowest noise levels largely consisted of mid-twentieth century single storey buildings. The other three prisons had all been built since the 1980s and suffered less than older prisons in terms of noise from one wing carrying through to another. The wings we visited, however, were all noisy places where much of the communication among prisoners and with staff was done through shouting.

Quite a number of prisoners complained about the level of noise and several felt their sleep was affected by it.



Prison health care

All of the 143 prisons in England and Wales have access to some general health care provision, delivered through health care departments (broadly the equivalent of general practice).

Around half have 24-hour onsite provision (Dale & Woods, 2001) which includes enhanced care facilities (in the past called prison inpatients or hospitals) and usually access to a qualified nurse during the night. The vast majority of prisoners in these enhanced health care units are admitted there for reasons of their poor mental health. A small number of prisons have dedicated mental health beds (Durcan & Knowles, 2006).

Prior to the introduction of inreach teams, these services were responsible for all mental health care in prisons. In most establishments, both still deal with large numbers of prisoners experiencing mental distress.

Primary care

Primary care services in prisons are provided by prison health care departments staffed mainly by nurses, but all prisons also provide access to GP services.

Previous studies have shown that primary care services in prisons do not appear to be well equipped to support people with mental health problems. Pearce *et al.* (2004) identified that while 58% of prison doctors worked with prisoners with mental health problems, most had not received any training in psychiatry.

All of the prisons in our survey had a GP service, but the arrangements varied. The contracted-out prison and young offenders institution were served by locum GPs who changed frequently during the survey period. This reportedly led to a lack of continuity in the prisoners' care. Both of these prisons also had 'inpatient' units and provided 24-hour health care. The other three prisons had day-based health care and two of these commissioned local community GPs to provide clinics within the prisons (the other was hiring locum GPs at the time of the review).

All of the prisons had mental health trained nurses on the prison health care staff during our review, but on the whole these tended to provide a generic health care function and practised little if any mental health work beyond some support in a crisis.

The women's prison had very limited access to female doctors, though it was possible with about five days' notice. Most of the prisoners were unaware that they could request a female doctor.

Consultations with GPs in the community tend to be short (often no more than 5 or 6 minutes). Consultations with GPs in prison can be shorter as prisoners consult with GPs at a considerably higher rate than the general population.

Both the YOI and contracted-out prison were attempting to develop specialised primary mental health care teams but with no additional resource. Staff sickness and leave meant primary mental health care staff were often withdrawn to cover other duties.

We have found similar circumstances in other prisons, one example being a visit to HMP Winchester, with the All Party Parliamentary Group on Prison Health. Attempts there to provide a specialised primary mental health care role by mental health nurses were undermined by the lack of additional resources and a re-organisation in other health care provision (All Party Parliamentary Group on Prison Health, 2006).

In the other three West Midlands establishments the operation of primary mental health care was left to those nurses who had mental health training and they had to fit it around other generic duties. Health care managers had tried to allow space and time for specialisation but only the women's prison had any kind of formal nurse-led primary mental health service. This was limited to a monthly session and ended when the post holder left the prison. Women who did attend this rated it highly. During the review the two training prisons offered no effective primary mental health care beyond the limited service offered by their GPs.

Health care staffing

Prison service statistics indicate there are somewhere in the region of 1,100 prison health care staff (HMPS, 2006). Most are nursing staff, working in the health care departments, from a variety of nursing disciplines. About a third have had mental health training, but most are employed in a generic health care capacity regardless of training.

Nurses in prison provide both primary and inpatient care in the enhanced health care units. Another common role is the distribution of medication to prisoners who are not allowed to have this in their own possession.

Some health care departments also include prison officers. Some of these will have undergone training in working in prison health and are known as health care officers. Their role is a mixture of security tasks and direct health care provision. The two PCTs responsible for health care in the five prisons we surveyed had chosen not to continue to deploy health care officers. As a consequence it appeared that nursing staff were engaged in security related tasks that otherwise might have been part of the health care officer role.

Inpatient care

Sainsbury Centre staff have visited a number of enhanced health care units. We have found that most of this 'inpatient' type care is provided mainly to prisoners with mental health problems but that it provides little of therapeutic value beyond containment and observation. The same was largely true for the two enhanced health care units in this survey.

Prisoners in these units experienced a more restrictive regime than they did in the normal prison wings, with less association time, less social contact, less access to activity and no meaningful occupation for much of the day. The vast majority of prisoners were there for reasons associated with poor mental health. In some cases this was related to repeated acts of self-harming or perceived risk

of suicide. In others it was for some other perceived enhanced vulnerability due to poor mental health. In the YOI some of the prisoners in the unit did prefer to be there than on a prison wing, where they felt anxious and vulnerable to bullying.

Staff in one of the enhanced health care units on one of our visits described being under pressure to accept a prisoner “who would not meet admission criteria in the NHS” but who had demonstrated ‘challenging’ behaviour in other parts of the prison. Staff on both units stated that such pressures had been even greater in the past but were now reduced.

Some of the prisoners we interviewed who were not in contact with inreach felt that they only had their mental health problems addressed at all in a crisis. One said he was admitted to the enhanced health care unit after self-harming, where for a few days he was able to talk about his problems. However, after a few days his self-harm / suicide risk was deemed to have reduced and he returned to his wing, where the help stopped abruptly.



Inreach

Most prisons now have access to inreach teams. These were set up to provide support for prisoners with severe and enduring mental health problems.

Inreach team staffing

Inreach teams have introduced a range of new disciplines to some prisons, including social workers and clinical psychologists. Only one of the prisons in our survey had access to clinical psychology, but all had access to some social work, albeit limited.

Prison psychiatry was something of a rarity until very recently (Smith, Baxter & Humphreys, 2002) with just a few forensic psychiatrists providing sessions to a small number of prisons (Birmingham, 2002). The introduction of inreach services has meant that psychiatrists (a mixture of general and forensic) provide sessional work more widely across the prison estate, though we have encountered prisons (outside the West Midlands) that have no sessional psychiatry provision or where the inreach service and psychiatrists are not part of the same team or even work for the same provider NHS trust.

The majority of the 360 new staff employed in inreach teams nationally are nurses. Recent research suggests that the average size inreach team is four whole time equivalent staff (Brooker *et al.*, 2008). By comparison, an estimate of how many inreach staff would be needed to offer an 'equivalent' service to a community mental health team outside prison suggested that a 'typical' men's prison of 550 would require 11 whole time equivalent practitioners (Boardman & Parsonage, 2007).

There is no implementation guidance for inreach teams such as that produced for community teams and this has resulted in variable working arrangements across the country. Some teams are dedicated to a particular prison and based within it. Others have external bases and some serve several prisons, providing sessions in each. The five prisons we surveyed were supported by two different inreach services, one dedicated to the YOI and the other covering the four adult prisons.

The total combined population in the adult prisons during our survey was 2,400, just below their full capacity. The inreach team had 5.3 whole time equivalent (WTE) clinicians, consisting of psychiatric nurses and some psychiatry sessions, plus 1.5 WTE management support. The public sector prisons also had access to social work and a gateway worker (working between prison health care and the inreach service, helping them to prioritise referrals and access to inreach).

The inreach team was resourced to provide one WTE member of staff for every 465 prisoners across the total full, or 'optimum', prison population. The four prisons were spread out with up to 40 minutes' journey time between the furthest prisons. All the prisons were within 30 minutes of the team's office base.

The other team serving the young offenders establishment had a total of 2.6 WTE clinicians, this being a mixture of psychiatric nurses, a social worker, and psychiatry and psychology sessions. The total

population when we visited was 480 (just below its full capacity). The team was resourced to provide one WTE staff for every 188 prisoners across the total optimum population. This team was drawn from one of the UK's few forensic child and adolescent mental health services and had direct access to medium secure hospital beds (part of the same service) for the juvenile population it served.

Caseloads of inreach teams

A conservative estimate of those requiring secondary care in prisons would be 20% of the total population of just over 80,000. This amounts to some 16,000 prisoners with a need serious enough for inreach (i.e. those with a serious mental illness, those with complex problems due to co-morbidity and those not responding to primary care level intervention). If this population is divided by the new inreach workforce of 360, this equates to caseloads for each mental health practitioner of 44.

Changing the Outlook (Department of Health & HMPS, 2001) envisaged that inreach teams would be the prison equivalent of community mental health teams (CMHTs). Government guidance on CMHTs (Department of Health, 2002) recommends that a CMHT in an area of average deprivation should have a caseload of 35, but for teams serving more challenging populations (e.g. with greater deprivation or more geographically spread) then caseloads should be much smaller. The recommended caseload size for assertive outreach teams in the community is 10-12 (Department of Health, 2000).

Prisons draw their populations from among the most socially deprived communities and prisoners will often have multiple problems (e.g. more than one mental health problem and / or substance misuse problems). Our audit of inreach caseloads in the West Midlands revealed that both teams are working with prisoners with quite marked mental health problems, comparable in terms of severity with inner-city CMHTs and some assertive outreach team caseloads that we have reviewed.

Both teams in this study had lowered their acceptance threshold in order to support prisoners with less severe conditions when they are in crisis.

Not all the prisoners who appeared to have symptoms of a serious mental illness when we interviewed them were in contact with an inreach team. It is likely that there were others who we did not meet who might at least benefit from an assessment.

Gareth's story

Gareth had lots to say in our interview but he was clearly unwell and appeared at times to be hearing and responding to voices. He told me that he had a long history of mental illness and mentioned that at one point he had been diagnosed with schizophrenia.

Gareth said he had not been referred to the inreach team and his notes gave no indication that he had. He was also complaining of pain in his ear and there was a discharge coming from this ear. Gareth said that he had been prescribed antibiotics and that the course of medication was almost finished. He asked me if I would enquire about him seeing the GP for his ear infection and also about a referral to the inreach team.

When I spoke to health care staff, they informed me he would have to complete an 'app' (application form) back on his wing to see the GP, and that this may take two or three days.

When I enquired about referral to the inreach team I was told he would automatically have been referred to it by his previous prison's inreach team. He had been transferred three weeks ago and had been on that team's caseload. When he was screened on transfer, however, his mental health history was not noted. I decided to refer Gareth directly to the inreach team. They saw him the following day and ensured the GP saw him the same day.

(Sainsbury Centre researcher)

Understanding of inreach

The understanding of the inreach role and function was limited across the prison communities we surveyed. Prisoners receiving inreach not surprisingly understood it quite well, but prisoners in the three adult male prisons who were not receiving inreach services were often unaware that there was a mental health team within the prison. They certainly were not clear on referral routes; nor indeed were many wing-based and other prison staff.

Several of the wing-based staff felt that there were prisoners under their charge who had mental health problems but who were not receiving any treatment. The officers we spoke to said that due to staff shortages (in their view) and resultant pressures of work they had little time to spend with prisoners and were unlikely to seek help for prisoners unless they clearly posed a threat to their own safety or that of others or to the good order and running of the wing.

Wing-based staff believed that little was on offer for most prisoners with mental health problems and that there was little point in referring them to the health care department. Prison officers were frustrated by both the lack of time they had to talk to prisoners and by the lack of responsiveness they perceived among health care services in the prisons. The two exceptions to this were the women's prison and the contracted-out prison, where wing-based staff were generally quite positive about health care provision (though not always knowledgeable about the full range of services and referral routes).

In the five West Midlands prisons inreach was under separate management arrangements to other mental health services. Primary mental health care was managed by prison health care managers while inreach services were run by NHS mental health trusts. As neither management shared the same vision for mental health, there was a sense of disjointedness between the two and there were tensions between them.

In our experience this is a much wider phenomenon and is not unique to the West Midlands. Many of the health care staff we interviewed said they were frustrated by what they saw as the high threshold entry criteria for the inreach team. There had been an expectation that the inreach team would see more than just those with severe and enduring mental illness and in truth some health care staff thought inreach should be dealing with all mental health.

The role and function of inreach was not particularly well understood by other parts of the prisons or even by senior staff in the prisons. This is perhaps not surprising as the health care department's role and function were also not particularly well understood by other parts of the prison and the same was true of prison psychology and other departments and services. It seemed that while prisons are contained environments, partnership and integrated working can prove quite difficult as different parts of the prison and services within it work quite separately and have limited exposure to each other.

Working with health care

Both inreach teams in the five prisons had offered to work with the primary care teams to help nursing staff develop an understanding of mental health issues. They had also offered supervision. In two prisons, there were attempts to set up primary mental health care nursing teams, and some clinical supervision was taken up by the staff in these. But in two other prisons there was resistance to this idea, and offers of joint work and clinical supervision were not taken up.

It was in these prisons that our researchers observed cases of people who clearly warranted at least an assessment by inreach, but no such referral was made nor indeed had there been any mental health assessment conducted by health care staff.

Steve's story

Steve was close to having served his sentence when he was referred to inreach. They assessed him as having considerable mental health need and as posing a potential danger to others post release. They urgently referred him on to a NHS medium secure forensic unit, who concurred with this view and indeed considered referring him on to a high secure hospital.

There was no evidence in the available medical notes that there had been any previous mental health intervention or referrals to inreach or psychiatry while in this establishment. Yet Steve had been in prison for some considerable time. I concurred with the view of the inreach team, and that of the medium secure unit's assessment team, that the mental health problems experienced by Steve would likely have been apparent earlier and that an earlier referral should have been made. (Sainsbury Centre researcher)

Both inreach teams appeared to have the care programme approach (CPA: see Box 3) in place, but there was limited adherence to it in the prison health care departments. With the emergence of the new offender management system, considerable thought will need to be given as to how CPA and offender management will interact.

Box 3: The care programme approach (CPA)

CPA is an approach to case management adopted by all secondary care mental health services in the community (i.e. outside prison) in England. A care coordinator is appointed to coordinate various elements of care and to organise multidisciplinary reviews of care. CPA should involve both users and carers in planning and reviewing care. The adoption of CPA in prison mental health care has been 'hit and miss' (Sainsbury Centre, 2008).

Working with substance misuse services

Staff engaged in substance misuse work with prisoners could usually identify a proportion of their clients with marked mental health problems. But they were usually unclear as to what, if any, mental health treatment they were receiving. Mental health practitioners likewise had limited knowledge about the involvement of substance misuse workers with individual prisoners.

The prisoners also commented on the disjointed nature of their care. It is well established that substance misuse is widespread in prisons and that many prisoners have a significant history of substance misuse. The vast majority of prisoners we spoke to reported having at some point had a substance misuse problem and many still had.

Staff of both services saw the need to work together but often felt time did not allow them to explore how this might be done. Instead, they tended to refer a prisoner to one another when they saw the prisoner's problems as being predominantly the concern of that service or if they reached an impasse in their own work.

Given the extent to which these two sets of issues (mental health and substance misuse) co-exist within the prison population it is not unreasonable to describe this co-morbidity or dual diagnosis as a 'default' for prison mental health care. Mental health services need to address substance misuse issues, probably through having the requisite skills within their service and through close collaboration and joint working with prison substance misuse services. This was largely not the case in these five prisons, nor is it the case in our experience across much of the prison estate.

Personality disorder

Just as 'dual diagnosis' could be argued as a default for prison mental health care, so too, arguably, is personality disorder. Many prisoners, through drug use and antisocial behaviour, would meet criteria for some forms of personality disorder. Quite a number of the prisoners we spoke to had been labelled as 'personality disordered' at some point in their past. This group generally reported receiving less in the way of mental health care, both inside and outside prison.

Many inreach teams report that they do not accept prisoners with personality disorder unless it co-exists with a serious mental illness. The two inreach teams serving these prisons adopted a pragmatic approach and were willing to see some patients with personality disorder. But they did not feel they had the skills to address this group.

The prisoners labelled with personality disorder all had mental health problems too, but these tended to be more moderate conditions such as moderate depression and anxiety.

Prison staff found this group frustrating partially because of the challenging behaviours they exhibited but also because in their view the prisoners clearly had problems but did not seem to meet the criteria for any service. Often prison staff were not seeking to hand over responsibility for these prisoners. They simply wanted advice and ideas about their management.

The prison system does have a small number of pilot units for those with personality disorder who pose the most risk ('Dangerous and Severe Personality Disorder', or DSPD). The majority of prisoners do not pose this level of risk and receive little in the way of support targeted to their needs.



User involvement

User involvement is a clear expectation of all community mental health care services, indeed in all of the NHS. Yet prison mental health care has yet to make any significant inroads. Prisons are primarily concerned with public protection and punishment. Rickford and Edgar (2005) believe that prison environments can “profoundly hinder” user involvement. The only user group we have been able to identify (Revolvers, supported by the charity Revolving Doors) works with ex-offenders rather than those currently in prison.

Although there is considerable evidence about the prevalence of mental health problems in prisons, little attention has been paid to prisoners’ experiences of mental health problems, the care they receive for them, or their ideas on how it could be developed in the future.

A recent exception to this is an evaluation of prisoner listeners (a peer support scheme available in most prisons) conducted across four prisons (Department of Health & Home Office, 2007). The researchers held one focus group in each establishment with a total of 75 subjects. The purpose of the exercise was to gauge the views of prisoners and the extent to which their health needs are being met, particularly on release from custody. The evaluation team had initially invited 11 prisons to take part and were disappointed that only a few took up the offer.

The most significant published examples of prisoner service user involvement in mental health are:

Nurse *et al.* (2003) ran focus groups to explore the influence of environmental factors on mental health from a prisoner perspective. Its findings indicated that “long periods of isolation with little mental stimulation contributed to intense frustration and anger and may influence the use of drugs to relieve tedium”. It also found an association between stress in prison officers and poor mental health among prisoners.

Jayne (2006) ran a two-day workshop for prison mental health inreach service development. Some workshop participants were sentenced prisoners involved in focus groups facilitated by practitioners. The prisoners taking part agreed that good mental health care in prison included:

- An ability to form trusting relationships with health professionals;
- Continuity of care and contact with practitioners;
- Not being misinformed or deceived with false information;
- Clear and detailed information regarding side effects of medications;
- Education about the nature of a prisoner’s illness;
- Prisoners’ involvement in their own care planning and pathways of care;
- Rapid transfer when acutely unwell;
- Treatment / therapy appropriate to a prisoner’s condition.

Another recent study that involved a significant number of prisoners in a development project concerned the introduction of a telepsychiatry service, (Leonard 2004a & 2004b). Telepsychiatry is a version of telemedicine, which allows health interventions to be conducted via communication technologies, meaning patient and practitioner can be in different locations during a consultation.

This study was primarily concerned with testing a new intervention and the user ‘involvement’ element concerned testing prisoners’ satisfaction with the new service.

Though not specifically research on prisoner mental health, the qualitative study on prison health care led by the late Gill Hek (Condon *et al.*, 2007) did include mental wellbeing in its investigation. This study was conducted across 12 English and Welsh prisons and involved in-depth interviews with a cross section of 111 prisoners. Many of the prisoners Hek’s team interviewed had a sense of hopelessness about their futures, but they report one case study where successful mental health treatment meant the prisoner felt more optimistic about leaving prison. This was a common finding in our study. Condon *et al.* also report on the mental distress caused in prison by poor and delayed physical health care, especially among those with chronic health problems.

In contrast to these reports, few published health needs assessments in prisons have featured any significant user engagement.

A needs assessment at HMP Liverpool is something of an exception as it included semi-structured interviews with nine detainees (Coffey & Church, 2002). A study at HMP Shepton Mallet (Fenton, 2003) employed interviews, but these were standardised clinical interviews designed to give an estimate of the prevalence of mental illness rather than involvement itself. A study at HMP Whitemoor (Cambridge Health Authority & HM Prison Service, 2001) issued a questionnaire to prisoners, and while this was an attempt at user engagement, it was very limited as there were few spaces for free-text answers.

There have been no published studies reporting prisoner experiences of mental health care and their views on future service provision since the introduction of the new inreach teams to prisons in England.

Our survey in the West Midlands is thus the only one, specifically, to date to seek on a significant scale (i.e. nearly 100 service users) the views and experiences of service users with mental health problems of prison mental health care.



Prisoners' views of health care and inreach

The majority of prisoners interviewed across the five establishments reported a negative experience of their prison health care department and were critical of it. Notable exceptions were women prisoners and those in contact with the inreach teams. Young prisoners had mixed views about the health care department in the YOI, but some were quite positive. Prisoners in the three adult male prisons were largely very critical of health care.

In terms of mental health care, the vast majority of prisoners receiving inreach were very positive about the care they received from it. The small number of women who had worked with the mental health trained nurse in their health care department were also positive as were the women who had attended a therapy group run by both this nurse and the inreach team. The fledgling primary mental health care services in the YOI and the contracted-out prison were yet to make an impression.

Health care departments

Prisoners were often critical of both the care that they received in the current establishment and health care departments in other prisons. The two prison health care departments which received the least criticism were those in the women's prison and the YOI. In the case of the former, most of the prisoners were actually quite positive, though the perceived lack of access to a female doctor was seen as a major deficit as was the absence (towards the end of the review) of a mental health trained nurse on the staff. There were quite mixed views of the YOI, but at least two prisoners thought the health care department had improved since previous spells in that establishment, and a small number were quite complimentary about the standard of care.

The vast majority of prisoners at the men's prisons were very negative and critical of their prison health care. The most common complaints were about health care staff's perceived attitudes and their interactions with them. Many prisoners objected to being referred to by their surname and prison number, particularly in the two category C training prisons, arguing that prison was de-personalising enough. Many prisoners felt that health care staff were often abrupt and rude and that there appeared to be a 'default' assumption that a prisoner was 'trying it on' when seeking support from health care. Another common complaint was that contact with nurses and doctors always felt rushed.

Prisoners' experiences of inreach

By contrast to general health care provision, prisoner feedback was hugely complimentary and positive about the prison inreach teams. Many prisoners had experienced multiple episodes of imprisonment and were able to compare the current episode with their past experience. Several reported that their engagement with inreach had resulted in a more positive experience of imprisonment.

Inreach staff were reported to act as advocates, in addition to spending time with prisoners working on their problems, they also spent time in liaison with a range of other services both within and without the prison. Several prisoners recognised this as a very important element of the service, helping to ensure continuity of care when they left the prison. They felt inreach staff had, for example, encouraged probation officers to get involved in planning for their resettlement earlier in their sentence than they had experienced previously.

Several prisoners, all men, said they didn't see the inreach team as a 'prison service'. This for them was essential in building a trusting relationship because, although some of these men could name prison staff that they liked or felt they got on well with, they were nevertheless always aware they were employed by the prison. A prisoner in another Sainsbury Centre study summed up this view:

"They (prison staff) are part of the punishment...it's hard to forget that."

The inreach service was seen as being there in the prison solely to support and provide help to the prisoners. Being viewed as an external service appeared to be intrinsic to this.

Many prisoners with an imminent release date felt much better prepared this time and more confident about the support that would be available to them in the community. Consequently they were also more confident about not returning to prison. It is, of course, not possible to state that inreach services are reducing levels of re-offending, but it is likely that the characteristics of good mental health care are similar to those of good resettlement.

Prisoners also commonly reported that the inreach teams had helped them to improve their mental health and had educated them about symptoms and medication.

Assessments

Prisoners complained about the repeated assessments that they had to undergo when they met a new professional. This can happen when they are referred from one service in a prison to another, when they are moved between prisons, or even within a team, between one professional and another. The assessments tended to be similar and the prisoners felt that they had to repeat the same story many times.

One prisoner noted that services were keen to assess but never seemed to intervene. The reasons for this were not always clear, but across both prisoner and staff interviews a number of reasons were put forward, most commonly:

- There is little in the way of evidence for 'what works' with prisoners with mental health problems, so assessment was the only intervention that took place.
- Services within prisons do not share information (an explanation for multiple assessments).
- Assessing is part of a risk averse culture, where assessment gathers more information on risk.

Treatment, care and support

The most common interventions were assessment and monitoring of a person's mental health. In primary mental health care these were usually the only interventions beyond the prescribing of medication. There were attempts to provide some counselling in three of the prisons but these were usually limited to a single counsellor offering some sessions each week. Relatively few prisoners could be seen by these services.

The vast majority of prisoners we interviewed said they experienced depression during their time in prison, and approximately half felt very low in spirits at the time of the interview. One prisoner described not eating for several days at a time when he felt very depressed and as a result had experienced significant weight loss. Eventually, he was referred to the prison GP, but in the prisoner's view the treatment focused on his weight loss rather than the depression that caused it.

Several other prisoners felt that they could get prescriptions for anti-depressants easily enough. When asked about what service they would most appreciate, however, the most common response was "someone to talk to" whom they could trust.

With the exception of prisoners in contact with an inreach team, the opportunity to talk to someone on an ongoing basis was largely not an option. In a crisis, the prisoners said they might talk to a listener (these are peers trained by the Samaritans to listen to prisoners in crisis), prison staff working in the prison's wings, or the chaplaincy. About a third of those we spoke to would never consider speaking to a listener, either because of a poor experience in the past or because they felt they could not trust a fellow prisoner.

A number of men disclosed during our interviews that they had been sexually abused as children. Three of these men described having previously disclosed this after having built up trust with a member of prison staff (usually health care). They had disclosed their experiences to these staff in the hope of receiving some ongoing support, but in each case they had been transferred to another prison at or around this time. All three felt they had been 'damaged' by the disclosure experience and each reported unresolved issues that 'plagued' them related to their past abuse. They said they would not risk building up trust with staff within the prison again.

Not all prisoners wanted to discuss past abuse, or felt they needed 'counselling' for it. But some of these wanted support in dealing with what they saw as the symptoms or consequences of unresolved trauma, such as preoccupation with the abuse, nightmares or more generalised anxiety.

Sainsbury Centre staff conducting the interviews felt that interventions to support prisoners who experienced past psychological trauma were lacking and neither of the inreach teams felt confident in addressing these needs.

A number of prisoners found it very difficult to ask for help. They felt that staff working in the wings (residential areas of the prison) had no training or understanding of their needs. One juvenile suffering from psychosis reported pushing the in-cell buzzer when he felt especially anxious and in need of support, but that often he was not able to explain what he needed, which frustrated wing staff responding to his calls.

We spoke to a number of prison officers, including senior officers based on prison wings. Most had not received any mental health awareness training but they said they could identify prisoners who they thought had mental health problems. One officer stated that little would be done except in drastic circumstances like self-harm, attempted suicide or violence. This officer, like others, doubted that the

health care department within the prison had much to offer prisoners like this and he saw little point in referring them. Officers commonly reported having little time to talk to prisoners and indeed little time to intervene in bullying on the wings unless confronted with overt violence.

Wing staff did not feel involved in mental health treatment and were generally not informed about what was being done with prisoners attending the mental health service. Some officers admitted that they were not interested.



Transfers

Transfers to the NHS

The Mental Health Act does not apply in prisons. Prisoners cannot be treated compulsorily under the Act and must be transferred to NHS hospitals. Prisoners requiring transfer for treatment in the NHS can experience long delays (Prison Reform Trust, 2005) both for assessment and placement, during which they may receive little or no treatment. In more recent times we have received reports that this has improved as a result of government guidance that states transfers should be completed within 14 days (Department of Health, 2007).

Nationally the number of people who are admitted to forensic mental health services directly from prison has increased in recent years (Rutherford & Duggan, 2007). Direct transfers from prison to medium secure (the most common destination for prison transfers) were up by 15% in 2006 from the previous year. Approximately half of these transfers occurred while prisoners were on remand in a local prison.

In the West Midlands, it has been reported that there were still delays in transferring prisoners to the NHS. Overall, though, there has been an improvement and the prisons we surveyed had reasonably good relationships with medium secure units in the region. The inreach teams had put considerable effort into this work and the team covering the four adult prisons had developed a transfer pack for professionals. Transfers out of region were, however, still problematic.

Transfers within the prison system

There is currently no national protocol for prison to prison transfer. Inreach teams work differently and not all appear to be as robust in the use of the CPA as the inreach teams in this survey. We observed prisoners arriving from other prisons who were not referred to the new prison's inreach team, despite the fact that they had been in contact with the inreach team in their previous prison and showed clear evidence of requiring ongoing care.

We were told that medical notes frequently do not accompany transferred prisoners and this might mean that vital medical information is not available to the receiving establishment. In the absence of the roll-out of the proposed national prison health IT system that communicates between prisons, medical notes need to accompany the prisoner in all cases of transfer. A hopeful sign is the piloting of a new system in several prisons across England. Many staff find this system quite useful, but it is still under development.

Both inreach and health care staff were often frustrated that prisoners who left the prison to attend court and who were expected to return were instead transferred with no information immediately available as to their new location.

It is possible, in order to continue medical treatment for mental health problems, to prevent a prisoner from being transferred ('medical hold'). Two prisoners reported having been medically 'held' but they were nevertheless transferred as the governors had overridden these decisions. Some of the staff we interviewed had also encountered such cases.

For some of the prisoners, transfers were part of a sentence plan: they expected to be in a particular type of prison at different points in their sentence. Most prisoners will be re-categorised at some point during their sentence. They are thought to pose less risk with time and can be contained in less restrictive environments. Local category B prisons usually have more extensive health care provision and so prisoners will often have some of their more marked needs met while remanded or in the early part of their sentence.

For a considerable number, however, their placement in the prison in which we met them did not seem to have been so well planned. Prison staff in the category C prisons reported that prisoners were transferred much more quickly than in the past. This, they said, was being done to create space in the system for prisoners arriving from court. They reported that one of the effects of this more rapid transfer was that prisoners had had fewer of their health care needs addressed. This posed a challenge for the less well-resourced health care units in these prisons.



Release

Most of the male prisoners we interviewed had experienced previous episodes in prison and were therefore able to comment on the post release experience. Very few prisoners reported having adequate support in place after previous sentences and quite a number used the word 'ejected' to sum up their previous experiences of leaving prison.

It was quite common for the prisoners we interviewed to have histories (self-reported during the interviews) of substance misuse. Substance misuse was commonly claimed to have played a part in their offending, e.g. thefts to support a drug habit, dealing in illicit substances and offending while under the influence of a substance. The prisoners we interviewed associated a return to significant, or what they deemed problematic, substance misuse with a lack of preparation for and support on release from prison. While looking forward to release from prison, many were apprehensive and a significant number were pessimistic about their chances of staying out of prison.

The least apprehensive group were those in contact with an inreach team. Those with a release date within a few months of the interview felt that there was better preparation for their future release with support already in place. For some this meant a named community psychiatric nurse (CPN) and community psychiatrist, who had often already visited them in prison. Efforts were also made to find them a GP and support for substance misuse problems following their release.

The most important thing for these prisoners was the effort inreach staff had put into getting other forms of support in place. Following liaison and advocacy by the inreach team with probation, for example, help was being offered in finding accommodation and training or even employment.

Early release

This survey was conducted before the Government introduced the 18 day (End of Custody Licence) early release scheme, designed to reduce pressure on prison places (Ministry of Justice / NOMS, 2007). A number of prisoners we spoke to had experienced early release, however. In each case the prisoner had been released on an electronic tag and their release date had been brought forward by several months.

Both prisoners and staff reported that in some cases the early release had meant that not all elements of resettlement could be put in place in time. This included no referral to a community mental health service, no registration with a GP and, for three prisoners, less than ideal accommodation: all of them in neighbourhoods where they had previously offended and close to associates in their previous offending and in two cases substance misusing behaviour.

Continuity of care

Continuity of care, between the community and prison, is a huge challenge. Half of sentenced prisoners are not registered with a GP prior to being sent to prison (Social Exclusion Unit, 2002).

In our survey, inreach teams, health care staff and prisoners all reported considerable difficulties in finding GPs willing to accept prisoners after release, particularly outside the West Midlands.

The inreach teams have had considerable success in ensuring mental health support post release, but have likewise found this more difficult for prisoners from outside the West Midlands. Additionally, inreach teams only serve a proportion of those with mental health problems.

From the prisoner perspective, security of tenure post release and training, work or other meaningful activity were also important.

While most prisoners who were in contact with inreach teams were more confident about their futures, the experience of virtually all of those who had experience of leaving prison previously was negative. They reported that elements of care were not put in place to support them on leaving prison, such as registration with a GP, referral to a mental health service or adequate support for substance misuse.

The prisoners we spoke to were even more negative about what they saw as the 'basics', such as 'decent' accommodation and support in getting benefits, being in place. Several prisoners said that while they received little support for their mental health in prison, the prison met their basic needs and took responsibility for many decisions concerning their day-to-day needs and activities. When they left prison they were 'suddenly back in charge', in most cases with no support, and with no history of having 'managed it all well before' during previous releases.



The barriers to change

Custom and practice

Much activity in prison health care departments could be labelled ‘custom and practice’. The term ‘custom and practice’ is used to describe professional behaviour that has become routine or ingrained and it is this characteristic that forms the justification for its repetition rather than any evidence in its favour.

Custom and practice might dictate the timing of an activity, the manner in which it is performed and even the entire activity. It can be quite hard to change. On more than one occasion the research team were told when questioning an activity “that’s how things are done here”.

Health care nurses appeared to engage in many duties that did not appear to require a qualified nurse. We have observed this in prisons in other parts of the country. Health care staff reported finding this frustrating. It was very common for nurses to spend considerably more than an hour faxing pharmacy sheets to the centralised pharmacy. Nurses were often assigned to GP clinics where they appeared to do little more than pass notes to the doctor, make entries in the notes following the consultation, fill out prescription sheets for the GP to sign and escort the prisoner between consultation and holding cell. Doubtless there are occasions when it is useful to have two trained health care practitioners present, but on the whole this ‘chaperoning’ appeared to be wasteful.

Much of the time of nursing staff in health care departments was spent dispensing medication. Relatively little was spent on reviewing medication, particularly for prisoners on psychotropic medication. All of the prisons were served by a single off-site centralised pharmacy service. There were often gaps of two days between a prescription being issued and medication being received. This was a big issue for many prisoners and even those on repeat prescriptions commonly experienced gaps in receiving medication. Medication prescribed on a Friday was often not available till the Monday or Tuesday and bank holidays would add a longer wait. Prisons across England and Wales vary in their pharmacy arrangements but many health care staff have reported similar difficulties especially around prisoners arriving close to weekends or public holidays.

Most health care staff felt they were short staffed. While this may be and indeed most likely is the case, the true picture of resourcing is masked by the day-to-day routines and practice in health care departments. This too is likely to be the case in other prisons in other parts of the country.

In two of the prisons we surveyed, it was common practice among prison health care staff to refer to prisoners by surname and prison number (e.g. Smith 4244). It was also reported to be common practice in other prisons among some staff. All but one prisoner objected to this and found it de-personalising. The vast majority of prisoners wanted to be referred to by their first name. There was considerable resistance by some staff to changing this practice and two staff shared the view that using a prisoner’s first name was a “privilege to be earned”.

Appointments

Another factor that made some of the health care departments less efficient was the absence of the sort of appointment system that community primary care services offer. Prisoners were generally escorted to health care departments in two movements (one in the morning and one in the afternoon). This generally meant that some prisoners had very long waits (sometimes over two hours) before they saw a health care practitioner for a contact that may only last a few minutes.

These waits in three of the prisons took place in holding cells. Several prisoners and staff described these as ‘grim’. One of the men’s training prisons was less restrictive and prisoners were offered appointment times. However, we observed these to be very ‘hit and miss’. There were particular difficulties for prisoners who did not work and who remained on the wings during the day as they had to be escorted to the health care department. It was easier in this prison for prisoners on work placements to attend health care as they did not require an escort.

We observed high non-attendance rates for general health care appointments in the four male prisons. The women’s prison, by contrast, had the least restrictive regime and the women prisoners were given greater responsibility in attending their appointments. There were also high non-attendance rates with the inreach teams in the four male prisons. Attendance was again much higher in the women’s prison.

Prisons with closed routes, such as the prison with vulnerable offenders, placed more restrictions on what times prisoners could be moved to and from health care. This meant that prisoners often had long stays in the health care holding cells, both before and after their appointments.

Non-attendance at mental health appointments, according to several prisoners, was often due to the fact that wing-staff and prisoners were not told the appointment times or to a shortage of staff to perform escort duties. Mental health staff were generally not informed in advance when escort staff would not be available to escort prisoners to their appointments. This was a particular problem for the inreach team serving the adult prisons as they were unlikely to be able to use their clinical time in another establishment without such warning.

On several occasions we observed prisoners arriving and having a wait in the holding cell only to learn that the clinic had been cancelled that day. They then had to wait until staff were available to escort them back.

Mental health – whose business?

Prison health care and inreach staff reported that on occasions there was a tendency to medicalise prisoners whom the regime found challenging. Both health care and inreach received referrals for clients who, in their view, did not have an identifiable mental health problem.

The prison staff we spoke to reported that they had little understanding of mental illness. Few of the staff we met had undergone any mental health awareness training. But there was a clear and unrealistic expectation among some health care staff, that the inreach services should “take responsibility for all prisoners with mental health problems”. There were similar findings in our review of London’s prison mental health services (Durcan & Knowles, 2006). The Sainsbury Centre believes that the mental wellbeing of prisoners is a whole prison responsibility and not just that of a small

specialist mental health team. But a lot of work needs to be done on developing mental health awareness among staff and changing their attitudes towards prisoners with mental health problems before this can happen.

Care versus custody

All prisons must provide a high level of security and vigilance for the safety and wellbeing of the staff who work in them, those imprisoned in them and the wider community. Punishments and incentives are important tools in the prison's armoury and are vital to its good order. When interviewing inreach staff, it was not the priority given to 'security' that was challenging in itself, but that on occasions its particular operation appeared unnecessarily inflexible (to those interviewed). They said it could at times be detrimental to the health of prisoners by interrupting or stopping courses of treatment.

One prison health care department applied 'punishments' to prisoners who failed to attend appointments. The 'punishments' were part of a prison-wide system and were essentially a 'three strikes and out' scheme. Once a prisoner achieved the third strike they lost privileges such as access to television. We witnessed this system in operation on several occasions. Non-attendance of inreach appointments was also being dealt with in this way, which the inreach team felt was inappropriate and sometimes counter-therapeutic. The prison has since agreed to end this practice with inreach patients.

Inattention to resettlement

It was fairly clear across all of the prisons that while the inreach teams did give consideration to what happened to a prisoner after their release; those prisoners not in contact with these services received very little support. Health care staff attempted to connect some prisoners with GPs, but for many prisoners the most they would receive was a card with the NHS Direct phone number.

It was our observation that the prisons as a whole gave relatively little attention to prisoners leaving the prison. While there were some resettlement schemes which attempted to address both accommodation issues and employment, prisoners with mental health problems appeared to be excluded from these. In the words of a manager of such a service:

"We are talking about a difficult to employ group (offenders)...adding mental health just makes it more difficult..."



Prisoners' views of their needs

Most prisoners were very modest in what they thought might best support them. Some prisoners had experience of mental health services in the community with which they could compare, but most had little or a very 'hit and miss' experience of mental health services.

'Someone to talk to'

When asking prisoners what they saw as being the best way to meet their needs more than three-quarters said something to the effect of "just having someone to talk to".

Few prisoners felt comfortable talking to the prisoners with whom they shared cells. There was more limited opportunity for 'private' conversations with prisoners who were not their 'pad-mates'. Many prisoners described a need to be guarded with other prisoners for fear that any vulnerability they reveal might expose them to bullying. Some of the prisoners we interviewed said that they disliked the prisoner officer staff on their wings or didn't trust them, but most said these staff simply didn't have enough time to talk at length with prisoners.

Many of the prisoners felt they had unresolved issues from their pasts, often linked to experiences of abuse – physical, sexual and of course emotional. For quite a few prisoners these 'unresolved issues' were "there in the background all the time". So, for at least some prisoners, "having someone to talk to" meant support in addressing these issues.

Planning for release

Quite a number of the prisoners we interviewed had the prospect of being released within a year of our conversation. Some of these had just weeks (even days in a small number of cases) until their expected release date.

Not surprisingly this was a major preoccupation for prisoners and a cause of considerable anxiety for many. Most of the men we spoke to had been in and out of prison several times and had experience of 'failure' i.e. re-offending, breaching licence conditions or returning to substance misuse. It was also a concern for these men that while their release was an important preoccupation for them; it did not appear to be one for the prison or for the criminal justice system.

For well over half the prisoners we interviewed, especially the men, preparation for, and support on, release was an important need. The sort of support they wanted included connecting with primary care services and mental health services. Most put accommodation and access to finance at the top of their list. Support with substance misuse was also deemed as crucial.

Most of the prisoners identified the first few days after leaving the prison as a critical period following release. A small number of prisoners felt that having someone to meet them on release was also important. For those who appeared to have the most pronounced substance misuse issues this was critical.

'Something to do'

The vast majority of prisoners wanted to be active during their time in prison. Those who attended education enjoyed it and those who attended work generally appreciated "having something to do", though for about half of these the work was monotonous. Most prisoners, including those with marked mental health problems, wanted to work and wanted it to be connected to the possibility of working outside.

Like people with mental health problems in the community, prisoners often see the most helpful 'interventions' as being those associated with activities of daily living rather than specific, mental health or psychological interventions. The latter were important too but often secondary.

Help in a crisis

As prisoners tended to have quite limited experience of mental health services it was possibly quite difficult for many of them to be precise about what specific interventions might help them. But many were precise about when they felt they needed help. A lot of prisoners felt the only time they got 'help' was in a crisis. Yet even getting help in a crisis was variable and particularly dependent on the time of day. Crises at night were the most difficult as there was no access to mental health professionals. In some of the prisons there was only access to any health care professional in extreme circumstances. Most prisoners did report being able to access a prisoner listener, but not all felt this was enough.

Therapy and medication

Prisoners on the two inreach teams' caseloads were more specific about the mental health interventions they needed and the role a mental health service might have in providing support.

They described the sort of 'talking therapies' they had found helpful and described what sounded like cognitive behavioural therapy and problem solving approaches among others. Several with a diagnosis of severe mental illness, such as psychosis and bipolar disorder, stated that they had been helped in recognising their symptoms and in identifying early signs and triggers related to a decline in their mental health.

Quite a number of those seeing inreach were on some form of medication. They appreciated receiving 'education' on medication and its effects, including side effects. Most reported that this was the first time any mental health professional had explained their medication. These prisoners also tended to feel a bit more in control of their medication, in that they felt they could talk about changing dosage or type of medication and have their views taken seriously.

Advocacy

A need many prisoners identified could be best summarised as advocacy or representation. Many prisoners appeared to feel powerless. They did not believe that they had much influence on decisions made about them. Those in contact with the inreach teams appreciated their attempt to represent their views and several were able to identify positive outcomes. Examples of this included: earlier preparation for their release, concerns over accommodation being addressed, medication being changed and contact with families being re-established.

Most prisoners, however, did not have access to this type of support and it was clear that advocacy of some sort was a need for many.



Conclusions

The reform of 'mainstream' mental health services was accompanied, in the most part, by detailed guidance and reference to the research evidence for each reform. Reform of prison mental health care, through the creation of inreach, did not have a research evidence base and was not accompanied by guidance.

The additional resource that went with these reforms was the most significant investment in prison mental health, probably ever. But it was never likely to be sufficient to address the needs of all of those with severe and enduring mental health problems, let alone the bulk of prisoners with more moderate problems.

Prison inreach

The introduction of inreach brought about a significant improvement in the mental health provision for the five establishments which were the focus of this study. This is true of other parts of the country too, but the picture is mixed. Recent evidence suggests that there are wide regional variations in funding for inreach services, with some spending twice as much per prisoner as others (Sainsbury Centre, 2008).

Inreach has been designed to serve those prisoners with severe and enduring mental health problems and while both the teams in this study had clearly broadened their scope, it was clear that most prisoners with mental health problems received little or no service.

Primary care

A significant gap in these establishments and many others (probably most) was in primary mental health care. Prison health care departments provide primary care services and while all five prisons' health care teams had mental health trained nurses at some point in the study, they either deployed them in a generic role or where there were attempts to allow specialisation this arrangement was vulnerable to staff shortage. This has been reported time and time again to us.

We have concluded that the generic nurse role does not serve prisoners with mental health problems well and that in every prison there should be access to dedicated mental health practitioners at the primary care level. The role of these practitioners is every bit as specialised and skilled as those of the inreach practitioner and would include provision of a 'crisis resolution' type response, rapid assessments, signposting, staff support and the ability to deliver short term evidence-based psychological interventions. Skills in working with prisoners labelled with personality disorder are crucial, as are skills for those with co-morbid problems (e.g. mental health and substance misuse).

problems). These practitioners might also have a role in supporting the resettlement of prisoners with more moderate mental health problems.

Both inreach and primary or prison health care tend to be mono-disciplinary, in that the profession that predominates is nursing. In contrast, we see a role for a variety of professions, disciplines and support staff. The prisoners we spoke to were often primarily concerned with ‘social’ aspects of their care (e.g. such as their housing post release) and access to agencies and professionals skilled in addressing these needs will be helpful.

Inpatient and day services

Only two of the prisons in this study provided inpatient care (24-hour enhanced health care). Prisoners incarcerated in these, and other similar units we have visited, lead a largely solitary existence with little in the way of meaningful activity to occupy them during the day. The vast majority of prisoners in inpatient care were located there because of concerns over their mental health. Inpatient care takes up considerable resource but provides a limited therapeutic regime beyond containment and observation.

Consideration needs to be given to increasing the day time therapeutic activity available to these prisoners and also extending access to day care to other prisoners with mental health problems.

While prisoners who had been in contact with a mental health inreach service reported a positive experience of it, even for this group the ‘mental health’ interventions were limited to when a much ‘stretched’ team could see them (often no more than once a week). Developing a day centre type service should increase both the opportunity to intervene with individuals and the number of individuals who could be supported.

Screening

Prisoners are a population with considerable health needs and have often neglected both their mental and physical health prior to coming into prison. Many prisoners have misused substances which has its own impact on health as well as masking symptoms. Screening for problems with health is therefore an important activity. Currently the model of screening is centred on a questionnaire-led interview at arrival (reception) to prison and is by and large a ‘one off’. This model is far from robust, as while prisoners may volunteer information at this point or later, there are many reasons why a prisoner may not: for example not wishing to expose vulnerability. Prison receptions are somewhat unpredictable and staff conducting them can have only limited time if more prisoners arrive than expected.

Equivalence

Policy on prison health care is currently predicated on the notion of equivalence, i.e. that prison health services be equivalent with those provided in the community (Department of Health & HM Prison Service, 2001). Prisons are not typical environments: indeed they hold quite atypical populations, with significantly higher concentrations of both physical and mental illnesses than the general population. Many misuse substances and suffer considerable social exclusion. In other words the ‘typical’ need in prison is a multiple one. For this reason careful consideration needs to be given to how the term equivalence is understood and applied. If it leads to simply replicating general community models of health care provision in prison then these are not likely to address this multiple need.

Our experience of visiting prisons, talking to prisoners and staff, is that while a prisoner may have a mental health problem at the ‘moderate’ level, this is just one of a number of vulnerabilities and issues. The ‘default’ for prisoners is to have a complex range of problems that interplay with each other. The type of service which will best be able to help a prisoner is one that takes a holistic view and one that is geared to address complexity.

The basics

The mental wellbeing of prisoners is not just the concern of mental health practitioners or indeed the NHS. When we discussed with prisoners their needs and what promoted their wellbeing, mental health specific interventions were of course mentioned but more basic and universal needs (e.g. housing, meaningful occupation, finance, friends and the opportunity to just talk about their concerns) were given greater priority. Most prisoners were more concerned about their futures and life post release. They wanted their time between now and then to be concerned with preparing them for release. It was frustrating for many prisoners that they felt that little in the way of such preparation was taking place.

The prisoners we spoke to were modest about how their needs might be met. Most stated that “having someone to talk to” was important to them and currently a rarity. The prisoners tended not to separate out their needs into categories such as ‘mental health’, ‘social’ and ‘physical’ and saw the meeting of one area of need as having a function in other areas. When we discussed their resettlement needs, prisoners did not necessarily see their being connected to a mental health service ‘on the outside’ or being registered with a GP as being a priority. From experience they knew that their most basic needs such as appropriate housing and access to adequate funds were vital. For those with histories of addiction the most immediate health need was support for this, as early as possible on release. This is not to say that prisoners did not think support from community-based mental health and health services was not important. The vast majority clearly did, but rather they viewed their needs in a hierarchical and entirely common sense fashion.

It struck us, just as it struck these prisoners, that there is not a whole ‘other’ set of rules or principles that need to be applied to prisoners with mental health problems. Prisoners, regardless of their mental health status, suffer from social exclusion, poor health, etc. Those with poor mental health have this on top of other vulnerabilities. Prisoners with or without mental health problems require ‘good care’ and management of their needs while in prison. On leaving, good quality resettlement is not likely to be that different for those with mental health problems than for those without them.

Preparation for release

From both this study and the visits we have made to many other prisons, it is clear that the degree to which a prison prepares those within it for release, or even thinks beyond the gate, is limited. Prisons, in spite of the creation of the National Offender Management Service (NOMS), remain in all practical terms disconnected from the outside world. Prison governors have little control and power beyond the gates and yet on a daily basis feel the pressure from the outside as more space within the prison estate is requested. Recent attempts to alleviate this pressure do little more than tinker around the edge of the problem and initiatives such as the early release scheme could even make things worse.

We spoke to a number of prisoners who had been released significantly earlier than they had originally expected, through tagging. The fact that we spoke to them suggests that tagging did not address their offending behaviour as they were once again in prison, through breach of conditions or through new offending behaviour. Each of these prisoners, though grateful at the time of their early release, felt that the early release had resulted in “even less planning than usual”.

Trauma

We spoke to 98 prisoners and many of these reported traumatic events in their past which clearly had and were having a significant impact on their lives. These events included torture, rape, physical and sexual abuse during childhood, and deaths of parents and siblings often at critical stages during their development. Very few of the prisoners we spoke to had received any counselling or support in living with trauma and yet such experiences evidently were taking a toll on their lives. To date this is a largely unexplored issue that requires more attention.

Transfers

Pressure on prison places means that many prisoners move within the prison system. It is our experience that this creates problems for both prisons and prisoners. The available care and health care skills mix varies between prisons and if, as our data suggests, many prisoners are re-categorised at an earlier stage in their sentence than they previously might have been (to create space in prisons that receive people straight from court) then some people will be moved to prisons that have not been geared up to meet their needs.

Prisoners' views

The study we conducted across the five prisons incorporated many different methods of data collection, but the single most useful method was talking with prisoners. Without our conversations with them we would not have been able to flesh out the level of need or have any real insight into their lives. The Sainsbury Centre believes this in itself is an important finding and that prisons and their mental and health care services need to recognise the valuable contribution that prisoner service users / experts by experience can make.

As stated in the foreword mental health is not the sole responsibility of mental health services. It is a community-wide responsibility. 'Recovery' in the wider community (i.e. that outside the prison) means engaging with many agencies in seeking the inclusion of people with mental health problems rather than excluding and segregating them.



Recommendations

This chapter makes recommendations for improving support for prisoners with mental health problems in England. It includes examples of innovative practice of which we are aware and which were operational during the time this report was being prepared.

Mental health awareness

Some mental health awareness training is being offered to prison staff, but clearly many prison staff have not yet received it. Given the volume of people with mental health problems in our prisons it is vital that greater efforts be made to provide good quality and ongoing awareness training to all prison staff.

Primary care

The most evident gap in prison mental health services is at the primary care level. Most prisons offer very little to prisoners who suffer mild to moderate mental health problems. There is a clear need to develop this area and develop a mental health practitioner role at this level. Currently many mental health trained nurses working in prison health care departments are expected to have a generic role and in practice more general health duties usually take pre-eminence over mental health ones. The primary mental health practitioner role is likely to be every bit as skilled as the inreach practitioner. Their functions would include the following:

- Supporting the screening for mental health problems;
- Carrying out more detailed assessment of all those identified with mental health problems;
- Working with a small caseload using brief interventions, e.g. cognitive behavioural therapy (CBT);
- Supporting the GP in medication reviews;
- Crisis assessment and support;
- Joint work with inreach services;
- Group work;
- Liaison with internal and external agencies.

HMP Liverpool – Mental health crisis service

This is a fledgling mental health crisis service consisting of one nurse dedicated to assessing people referred for some form of mental health crisis. The nurse provides a rapid assessment, very brief interventions, some follow-up work, onward referral and signposting to other services.

Stepped care

An adaptation of the ‘stepped care’ approach to managing mental health (Box 4) may have a lot to offer prison mental health care as this could emphasise the responsibilities and ‘interventions’ of all prison services, clinical and non clinical as well as signpost ‘next steps’ and referral routes for more serious problems.

Box 4: Stepped care

Stepped care is a system of delivering and monitoring treatments, so that the most effective, yet least resource-intensive, treatment is delivered to patients first. It is recommended in NICE guidelines as the method by which scarce resources should be most efficiently delivered, in order to provide accessible and effective treatments.

Such systems seek to enhance the efficiency of service delivery, by providing low intensity ‘minimal interventions’ to a proportion of patients in the first instance, before providing more intensive treatment to those who do not improve with the first step. Routine and scheduled monitoring of patient outcomes is a critical aspect of stepped care, allowing treatments to be stepped up, should this be required.

The most common ‘minimal interventions’ are those that are less dependent on the availability of therapists, and focus on patient-initiated use of evidence-based ‘health technologies’, such as books, video and audiotapes, computer programmes and internet sites. They are facilitated by new workers such as graduate mental health workers or existing workers with new roles, such as nurses, psychologists and counsellors. Other steps can include brief interventions, group interventions and one-to-one psychological therapy, all requiring different levels of psychological therapies skills, and a rich mix of appropriately trained personnel.

(CSIP North West Regional Development Centre, 2007)

HMP Liverpool – Primary care psychological interventions service

Five staff: psychologists, a nurse trained in CBT and two graduate workers, provide short term evidence-based interventions for those with mild to moderate problems and follow a stepped care model.

Screening

Prisons still struggle to identify mental health problems among prisoners on arrival. A major rethink about how health screening is done is required. Attempting to screen in busy reception areas clearly is not satisfactory. Prisons in this study found it difficult to organise follow-up screening.

HMP High Down – Well Man’s Clinic

A senior nursing assistant provides a follow-up clinic to all newly arrived prisoners (effectively a second stage screening), providing routine physical assessment (e.g. blood pressure monitoring), taking blood tests for further investigation and reviewing mental health and wellbeing. All prisoners are seen within 24 hours of arrival. The nursing assistant is overseen by qualified nursing staff. This service aims to identify any physical and mental health issues missed at reception.

Outreach

Consideration needs to be given to whether a more intensive outreach service model (reaching out to the prison wings) might better support many of those prisoners who currently are admitted to prison enhanced health care units (prison hospital wings) and whether the considerable resource that goes into this form of inpatient care is best value. Some prisons, outside the cohort reviewed in this study, have developed day care based facilities, based on the community mental health day centre model, and these can be used by a greater number of prisoners with mental health problems. Of course, some prisoners, albeit a minority, located in the inpatient units are there for physical illness / disability and will continue to require something equivalent to a hospital bed.

Seamless provision

Prisoners tend to have multiple issues and needs. Looked at individually, these often fall short of the entry criteria of services ('sub-threshold'). This means that although they are quite disabled by the totality of their issues, such prisoners may receive little help. There needs to be greater integration and collaboration between services and multi-agency forums for joint case management and information sharing. Working towards seamless provision should be the aim of all 'care' agencies within a prison.

Prison mental health care will require greater investment, but not necessarily just in mental health services. What is required most is greater integration between health, mental health, substance misuse, prison psychology, probation and resettlement and other agencies working within prisons.

HMP Liverpool – Single point of referral meeting

Staff from a variety of agencies (inreach, a GP, enhanced health care staff, dual diagnosis workers, forensic mental health, general psychiatry, court liaison, prison mental health crisis staff, and substance misuse staff) meet every week to discuss all recent referrals, allocate unassigned cases, review progress and agree joint working arrangements.

HMP Dovegate – piloting an ‘Interventions’ department

The primary mental health care, substance misuse, safer custody and prison psychology services are planning to combine into a ‘single service’ to increase joint working. The inreach service will join as a ‘virtual’ element of the new service. Each service will continue its individual function but the new model will improve communication. This will prevent duplication of work and ensure that prisoners with multiple problems, such as mental health problems and substance misuse, do not ‘fall into the gaps’ between services.

Resettlement

For the vast majority of prisoners, prison is just one part of a pathway along which they pass and services in prison need to be commissioned with this in mind. Rather than the commissioning of services at different parts of the pathway we need to be commissioning whole pathways. Prison needs to be seen as just a part of an ‘end to end’ managed system, where both entry and exit and life beyond the walls are catered for as well as the time within the walls. Therefore far greater priority needs to be given to the resettlement of all prisoners and of course those with mental health problems. This must prioritise the most basic ‘survival’ needs first and those issues or problems that are most likely to derail any resettlement process (e.g. appropriate accommodation and support for substance misuse problems). Women, children and young people may need specific provision for resettlement based on their particular needs.

HMP Winchester – Resettlement scheme for prisoners with mental health problems

Using additional ‘inreach’ funds provided in 2007, Mind Hampshire has been commissioned to conduct a three-year project supporting the resettlement of prisoners with mental health problems. This project will support prisoners with more moderate mental health problems as well as those with severe and enduring mental illness. The first year will consist of a scoping study, looking at the need for the service and how prisoner resettlement needs might be met. The findings of this scoping will define the priorities for the remaining two years.

Addressing trauma

There should be further research to understand the impact of psychological trauma on offenders. We also recommend that effective treatments for psychological trauma that have been developed in other settings should be adapted for use in prisons, and that these programmes should be evaluated to measure their effectiveness.

Listening to prisoners

As the Sainsbury Centre has learned in this study, prisoners can make a huge contribution to the understanding of their needs and problems and how these might be met. Forums that support and encourage this should be established across the secure estate. These should reflect the diversity in the prison population, in terms of age, gender, race, culture and sexual orientation.

In addition we would urge the development of expert peers and peer mentors and see these as making a valuable contribution to the Listeners' Schemes available in virtually all prisons across England and Wales.

HMP Styal and Liverpool – Mentoring scheme

HMP Styal and HMP Liverpool have until recently had a scheme provided by Impact (<http://www.kesa.ee/download/impactmentoring.pdf>) offering both employment guidance and mentoring training to prisoners with stable mental health problems. The mentoring training enabled prisoners to provide peer support to other prisoners. An employment guidance worker continued to provide support after the prisoners were released. Most of the prisoners taking part in the scheme subsequently found employment.

HMP Downview – Expert patients' pilot

A group of prisoners are being trained as 'expert patients' (and paid at £15 per week) to act as an extension of the mental health team in a support worker role, providing peer support and mentoring. The expert patients will have a role in engaging their peers with other services and work on motivation.

HMP High Down – BME engagement pilot and scoping study

A year long review of the mental health needs of Black and minority ethnic (BME) prisoners is about to report. This group form a significant part of the prison population but do not use health and mental health services proportionately. The evaluation will detail unmet needs and recommend methods for better engagement.



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