NATIONAL PRISONER HEALTHCARE NETWORK

MENTAL HEALTH SUB GROUP

IMPLEMENTATION REPORT

Post Consultation

April 2016

Contents

Table list

INTRODUCTION

This report sets out progress regarding the implementation of the recommendations contained within the National Prisoner Healthcare Network Mental Health Sub Group Report (NPHN, 2014). The Executive Summary of the original report is provided in **Appendix 1.**

This report has been prepared for the Advisory Board of the National Prisoner Healthcare Network for members to note progress to date and to consider future actions in respect of the mental health needs of the prisoner population. It is recommended throughout the report that NPHN Board and NPHN Office have an important role in monitoring the progress of these recommendations, through the implementation of a standard audit tool.

2. REMIT

After the initial workstream had presented its findings the NPHN Advisory Board asked that an implementation group should be established to support the introduction and development of the recommendations that had been made.

The remit of the implementation group was;

1. To agree what recommendations should be implemented and how this would be managed.

2. To prioritise actions to be implemented and agree a timeframe for implementation.

3. To agree a lead person and sub groups, for each recommendation.

4. To agree an implementation plan and expected outcomes for each group.

5. To co-ordinate the work of the individual groups and to develop a reporting structure for reference to the Mental Health Workstream and to the NPHN.

3. MEMBERSHIP

The membership of the group and the recommendation each member had responsibility to lead and take forward is set out in Appendix 2. The original mental health workstream membership continued to be available to those in the implementation group to act as a reference group as required.

PROGRESS AND ACTIONS

The group sought to identify progress and actions required against each of the recommendations within the 2014 NPHN Mental Health sub group report. The progress and actions required for each area of work are described below under section 5.

In addition, Table 3 (page 26 - 28) has been included to summarise the specific actions requested by the Implementation Group to support the recommendations from the 2014 NPHN Mental Health Report. In table 3, against each action, the agency or part of an organisation that will be required to take actions forward has been shown. It is recommended by the Implementation Group that consideration should be given to

establishing a monitoring and reporting process through the NPHN office to follow the implementation of these recommendations and actions.

4a. NEEDS ASSESSMENT

Recommendation 1
An updated national assessment of the mental health needs of prisoners should be carried out.

Progress
The group undertook a short exercise to consider the most appropriate means of undertaking a mental health needs assessment by looking at previous approaches and studies from within the UK and internationally. The detail of this exercise is described in **Appendix 3** and the various options are set out in Table 1.

Actions
The National Prisoner Healthcare Network Advisory Board should select and implement the most appropriate methodology from the options detailed below in conjunction with the Needs Assessment paper contained in **Appendix 3.**

Table 1 Options Appraisal of Respective Methodologies

Study	Title	Resource required	Cost (Estimate)	Advantages	Disadvantages
1	Clinical Survey e.g. Prevalence of psychiatric morbidity among remand prisoners in Scotland Davidson et al 1995	Psychiatrists conducting interviews equating to 1 Clinician time x 1 year Administration. Analysis and write up	£250k	Comprehensive. Specific. Gold Standard.	Cost Time to complete.
2	Survey e.g. Psychiatric morbidity among prisoners in England and Wales. Singleton et al 1997	Face to face interviews by a survey team with prisoners over a three month period in a number of different establishments Administration and write up	£200k	Specific to mental health disorders Use of comparative data with individuals in households	Cost Time consuming Engagement/ training of a survey team – not clinicians
3	Triangulation of existing data e.g. Prison Health in Scotland - a healthcare needs assessment Graham, L 2007	Researcher Part Time for six months Administration Analysis and write up	£50K	Specific to Scotland Short Time Frame	Generic - not specific to mental health Used existing data Pragmatic approach to data collection
4	Systematic Review and Meta-analysis e.g. Severe mental illness in 33 588 prisoners worldwide: systematic review and meta-regression analysis Fazel et al 2012	Not applicable	nil	Current reference source that we could continue to utilise as useful comparative data from a global perspective	Results may not be directly applicable to Scotland
5	SPS annual prisoner survey e.g. SPS 2013	Questionnaire A survey team	£50K	Specific to Scotland Good response	Relates to a point in time Limited number

		Administration and write up		rate (60% in 2013) Tried and tested approach to data collection in Scottish Prisons Credible and recognised as a source of robust prisoner information	of questions that may be added

Recommendation 2
ViSION should be utilised on a national basis to provide on-going data on prisoners' mental healthcare needs.

Progress
There is recognition that Vision is a primary care General Practionser IT System and as such will experience limitations in its application for secondary care purposes. It was concluded that ViSION is not fit for purpose regarding mental health. The actions set out below reflect this view.

There is variation across the prison estate in the use of Vision when recording consultations by visiting psychiatrists. Progress notes are added but detailed consultations require to be dictated, typed and logged onto the system. Individual arrangements are in place for this in some prisons but in others such systems are not available leading to a deficit in the medical records. There is no facility to store paper records of consultations.

The GP Clinical IT System is due to be retendered in the next two years.

Action
- All practitioners should use the Mental Health Guidelines on VISION pending development of a fit for purpose IT system.
- The specification for any new system should include the requirements to allow appropriate recording and analysis of clinical information for prison settings.
- The National General Practitioner Facilitators Group should consider the use of digital dictation or digital pen and paper (e.g. Livescribe) to solve the problem for mental health in the meantime in liaison with NHS Board Leads for Prisoner Healthcare.
- NHS Boards should ensure that systems are in place in all prisons for the adequate recording of clinical records. This should include access to administrative support.

4b. SERVICE MAPPING

Recommendation 1
A comparison exercise should be carried out between standard resources for community mental health teams and mental health teams in prisons which takes account of the greater psychiatric morbidity found in prisons, the prison environment and the combined primary, community and specialist services roles of the prison mental health team. Equivalence of provision between community and prison mental health services is important as is the development of services within prisons that meet the level of assessed need.

Progress
In undertaking a review of workforce models currently in place the group sought to look at examples from across Scotland. The group compared community workforce models, including the Forensic Community Mental Health Team workforce model adopted by NHS Greater Glasgow and Clyde (**Appendix 4**) and compared this to the resource available within the prison setting following transfer in 2011. This is summarised in **Appendix 4** and full details are available in Appendix 6 of the original NPHN Mental Health Report. The results demonstrate a significant difference in staff complements and skill mix. Prisoner mental healthcare is under resourced.

Though Health Boards offer a range of mental health workforce models applicable to different settings, the group recognised the absence of any current toolkit that could be used to determine the workforce associated with prisoner healthcare and that associated with the delivery of mental health services. The group would therefore suggest that there would be value in this being addressed under the auspices of Scottish Government who have supported the development of workforce planning tools for use in other areas of healthcare provision.

Action
The NPHN Advisory Board should request that Scottish Government develop a workforce planning toolkit for prisoner healthcare, including mental healthcare.

Recommendation 2
The Mental Welfare Commission Report on Prisons (2011) set out key messages for prisoner mental healthcare. These should be implemented.

Progress

Each of the NHS Boards is at varying stages in respect of their responses to these recommendations Individual Boards will provide detail of implementation to the National Prisoner Healthcare Network as part of their progress reporting through the audit tool that is being developed currently by the network.

Action
Health Boards should continue to apply and monitor the key messages and recommendations within the MWC report to help drive improvement of services to those experiencing mental health problems in prison.

4c. MODELS OF CARE

Recommendation 1
A model of a prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services should be adopted. Access to the appropriate level of service will depend on the tiered care model. Provision of services should be competency based.

Progress

This model is in place across the prison estate.

Initially an Education and Training sub group of the National Prisoner Healthcare Network was formed with the remit to consider and advise on the following;

- a suite of education and training options for services engaged in police custody and prisoner healthcare.
- frameworks for education and career progression for health professionals working in the prison environment,
- developing training and competencies for health operational staff working in the Scottish Prison Service and in Police Custody.

However there was a decision taken by the group looking at competencies not to continue with the development of a competency framework for all healthcare staff but instead to create a portal that would be managed by NES. This is other than for psychiatrists where The Royal College recommendations in respect of competencies have been accepted.

The portal was developed to have a suite of training and learning resources that are identified through collaboration between NES and the professional lead nurse for the National Prisoner Healthcare Network. The School of Forensic Mental Health develops and provides educational courses and materials in conjunction with NES and NPHN to meet the identified needs. .

Action
Accept competencies recommended for psychiatrists, develop a suite of training resources through a learning portal managed by NES and School of Forensic Mental Health to support multidisciplinary competency development.

Recommendation 2
Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.

Progress
A joint working model is in place in some prisons. There is input on an as required basis by Addiction Psychiatrists to prisons. There is marked variation in practice across prisons.

Action
Each health board should be asked to identify a mechanism for formal liaison between mental health and addiction services in its prisons.
See section 4.g on comorbidity.

Recommendation 3
Develop a standardised process for family and carers to liaise with a prisoner mental health team.

Progress
Signpost developed – see **Appendix 5**.

Action
A standard signpost available for family and carers to liaise with prison mental health teams to be adopted by each prison healthcare team (Appendix 5).

Recommendation 4
Prison mental healthcare standards should be developed and audited.

Progress
Standards for prison mental health care have been published by the Royal College of Psychiatrists (2015). See **Appendix 6**.

Action
It is recommended that the standards for prison mental health care published by the Royal College of Psychiatrists (2015) (Appendix 6) are adopted by the Advisory Board and that health boards are asked to engage in this process.

Recommendation 5
The prison mental health team should be multidisciplinary and planning should be carried out to provide guidance on the membership of a team. This workforce planning should delineate the composition of an appropriate prison mental health team allowing for prison population, mental disorder prevalence rates, any updated needs assessment, environment challenges, and the tiered care approach to mental disorder.

Progress
Multi-disciplinary mental health care team has been delineated as far as possible by the needs assessment stream.

Action
NHS Boards should ensure that a full multi-disciplinary team is available in prisons as set out in **Appendix 1**, section 3.

Recommendation 6
There should be an overview of the tools required to assure fitness to practice including:

- Competency Framework for healthcare staff
- Education and Training Framework for health and operational staff.

Progress
There was a decision taken not to continue with the development of a competency framework but instead to create a portal managed by NES. A suite of training resources are identified through collaboration between NES and the professional lead nurse for the National Prisoner Healthcare Network. The professional lead nurse will also establish links with the Forensic Network and the Police Custody Network to ensure learning resources suitable for their needs are included in the portal.

Adopt recommended learning resources
Increase awareness of educational and training resources in liaison with the Forensic Network, School of Forensic Mental Health and the Police Custody Network. Develop quarterly meetings between the professional nurse for the National Prisoner Healthcare Network and NES to ensure the learning portal is up to date and relevant.

Recommendation 7
Joint Governance arrangements between NHS Scotland and the Scottish Prison Service for the management of mental health provision should be defined.

Progress
Following discussion it was agreed that as prison health care is entirely the responsibility of the NHS that local health board governance arrangements should be utilised.

Action
Each health board should ensure that their governance arrangements have been extended to include prison health care.

Recommendation 8
A National Prison Mental Healthcare Steering Group should be established to oversee this model and standard building work.

Progress
Steering Group in place via the implementation group. This is a short life working group. The Scottish Prison Service would welcome the opportunity to participate.

Action
The Advisory Board should establish a monitoring and reporting process through the NPHN office to follow the implementation of these recommendations and actions.

4d. LEARNING DISABILITY

Recommendation 1
There should be an awareness raising initiative concerning learning disability within Scottish prisons. This is the starting point for working to meet healthcare needs and provide people with learning disabilities and staff in prisons with the support that they require.

Recommendation 2
"Learning Disability awareness" training should be provided to SPS staff, initially targeting new staff.

Recommendation 3
Screening should be introduced into Scottish Prisons for adults with learning disability (AWLD). This will allow recognition of needs and identify individuals with "learning difficulties". The use of the Learning Disability Screening Questionnaire should be considered.

Progress against Recommendations 1, 2 and 3
Awareness raising and training: Prison Officer Learning Disability and Difficulty awareness training has taken place in the three Forth Valley prison establishments. There are plans to reduce its length from two days to 90 minutes.

Screening: The "Do-It Profiler", a computer based assessment tool **(Appendix 7)** is being piloted by the SPS in the 3 NHS Forth Valley establishments at the present time. The "Do-It Profiler" tool does not provide screening for LD per se, BUT as part of a thorough assessment will flag up prisoners with complex needs, allowing such individuals to be more formally assessed for LD *and* learning difficulties. The learning disability subgroup considered that this may be better than superficially screening all prisoners. The cognitive component required to screen for learning disability was not originally included but this has just been rectified. An evaluation will be undertaken to determine if the tool will be useful across the prison estate.

Action
All new SPS staff should have learning disability AND learning difficulty training as part of their core induction programme - NPHN Advisory Board should monitor the progress of this intervention.

The evaluation of the "Do-It Profiler" tool should be tracked and reviewed. This is to be taken forward by Jim King, SPS head of offender learning.
NPHN Advisory Board to monitor the progress of this intervention. If this is unsuccessful, the NPHN Advisory Board should revisit the use of a screening tool.

Recommendation 4
Formal liaison between health staff in prisons and community /forensic LD services should be established. There is also an important role for the Forensic Network and other organisations, e.g. Association of Real Change (ARC) in terms of promoting best practice and sharing resources / training, materials (especially with regard to modified therapeutic treatment programmes).

Progress
Formal liaison for prisoners with LD: Directory of LD services (**Appendix 8**) is now available for SPS staff. This will allow staff within establishments to informally contact a professional from a prisoner's local LD service if required. The Forensic Network Clinical Forum is open to all clinical and prison service staff.

Action
The Directory of Learning Disability Services should be updated annually by the Forensic Network Office and placed on the Forensic Network website.

Recommendation 5
A *short-life* working group should be established to take forward the above recommendations; to re-visit the comprehensive "No One Knows" recommendations (**Appendix 9)**; to work closely with colleagues from NHS Greater Glasgow and Clyde on their project to address prison healthcare for AWLD; and to develop links with Scottish Consortium for Learning Disabilities with regard to their impending research into People With Learning Disabilities in the Scottish criminal justice system.

Progress
This recommendation was reviewed by the learning disability sub group.
The NHS Greater Glasgow and Clyde Prison Healthcare Project for People with Learning Disability Final Report was published in 2014. It included a 16 week screening pilot study in its 3 prisons and found ten individuals with learning disability, in other words a low prevalence rate – see tables 1-3. Its 18 recommendations are similar to those found in "No One Knows".

Table 2 - HMP Barlinnie

Forms reviewed	2042
Referrals generated	227 = 11.11%
PWLD Identified	7 = 0.34% of all forms reviewed 3.08% of referrals screened

Table 3 - HMP Low Moss

Forms reviewed	426
Referrals generated	69 = 16.19%
PWLD Identified	2 = 0.46% of all forms reviewed 2.89% of referrals screened

Table 4 - HMP Greenock

Forms reviewed	116
Referrals generated	12 = 10.34%
PWLD Identified	1 = 0.86% of all forms reviewed 8.30% of referrals screened

The NPHN-Mental Health Report recommendations on learning disability were addressed as above. The need to develop a consistent plan for the development of services for people with learning disabilities in custody was recognised. Some of the current developments have been disconnected. The "No One Knows" recommendations, progress and actions are listed in **Appendix 9.**

Action

The "No One Knows" actions listed in **Appendix 9** should be tracked by the NPHN Advisory Board.

4e. ADVOCACY

Recommendation 1
All prisons should have an independent Advocacy Service for prisoners with mental disorders. Responsibility for this rests jointly with the local health board and local authority.

Progress
The group undertook a Scoping Exercise to establish the status of advocacy services.

From the responses received and discussions with prison health care managers, all prisons provide some level of access to Independent Advocacy provision. However, the term advocacy is utilised within prisons in a variety of ways and not solely as set out under the Mental Health (Care and Treatment) (Scotland) Act 2003. It was not possible to determine if every prisoner has their statutory obligation met and consequently the group concluded that an incomplete picture of Independent Advocacy provision still remains.

Clarity on the security and continuity of funding was highlighted as a predominant issue and funding arrangements still remain extremely variable. There was also no indication of specific funding from the Local Authorities.

There were clear examples of good practice, particularly from HMP Kilmarnock, HMP Perth and HMP Addiewell. This highlighted an opportunity for the possible development of a model of implementation and for good practice to be shared. As this is an operational responsibility, there are opportunities to network this good practice at national operational forums and within the newly developed Advocacy Forum for Advocacy agencies working within the prison environment.

Action
Health Boards should set out their provision of advocacy under the Mental Health (Care and Treatment) (Scotland) Act 2003 within their local prison(s) and the process for advertising.

4f. PROBLEM BEHAVIOURS

Recommendation 1
A problem behaviour service should be developed within Scottish Prisons in line with the Serious Offender Liaison Service in the Community. It should work jointly with the forensic psychology service in prisons.

Recommendation 2
The mentalisation based service for female offenders should be evaluated and extended to male services if appropriate. It is recognised that this is one of a range of potential interventions for people with personality disorder.

Progress
This is a longer term undertaking and a group has been established to meet these aims chaired by Dr Jon Patrick, Consultant Forensic Psychotherapist, NHS Lothian and Dr Judi Bolton, Clinical Psychologist, NHS Greater Glasgow and Clyde. A draft pathway has been agreed by the group.

The evaluation of Mentalisation Behaviour Therapy (MBT) for female offenders in HMP Edinburgh is ongoing. A proposal to extend MBT to male offenders is being developed.

Actions
The Board is asked to note the progress with these recommendations and to support and monitor the ongoing work of this group.

4g. COMORBIDITY: Mental illness or Learning Disability and Substance Misuse

Recommendation 1
Services will require clear, cohesive and consistent operational and clinical policies for the management of prisoners with dual diagnosis (mental illness or learning disability plus substance misuse).

Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.

Progress
Operational and clinical policies for the management of prisoners with dual diagnosis are not in place. A joint working model is in place in some prisons. There is input on an as required basis by Addiction Psychiatrists to prisons. There is marked variation in practice across prisons.

Action
Health Boards should produce clear, cohesive and consistent operational and clinical guidelines for the management of prisoners with comorbid mental health and substance misuse problems.

Recommendation 2
There needs to be an agreed, evidence-based process for the prompt assessment and recognition of co-occurring substance misuse and mental health problems within prisons.

Progress
The feedback from practitioners delivering services was that a validated screening tool would be helpful in assessing the degree/severity of comorbid mental health and substance misuse problems. However, any screening tool used should be part of a comprehensive assessment. The Maudsley Addiction Profile (MAP) is a validated tool for assessing the severity of comorbid mental health and substance misuse problems. The MAP has been used in a number of prison settings in this context. The MAP is free to use, as is the Treatment Outcomes Profile (TOP) which is a cut down MAP which has been used by the National Drug Treatment Monitoring System for prisons by Public Health England.

Action
NHS Boards and prison health centres should arrange for those identified at reception as having comorbid mental health and substance misuse problems to have the severity of these conditions assessed using a validated screening tool such as the Maudsley Addiction Profile or the Treatment Outcome Profile where appropriate. Such screening tools should be used as part of a comprehensive assessment to inform future management plans.

Recommendation 3
To improve care for people with dual diagnosis within prison, it is imperative that improvements be made in the way that mental health and substance use services interface. Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.

Progress
In order to support NHS Boards to deliver this recommendation from the original report we were of the opinion that NHS Boards must ensure provision of integrated care pathways to address both mental health and substance misuse problems via a single practitioner. Health Centre Managers reported that management of those identified with comorbid mental health and substance misuse problems can vary depending upon the resources available in the clinical team. After the initial assessment at reception some establishments are able to offer an integrated management approach through a single practitioner while others are not.

Action
Each health board should be asked to identify a mechanism for formal liaison between mental health and addiction services in its prisons.

Recommendations 4 and 5
There is evidence that integrated care is best practice for people with dual diagnosis. This entails that workers should be skilled and competent in providing comprehensive care. It is recognised that workers in mental health and substance use services often lack the skills and confidence to provide this care. This is also likely to be the case within the prison service. Therefore, staff must have an adequate working knowledge of the issues that are pertinent to dual diagnosis.

Progress

We were of the opinion that delivery of recommendations 4 and 5 from the original Mental Health report should be facilitated by NHS Staff involved in service provision to those identified as having comorbid mental health and addictions issues undertaking and completing the 'Co-occurring Substance Misuse and Mental Health' e-learning module available to NHS staff though the CPD menu of LearnPro.

Actions
Practitioners should also complete , 'Core Behavioural and CBT Skills for Relapse Prevention and Recovery Management', which includes a focus on developing an integrated approach to addressing co-occurring substance misuse and mental health, based on evidence-based interventions when it becomes available as an e-learning module.

Recommendation 6
There should be consultation between the NPHN working groups on mental health and substance misuse to ensure that all recommendations are consistent.

Progress
Cross-membership between the Mental Health Implementation Group and the Substance Misuse Workstream was put in place to ensure that a consistent approach to the management of these conditions is achieved.

Action
Not required

4h. TELEMENTAL HEALTH

Recommendation 1
As outlined in the Review of Telemental Health (2009) videoconferencing (VC) has been extensively used in mental health services across the world, notably in the USA, Canada and Australia. Clinical applications include the complete patient age range and a very broad range of clinical settings. These include emergency and mental health act assessments, standardised psychological testing and a variety of therapies and treatments.
Based on this evidence we would recommend the use of VC for the following
To improve access to a range of specialist MH and Learning Disability services
To improve access to a range of specialist clinical services
To improve access to staff training. For example, **substance misuse** and the **New to Forensic Course**
To facilitate both supervision and mentoring

Recommendation 2
Telephone services – by providing prisons with improved access to secure telephony, a range of **guided self-help and CBT services** should be offered to increase access to the psychological therapies, such as those offered by NHS 24

Recommendation 3
Online MH Services – as more MH services are designed to be delivered via computerised technology these should be developed and tested specifically for the prison population. For example, NHS Tayside and Forth Valley currently hold licences for the **computerised CBT (cCBT)** system which is used in general psychology services in these regions. Forth Valley provides **50% of its CBT by computer** and this is well received by patients and GPs.

Recommendation 4
Digital TV Platform – work is ongoing to develop a Prison TV Channel in HMP Shotts. This will be a good opportunity to test if this medium can be used to provide Mental Health information and services. Other health information such as smoking cessation, weight management and long term condition information should also be developed.

Recommendation 5
Internet Broadcasting and Podcasts – **digital media** should be used to improve access to a range of training and education for staff and patients. We should work with a variety of stakeholders to ensure we exploit this technology to its full potential.

Recommendation 6
It may be possible to deliver some specialist services to the SPS on a regional or national basis. This would provide **economies of scale** for example Out of Hours (OOH) service provision. This is the model used in Airedale NHS Trust where significant saving has been achieved.

Recommendation 7
SCTT will develop an implementation plan for the above recommendations. This will address the financial implications of these recommendations and include an evaluation plan for the proposed interventions.

Progress
The Board is asked to note the progress made in provision of telemental health resources to prisons set out in Table 4. This contains recommendations for further provision. The Board is asked to note that the role of Service Development Manager, Scottish Centre for Telehealth & Telecare has been discontinued. A meeting was held with the Medical Director of NHS 24 to discuss who will provide the essential ongoing leadership. A joint meeting between NHS 24 telemental health and SPS is being facilitated in January 2016.

Action
Health boards should review the e-health provision and recommendations for its prisons as set out in Table 4 and take this forward as required.
NHS 24 Telemental Health to develop bid to Scottish Government to provide consistent services across all prisons.
SPS to provide leadership on access and organisation of telemental health services across all prisons.
NPHN Office to monitor telemental health service development.

TABLE 5
Telehealth Services across Scottish Prisons
Scottish Centre for Telehealth & Telecare – April 2015

NHS Board/Prison	Services	Description of services & Recommendations	Contacts
NHS Ayrshire & Arran HMP Kilmarnock	Telephone CBT from NHS 24 now live Videoconferencing (VC) services in development	Referrals can be made to NHS 24's Telephone CBT Service - Living Life Recommendation - the prison should develop services using the new VC unit that was purchased and installed in the prison health centre.	Craig.stewart@aapct.scot.nhs.uk Tony.mclaren@nhs24.scot.nhs.uk
NHS Greater Glasgow & Clyde HMP Greenock	Videoconferencing (VC) services in development to link Forensic Physician to HMP Greenock for weekend admissions	NHS Jabber software being installed on all prison healthcare PC's to facilitate VC consults with Forensic Physician and meetings. Recommendation - the new Jabber software is used to link up all 3 prisons in GG&C and used to increase access a range of specialist services such as Teleneurology.	jayne.miller3@nhs.net brucehenderson@nhs.net
NHS Lanarkshire HMP Shotts	Videoconferencing (VC) services in development. Mental health content for new prison TV channel in development Telephone CBT services in development With NHS 24	Recommendation - that MH services are developed for the prison in line with those from the report from the Mental Welfare Commission e.g. access to psychological services.	Paul.o'neill@nhs.net Tony.mclaren@nhs24.scot.nhs.uk p.horn@nhs.net
NHS Lothian HMP Addiewell HMP Edinburgh	Videoconferencing (VC) services established.	VC used to deliver weekly input to prison healthcare meetings to HMP Edinburgh	alex.quinn@nhslothian.scot.nhs.uk

		Recommendation - that services such as CBT/clinical support should be developed using the new VC unit that was purchased for HMP Addiewell by the SCTT.	
NHS Tayside HMP Perth HMP Castle Huntly	Videoconferencing services established for Teleneurology from Ninewells Hospital, Dundee to HMP Perth Telephone CBT services in development with NHS 24	VC used to deliver monthly epilepsy services from Consultant Neurologist and Epilepsy Specialist Nurses in Ninewells Hospital Further recommendations include: Rolling out the new epilepsy service from Perth Royal Infirmary so that more patients can have an epilepsy review/management. Service developments currently underway - to explore Beating the Blues using CD's on the prison PC's as a stand alone service to Perth & Castle Huntly. **Recommendation – to improve access to the psychological therapies for the prison population. If this work (Beating the Blues via CD's) is successful it could be rolled out across other prisons in Scotland and would address the issues of equivalence and equity to these services.**	i.morrison@nhs.net jacquirobertson@nhs.net airlie.dewar@nhs.net anne.joiner@nhs.net diane.perera@nhs.net Alison.peaker@nhs.net tony.mclaren@nhs24.scot.nhs.net for Tel. CBT @ NHS 24

4i. COMPETENCIES

Recommendation 1
NPHN should adopt the competencies listed for psychiatrists working in prisons as a national standard for NHS Boards.

Progress
In place and available on Forensic Network Website. See **Appendix 10**.

Action
Complete.

Recommendation 2
NPHN should await the outcome of the NES Education and Training sub group to support those working in prisons and police offices.

Progress

Initially an Education and Training sub group of the National Prisoner Healthcare Network was formed with the remit to consider and advise on the following;

- a suite of Education and Training resources for services engaged in police custody and prisoner healthcare.
- frameworks for education and career progression for health professionals working in the prison environment,
- developing training and skill set for health operational staff working in the Scottish Prison Service and in Police Custody.

However there was a decision taken not to continue with the development of a competency framework for other disciplines but as part of the work of the above subgroup a portal has been created which is managed by NES. The group has subsequently completed work and has now been replaced with quarterly meetings between the Programme Director from NHS Education for Scotland and the professional Nurse Lead for the NPHN who in collaboration identify training requirements and learning resources for each of the relevant work streams.

The professional lead nurse will also establish links overtime with the Forensic Network, School of Forensic Mental Health and the Police Custody Network to ensure learning resources suitable for their needs are included in the portal.

The NES Knowledge Network portal has been developed to support practitioners working in prison and police custody healthcare. This was launched at the end of June 2014. Various educational resources are contained within this portal.

The Portal has been updated with the following resources which will support the mental health agenda;

1. See, Think, Act: Relational Security,
2. Motivational Interviewing,
3. Introduction To Trauma,
4. Emotion Matters,
5. The 10 Essential Shared Capabilities for Mental Health Practice,
6. Mental Health Care and Treatment Act,
7. Respecting and Protection Adults at Risk in Scotland,
8. Dementia Skilled – Improving Practice, and

9. Informed about Dementia DVD – Improving Practice.

Action
The Advisory Board is asked to note the changes shown above and to promote the collaboration between the NHS Boards, NES, the School of Forensic Mental Health and the three Networks; National Prisoner Healthcare, Police Custody and Forensic.

Additional information added to the list populated on the NES portal over time will also be publicised through the National Prisoner Healthcare Network and Forensic Network websites which will be used as sources of information on all matters of prisoner healthcare.

Recommendation 3
NPHN should develop competencies for all healthcare staff working with offenders. Training should be provided and practice standards agreed and monitored.

Progress
Guidance from NHS Education for Scotland suggested that a competency framework would potentially be difficult to implement and consequently underutilised. It was therefore agreed that a suite of learning resources more appropriately meets the needs of those working in prisoner healthcare and police custody rather than competencies being developed. An infrastructure has been put in place between the NPHN and NHS Education for Scotland to ensure resources are identified and made available.

Action
Adopt recommended learning resources
Increase awareness of educational and training resources and educational requirements of the Forensic Network and the Police Custody Network by including them in quarterly meetings between the professional nurse for the National Prisoner Healthcare Network and NES to ensure the learning portal is up to date and relevant.

4j. PLACEMENT OF PRISONERS

Recommendation 1
To consider the placement of prisoners, including the flow of information to, from and between prisons.

Progress
SPS is undertaking a policy review of the management and guidance of prisoner transfers.

Action
Health Boards should note the progress of the SPS policy review of the management and guidance of prisoner transfers and implement, support and monitor the impact of this work.
NPHN Office to monitor progress.

Recommendation 2
To examine the links with other NPHN work streams.

Progress
A review of the national Memorandum of Understanding (MOU) between NHS and SPS is currently being undertaken. The outcome of this review will be tabled at a future NPHN Advisory Board.

Action
Health Boards should review their existing information sharing arrangements in relation to the management of prisoner transfers including the guidance within the national Memorandum of Understanding and Information Sharing Protocol (ISP).

5. Summary of Required Actions

Table 5 summarises the actions required to complete the recommendations from the original 2014 NPHN Mental Health Report. Overlap recommendations between areas of work are identified.

ACTIONS REQUIRED TO SUPPORT RECOMMENDATIONS FROM NPHN MENTAL HEALTH 2014 REPORT	BY WHOM
NEEDS ASSESSMENT	
1. The National Prisoner Healthcare Network Advisory Board should select and implement the most appropriate needs assessment methodology from the options set out in section 4.and the Needs Assessment paper contained in **Appendix 3;** and determine a mechanism to progress this.	NPHN Advisory Board NHS Boards
2. All practitioners should use the Mental Health Guidelines on VISION pending development of a fit for purpose IT system. • The specification for any new system should include the requirements to allow appropriate recording and analysis of clinical information for prison settings. • The National General Practitioner Facilitators Group should consider the use of digital dictation or digital pen and paper (e.g. Livescribe) to solve the problem for mental health in the meantime in liaison with NHS Board Leads for Prisoner Healthcare. • NHS Boards should ensure that systems are in place in all prisons for the adequate recording of clinical records. This should include access to administrative support.	NHS Boards National GP Facilitators Group NHS Boards
SERVICE MAPPING	
1. The NPHN Advisory Board should request that Scottish Government develop a workforce planning toolkit for prisoner healthcare, including prisoner mental healthcare.	NPHN Advisory Board
2. Health Boards should continue to apply and monitor the key messages and recommendations within the MWC report to help drive improvement of services to those experiencing mental health problems in prison.	NHS Boards
MODELS OF CARE	
1. Accept competencies recommended for psychiatrists, develop a suite of training resources through a learning portal managed by NES and School of Forensic Mental Health to support multidisciplinary competency development.	NHS Boards
2. Each health board should be asked to identify a mechanism for formal liaison between mental health and addiction services in its prisons. See section 4.g on comorbidity.	NHS Boards
3. A standard signpost available for family and carers to liaise with prison mental health teams to be adopted by each prison healthcare team (Appendix 5).	
4. It is recommended that the standards for prison mental health care published by the Royal College of Psychiatrists (2015) (Appendix 6) are adopted by the Advisory	NHS Boards

Board and that health boards are asked to engage in this process. 5. NHS Boards should ensure that a full multi-disciplinary team is available in prisons as set out in **Appendix 1**, section 3. 6. Adopt recommended learning resources. Increase awareness of educational and training resources in liaison with the Forensic Network, School of Forensic Mental Health and the Police Custody Network. Develop quarterly meetings between the professional nurse for the National Prisoner Healthcare Network and NES that ensure the learning portal is up to date and relevant. 7. Each health board should ensure that their governance arrangements have been extended to include prison health care. 8. The Advisory Board should establish a monitoring and reporting process through the NPHN office to follow the implementation of these recommendations and actions.	NPHN Advisory Board/NHS Boards NHS Boards NHS Boards Prison/ Healthcentre Managers/ NPHN Professional Nurse NHS Boards NPHN Advisory Board
LEARNING DISABILITY	
1, 2 & 3 All new SPS staff should have learning disability and learning difficulty training as part of their core induction programme. NPHN Advisory Board to monitor the progress of this intervention. The evaluation of the "Do-It Profiler" tool should be tracked and reviewed. This is to be taken forward by Jim King, SPS head of offender learning. NPHN Advisory Board to monitor the progress of this intervention. If this is unsuccessful, the NPHN Advisory Board should revisit the use of a screening tool. 4 The Directory of Learning Disability Services should be updated annually by the Forensic Network Office and placed on the Forensic Network website. 5 The "No One Knows" actions listed in **Appendix 9** should be tracked by the NPHN Advisory Board.	SPS NPHN Advisory Board
ADVOCACY	
1. Health Boards should set out their provision of advocacy under the Mental Health (Care and Treatment) (Scotland) Act 2003 within their local prison(s) and the process for advertising this across Scotland.	NHS Boards
PROBLEM BEHAVIOURS	
1&2. The Board is asked to note the progress with these recommendations and to support and monitor the ongoing work of this group.	NPHN Advisory Board

COMORBIDITY	
1. Health Boards should produce clear, cohesive and consistent operational and clinical guidelines for the management of prisoners with comorbid mental health and substance misuse problems. 2. NHS Boards and prison health centres should arrange for those identified at reception as having comorbid mental health and substance misuse problems to have the severity of these conditions assessed using a validated screening tool such as the Maudsley Addiction Profile or the Treatment Outcome Profile where appropriate. Such screening tools should be used as part of a comprehensive assessment to inform future management plans. 3. Each health board should be asked to identify a mechanism for formal liaison between mental health and addiction services in its prisons. 4. & 5. Practitioners should complete 'Core Behavioural and CBT Skills for Relapse Prevention and Recovery Management', which includes a focus on developing an integrated approach to addressing co-occurring substance misuse and mental health, based on evidence-based interventions when it becomes available as an e-learning module.	NHS Boards NHS Boards NHS Boards Prison health centre managers
TELEMENTAL HEALTH	
1. Health boards should review the e-health provision and recommendations for its prisons as set out in Table 3 and take this forward as required. NHS 24 Telemental Health to develop bid to Scottish Government to provide consistent services across all prisons. SPS to provide leadership on access and organisation of telemental health services across all prisons. NPHN Office to monitor telemental health service development.	NHS Boards/ NHS 24/ SPS/ NPHN
COMPETENCIES	
1. The Advisory Board is asked to note the changes shown above and to promote the collaboration between the NHS Boards, NES, the School of Forensic Mental Health and the three Networks; National Prisoner Healthcare, Police Custody and Forensic. 2. Additional information added to the list populated on the NES portal over time will also be publicised through the National Prisoner Healthcare Network and Forensic Network websites which will be used as sources of information on all matters of prisoner healthcare. 3. Adopt recommended learning resources. Increase awareness of educational and training resources and educational requirements of the Forensic Network and the Police Custody Network by including them in quarterly meetings between the professional nurse for the National Prisoner Healthcare Network and NES to ensure the learning portal is up to date and relevant.	NPHN Advisory Board
PLACEMENT OF PRISONERS	
1. Health Boards should note the progress of the SPS policy review of the management and guidance of prisoner transfers and implement, support and monitor the impact of this work. NPHN Office to monitor progress.	NHS Boards

2. Health Boards should review their existing information sharing arrangements in relation to the management of prisoner transfers including the guidance within the national Memorandum of Understanding and Information Sharing Protocol (ISP).	NHS Boards

Appendices

Appendix 1

EXECUTIVE SUMMARY

NATIONAL PRISONER HEALTHCARE NETWORK

MENTAL HEALTH SUB GROUP

February 2014

Report

The responsibility to deliver primary and community healthcare to prisoners in Scotland transferred from the Scottish Prison Service (SPS) to NHS Scotland on 1 November 2011. The National Prisoner Healthcare Network (NPHN) was formed and established ten work streams to address issues around prisoner healthcare.

TERMS OF REFERENCE

The Mental Health working group was established to consider the mental health needs of the prison population

Inclusions

- all forms of mental disorder, including learning disabilities and personality disorder
- all prisons and prisoners in Scotland (including young offenders and private sector)

Exclusions

- Mental health services provided outwith prisons in Scotland

MEMBERSHIP

The membership reflects the geographical, professional, managerial and service backgrounds of those working in prison mental health.

MEETINGS

The NPHN Mental Health Sub Group met monthly and had nine meetings in total.

The NPHN Mental Health Working Group reported directly to the NPHN. It provided monthly highlight reports to the NPHN team.

OBJECTIVES and COMMENT

The aim of the group is to create a mental health and learning disability service within prisons where the provision of care for prisoners is equivalent to the care received for people in the community.

The following specific objectives were set:

1. Needs Assessment
To review the current literature on the mental health needs assessment of prisoners in Scotland.

To develop a methodology for initial and on-going mental health needs assessment and care planning of prisoners.

The literature was reviewed and a table of prevalence studies in Scottish Prisons prepared. The last needs assessment of prisoner mental healthcare was carried out fourteen years ago and up to date information is required for the planning of services. The current database within prisons would allow the collation of only basic data for on going needs assessment to be gathered.

2. Service Mapping
To map the provision of mental health services currently provided within Scottish Prisons.

A service mapping exercise was carried out which found marked variation in the provision of nursing and psychiatric sessions for each establishment. These findings appeared to be based on largely historical factors rather than on any true assessment of need.

3. Model of Care and Service Provision
To develop a model of care that will improve mental health services to prisoners and make them equivalent to those found in the community.

To lead and co-ordinate the development of mental health services for prisoners that build on examples of good practice of multi-disciplinary and multi-agency working within Scotland, the UK and internationally.

At present the mental health teams in prison are not truly multidisciplinary, representative of mental health services found elsewhere in the NHS or designed to meet the level of need in the populations they serve.
The group identified a range of issues relating to the required services that should be considered when developing models of care from prisoners. These include:

- Acceptance of the principle of equivalence of provision of prison mental health services with those provided in the community
- Recognition that the prevalence of mental disorder and the experience of trauma in the prison population is in excess of that found in the community
- Acknowledgement of the need for partnership working.
- Health and social care provision in prisons is the joint responsibility of both Justice and Health and therefore any mental health model of care must be constructed to include the governance arrangements that need to be in place to ensure both parties understand and operate within the boundaries of their responsibilities.
- Recognition of the range and complexity of mental disorders in the prison population and the need for services for prisoners with mental illness, learning disability, drug and alcohol problems, comorbidity and personality disorders /

problem behaviours. Compounding the challenge of developing appropriate models of care is the wide ranging needs of the prisoner population which is dispersed across the 16 prison establishments in Scotland. This includes the young offender population and an ageing cohort.

- There was acceptance of the principle that those with major mental disorder should be cared for in hospital rather than prison. An audit of transfer to hospital from prison found that sixteen of the twenty-two patients involved were transferred within 3 days of referral (Fraser, Thomson and Graham, BMJ 2007).
- The need for in reach work by Community Mental Health Teams where geographically possible for existing patients or those likely to require ongoing care on release
- The need for throughcare arrangements that link prisoners to services in the community.
- Recognition of the challenges of the prison environment to the effective care for those with mental disorders is essential. The physical environment and the prison rules are necessary to maintain order and safety of all concerned. However they can present challenges: examples of this may include access to patients, or conflict between the provision of mental health treatment and security, such as when prescribing psychotropic medication. For these reasons regular dialogue between healthcare and prison management will be necessary to enable appropriate planning and delivering of services.
- The need to increase support for self-help approaches: through the chaplaincy service, listener scheme or access to tele-mental health packages.
- Potential for the use of modern technology to provide telehealthcare
- Adoption of a health promoting and prevention approach – consistent with 2020 Vision
- The need for workforce planning to delineate the composition of an appropriate prison mental health team, allowing for prison population, mental disorder prevalence rates, environmental challenges, and the tiered care approach to mental disorder.
- Recognition of lack of clinical psychology input in prisons but presence of forensic psychologists.
- Consideration of the overlap between risk assessment, offending behaviour work and mental health interventions and respective roles of forensic psychologists, prisoner programmes staff and mental health teams.
- Requirement to assess the educational needs of prison operational staff and provision of educational packages to meet these needs

Having considered these issues, the following components were considered essential to a successful model of prisoner mental healthcare:

1. A prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services. Access to the appropriate level of service will depend on the tiered care model. Provision of services will be competency based.
2. Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.
3. The prison mental health team should have the following components: mental health, addictions and learning disability nursing staff, general practitioners, psychiatrists, allied health professionals such as occupation therapists, social workers and clinical psychologists. In addition, within a prison setting input from prison governors, operational staff, forensic psychologists, third sector providers and chaplaincy would be expected.
4. The team should be cohesive and the wider roles of team members found in the community should be fulfilled: for example, supervision, service development, leadership, education and advocacy.

5. Mental health nurses should be used for that role alone and not wider general physical health duties.
6. Psychological input should be provided on a tiered basis as set out in the Psychological Matrix. This is competency based.
7. Standards for prison mental healthcare should be developed and services inspected.
8. The working methods of a prison mental health team should include:
    - Screening
    - Referral system to prison mental health team
    - Standardised assessment, including diagnosis and formulation
    - Treatment planning
    - Use of condition specific integrated care pathways
    - Access to psychological therapies: using a matched step care approach and offering a range of modalities e.g. self-help, telemental health, individual therapy
    - Access to programmes that cover both clinical and criminogenic needs, such as substance misuse
    - Throughcare
    - Access to independent advocacy
    - Liaison with family and carers with regards to information sharing.
    - Liaison with relevant third sector organisations.

4. Comorbidity

To consider the needs of those with co-morbid mental health and substance misuse problems.

Approximately 75% of prisoners have a drug misuse problem and a similar percentage a problem with alcohol misuse. There is a significant overlap between the population with a mental illness and learning disability, and those with substance misuse. At present mental health and substance misuse services in prisons are organised separately.

5. Telemental Health

To review the use of tele-mental health services in prisons for the delivery of psychological therapies, preparation of court reports, urgent assessments and peer support / training.

The Scottish Centre for Telehealth and Telecare (SCTT) has successfully demonstrated the potential for use of video conferencing in prisons for clinical care, training and supervision; and the potential use of NHS 24 psychological based programmes on a telecare platform. This would help to address the problem of lack of psychological treatment within prison.

6. Competencies

To develop agreed core competencies for mental health staff working in prisons (linked to the generic competencies being developed for offender health).

To develop first aid mental health training for officers and non-mental health NHS staff to raise awareness and build capacity in mental health competencies within prisons.

Competencies have been developed for psychiatrists working in prison. The police custody health group is currently developing a competency framework for healthcare staff in police custody settings. In addition, a New to Forensic Programme on Managing Medical Conditions in Custody is being developed, and the New to Forensic: Essentials in Psychological Care will be published soon. This is a complementary programme to the New to Forensic Programme.

7. Placement of Prisoners

To consider the placement of prisoners, including the flow of information to, from and between prisons.
To examine the links between other NPHN workstreams such as throughcare.
To consider the transfer and transport (including care of prisoners during transport) of prisoners.

The SPS has a national process for all establishments to follow when transferring prisoners to another prison. The process ensures all significant and relevant information (including health care) is obtained, considered and recorded as part of the decision making process prior to transferring the prisoner. Issues of prisoner placement arose during the Group's discussions, chiefly concerning the placement of prisoners, their movement within SPS and the flow of information with them as they move around the SPS estate. In addition, some concerns were raised about the suddenness of some transfer and the means of transportation of prisoners. The importance of throughcare was fully recognised.

Note
These issues have been identified but are not addressed within this report.

8. Safety of Visiting Staff

To consider the safety of visiting staff and to review the arrangements made for them.
The SPS national guidance agreed between National Partners sets out the principles that all SPS establishments should follow when utilising Non-Operational staff in an operational environment. The guidance provides a framework for Local Partners to work within and allows for such local flexibilities as may be required to meet service needs. NHS Greater Glasgow and Clyde has a working group which is considering the safety of visiting staff to prisons. A questionnaire has been circulated

Note
Given the on going work on these issues at this time, the Working Group has therefore not specifically addressed these.

9. National Guidance

To ensure that revised national guidance is provided by Scottish Government to support NHS Boards to follow a consistent process to access forensic health facilities for prisoners who have been resident in a prison within another health board area for more than 6 months. Responsible Commissioner Guidance document NHS HDL (2004) 15.37.

Note
This guidance was issued on 05th March 2013.

Recommendations

1. Needs Assessment

- An updated national assessment of the mental health needs of prisoners should be carried out.

- ViSION should be utilised on a national basis to provide on-going data on prisoners' mental healthcare needs.

2. Service Mapping

- A comparison exercise should be carried out between standard resources for community mental health teams and mental health teams in prisons which takes account of the greater psychiatric morbidity found in prisons, the prison

environment and the combined primary, community and specialist services roles of the prison mental health team. Equivalence of provision between community and prison mental health services is important as is the development of services within prisons that meet the level of assessed need.
- The Mental Welfare Commission Report on Prisons (2011) set out key messages for prisoner mental healthcare. See Appendix 7. These should be implemented.

3.1 Models of Care and Service Provision

- A model of a prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services should be adopted. Access to the appropriate level of service will depend on the tiered care model. Provision of services should be competency based.
- Mental Health and Addiction Teams within prisons need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.
- Develop a standardised process for family and carers to liaise with a prisoner mental health team.
- Prison mental healthcare standards should be developed and audited.
- The prison mental health team should be multidisciplinary and planning should be carried out to provide guidance on the membership of a team. This workforce planning should delineate the composition of an appropriate prison mental health team allowing for prison population, mental disorder prevalence rates, any updated needs assessment, environment challenges, and the tiered care approach to mental disorder.
- There should be an overview of the tools required to assure fitness to practice including:
- Competency Framework for healthcare staff
- Education and Training Framework for health and operational staff.
- Joint Governance arrangements between NHS Scotland and the Scottish Prison Service for the management of mental health provision should be defined.
- A National Prison Mental Healthcare Steering Group should be established to oversee this model and standard building work.

Recommendations

- A model of a prison mental health team that bridges the divisions found in the wider society between primary and community mental health teams, and specialist services should be adopted. Access to the appropriate level of service will depend on the tiered care model. Provision of services should be competency based.
- The prison NHS mental health and addictions provisions should be amalgamated to form one team.
- Develop a standardised process for family and carers to liaise with a prisoner mental health team.

Learning Disability

- There should be an awareness raising initiative concerning learning disability within Scottish prisons. This is the starting point for working to meet healthcare needs and provide people with learning disabilities and staff in prisons with the support that they require.

- "Learning Disability awareness" training should be provided to SPS staff, initially targeting new staff.

- Screening should be introduced into Scottish Prisons for adults with learning disability (AWLD). This will allow recognition of needs and identify individuals with "learning difficulties". The use of the Learning Disability Screening Questionnaire should be considered.

- Formal liaison between health staff in prisons and community /forensic LD services should be established. There is also an important role for the Forensic Network and other organisations, e.g. Association of Real Change (ARC) in terms of promoting best practice and sharing resources / training, materials (especially with regard to modified therapeutic treatment programmes).

- A *short-life* working group should be established to take forward the above recommendations; to re-visit the comprehensive "No One Knows" recommendations; to work closely with colleagues from NHS Greater Glasgow and Clyde on their project to address prison healthcare for AWLD; and to develop links with Scottish Consortium for Learning Disabilities with regard to their impending research into People With Learning Disabilities in the Scottish criminal justice system.

Independent Advocacy

- All prisons should have an independent Advocacy Service for prisoners with mental disorders. Responsibility for this rests jointly with the local health board and local authority.

Problem Behaviours

- A problem behaviour service should be developed within Scottish Prisons in line with the Serious Offender Liaison Service in the Community.

- The mentalisation based service for female offenders should be evaluated and extended to male services if appropriate. It is recognized that this is one of a range of potential interventions for people with personality disorder.

Co-morbidity

- Services will require clear, cohesive, and consistent operational and clinical policies for the management of prisoners with dual diagnosis (mental disorder and substance misuse).

- There needs to be an agreed, evidence-based process for the prompt assessment, and recognition of co-occurring substance misuse and mental health problems within prisons.

- To improve care for people with dual diagnosis within prison, it is imperative that improvements be made in the way that mental health and substance use services interface. Mental Health and Addiction Teams across services and agencies need to work together in managing dual diagnosis. In some NHS areas amalgamation of services may be appropriate.

- There is evidence that integrated care is best practice for people with dual diagnosis. This entails that workers should be skilled and competent in providing comprehensive care. It is also recognised that workers in mental health and substance use services often lack the skills and confidence to provide this care. This is also likely to be the case within the prison service. Therefore, staff must have an adequate working knowledge of the issues that are pertinent to dual diagnosis.

- Given that staff need to be skilled and competent in both mental health and substance use assessment and interventions, there will be a need to raise the levels of competence of the workforce, facilitating joint working between substance use and mental health.
- There should be consultation between the NPHN working groups on mental health and substance misuse to ensure that all recommendations are consistent.

5. Telemental Health

- As outlined in the Review of Telemental health (2009) videoconferencing (VC) has been extensively used in mental health services across the world, notably in the USA, Canada and Australia. Clinical applications include the complete patient age range and a very broad range of clinical settings. These include emergency and mental health act assessments, standardised psychological testing and a variety of therapies and treatments.
  Based on this evidence we would recommend the use of VC for the following
  - To improve access to a range of specialist MH and Learning Disability services
  - To improve access to a range of specialist clinical services
  - To improve access to staff training. For example, **substance misuse** and the **new to forensic course**
  - To facilitate both supervision and mentoring

- Telephone services – by providing prisons with improved access to secure telephony a range of **guided self-help and CBT services** should be offered to increase access to the psychological therapies, such as those offered by NHS 24.

- Online MH Services – as more MH services are designed to be delivered via computerised technology these could be developed and tested specifically for the prison population. For example, NHS Tayside and Forth Valley currently hold licences for the **computerised CBT (cCBT)** system which is used in general psychology services in these regions. Forth Valley provides **50% of its CBT by computer** and this is well received by patients and GPs

- Digital TV Platform – work is ongoing to develop an **Alcohol Brief Intervention (ABI) and CBT** for this platform. When ready, this should be tested in the prison environment as many prisoners now have access to a digital television. Other health information such as smoking cessation, weight management and long term condition information should also be developed.

- Internet Broadcasting and Podcasts – **digital media** should be used to improve access to a range of training and education for staff and patients. We should work with a variety of stakeholders to ensure we exploit this technology to its full potential.

- It may be possible to deliver some specialist services to the SPS on a regional or national basis. This would provide **economies of scale** for example Out of Hours (OOH) service provision. This is the model used in Airedale NHS Trust where significant saving has been achieved.

- SCTT will develop an implementation plan for the above recommendations. This will address the financial implications of these recommendations and include an evaluation plan for the proposed interventions.

6 Competencies

- NPHN should adopt the competencies listed for psychiatrists working in prisons as a national standard for NHS Boards.

- NPHN should await the outcome of the NES Education and Training sub-group, to support those working in prisons and police offices, review of competencies for staff working with offenders.

- NPHN should develop competencies for all healthcare staff working with offenders. Training should be provided and practice standards agreed and monitored.

Placement of Prisoners

- NPHN should await the report from the throughcare working group and consider if any specific work on mental health issues is required on this, or the other issues listed above, at that time.

8 Safety of Visiting Staff

- NPHN should await the report from NHS Greater Glasgow and Clyde working group on the safety of visiting staff to prisons and consider if any further action is required. A questionnaire has been circulated as outlined in Appendix 12.
- Any safety concerns should be addressed immediately with the staff present and reported to the relevant prison Governor.

9 National Guidance

- Guidance was issued on 5th March 2013 and resolves the issue of NHS Board responsibility for transfer to psychiatric hospital depending on the location of prisons.

Appendix 2 - Membership

Dr Melanie Baker	Consultant Forensic Psychiatrist	HM Prison Barlinnie (NHS GG&C)	Models of Care Lead
Tom Byrne	National Prisons Pharmacy Advisor	Healthcare Improvement Scotland	Comorbidity Lead
Jane Cantrell	Programme Director	NHS Education Scotland	Competencies
Dr Fergus Douds	Consultant Learning Disability Psychiatrist	The State Hospital	Learning Disabilities Lead
Cathy Dorrian	Service Development Manager – National MH Programme	NHS 24	Telemental Health Lead
Rosemary Duffy	Clinical Manager	HMP Glenochill	Learning Disabilities Support
Louise Hammell	Public Health Officer	NHS Forth Valley	Joint Advocacy Lead
Tom Jackson	Chief Officer	Glasgow Community Justice Authority	Advocacy Lead
Lesley McDowell	Health Strategy & Suicide Prevention Manager	Scottish Prison Service	Telemental health & placement of prisoners
John Porter (co-chair)	National Prisoner Nurse Advisor	Healthcare Improvement Scotland	Competencies/Needs Assessment & Service Mapping Lead & Co-Chair
Craig Stewart	Clinical Service Manager for Adult Community Mental Health Services (ACMHS) & Prison Healthcare	HMP Kilmarnock	Placement of Prisoners Lead
Dr Nicola Swinson	Consultant Forensic Psychiatrist	The State Hospital	Problem Behaviours Lead
Professor Lindsay Thomson (Chair)	Medical Director	The State Hospital & Forensic Network	Chair

Appendix 3 – Needs Assessment Options Paper

NATIONAL PRISONER HEALTHCARE NETWORK (NPHN)

MENTAL HEALTH WORKSTREAM

MENTAL HEALTH - NEEDS ASSESSMENT OPTIONS PAPER

Introduction

At the point of its inception the NPHN created a number of workstreams to consider specific aspects of prisoner healthcare needs. A mental health workstream was set up with membership from across Scotland with expertise in mental health and prisoner healthcare. The workstream made a number of recommendations one of which was the formation of a second group who prepared outline implementation plans for use by NHS Boards locally.

A further recommendation was that a full mental health needs assessment required to be undertaken.

Specifically the workstream recognised that;

It had been a number of years since an assessment of prisoner mental healthcare needs had been conducted and as a consequence up to date information was required for the effective planning of services.

The workstream recommended in its final report that;
It is important to carry out a national needs assessment of prisoners' mental health to find an accurate and up to date baseline and that there was a need to;

> *Review current literature on the mental health needs assessment of prisoners in Scotland, and*
> *Develop a methodology for initial and on-going mental health needs assessment and care planning of prisoners.*

In response to this recommendation a number of recognised texts were sourced both from within the UK and internationally. These were considered in respect of the methodologies that were applied and the advantages and disadvantages of each approach. An estimate of the cost of applying these methodologies, should the Advisory Board support such a commission, was then calculated. This paper summarises this information for consideration by the National Prisoner Healthcare Network Advisory Board to enable them to decide on how best to proceed with the recommendation to pursue a needs assessment based on the recommendation of the workstream.

Literature Search

A literature search revealed a fairly limited number of studies and exercises that had been conducted into mental health needs assessments of prisoners. Each previous study or exercise sourced selected has been described in this paper in terms of its aims, methodology, results and conclusions. A table has been constructed showing the respective advantages and disadvantages of the methodologies applied in each approach. Additionally an estimate of the cost of the exercise and the time and resource that would potentially be required has been given to enable the Advisory Board to make a choice appropriate to current needs and available resources. The Advisory Board may decide that the data available from the previous studies described in this paper is sufficient for their needs at this time or that a study that can be correlated with data from previous studies is an option.

Those selected that have been included in this paper for consideration are;

1. PREVALENCE OF PSYCHIATRIC MORBIDITY AMONG REMAND PRISONERS IN SCOTLAND.

M Davidson, M S Humphreys, E C Johnstone, D G Owens 1995

Background
Determining the prevalence of psychiatric disorders among remand populations has been made a priority in England and Wales. Differences in legal process and psychiatric services in Scotland make similar research there important.

Method
Demographic data were collected on 389 prisoners, the clinical Interview Schedule was completed and cognitive function assessed. Interviews were conducted by 12 psychiatrists across 9 prison establishments and lasted 20 to 30 minutes. Participation in the interviews was on a voluntary basis, in addition medical records of non volunteers were also assessed.

Results
The prevalence of major psychiatric disorders was low however there was evidence of a extensive use of mental health resources by the population interviewed Less severe symptoms were more common with higher incidences of depression, depressive ideas and anxiety than the population of a general practice. The sample was of average IQ, but low educational attainment. Reported drug and alcohol abuse was high.

Conclusions
Few of those interviewed required hospital care, but other symptoms and drug-related problems may place heavy demands on prison medical and psychiatric services.

2. PSYCHIATRIC MORBIDITY AMONG PRISONERS IN ENGLAND AND WALES.

Singleton, N., Meltzer, H. & Gatward, R. (1998) London: Office for National Statistics.

Background

The Survey of Psychiatric Morbidity among Prisoners in England and Wales was commissioned by the Department of Health in 1997. It aimed to provide up-to-date baseline information about the prevalence of psychiatric problems among male and female remand and sentenced prisoners in order to inform policy decisions about services. Wherever possible, the survey utilised similar assessment instruments to those used in earlier surveys to allow comparison with corresponding data from the OPCS/ONS surveys of individuals resident in private household, institutions catering for people with mental health problems, and homeless people (see SNs 3560, 3585 and 3642 respectively). In addition the survey aimed to examine the varying use of services and the receipt of care in relation to mental disorder and to establish key, current and lifetime factors which may be associated with mental disorders of prisoners.

Methodology

The study included prisoners aged 16 to 64 years in all prisons in England and Wales during October to December 1997. The samples chosen for the survey were male remand, male sentenced and female prisoners and included those who had been in prison both for less than 12 months, which accounted for 60% of the survey and those who had been in prison for more than 12 months which equated to 40% of the survey.

In total 3563 prisoners were interviewed. Data was collected by Face-to-face interview and transcription of existing materials where data was also obtained from (a) medical records - first reception health screening form and prescription charts, and (b) Local Inmates Directory System (LIDS).

Conclusions

The main factor associated with the presence of significant neurotic symptoms was the number of stressful life events respondents had experienced. The odds of having significant levels of neurotic symptoms increased with the number of stressful events until the odds for those who reported 11 or more such events were 18 times those for respondents who had not experienced any stressful events.

Also, victimisation during the current prison term was associated with twice the odds of having significant neurotic symptoms compared with those who had not been victimised. Hazardous drinking in the year before coming to prison was associated with the type of household people were living in, their employment status, previous convictions and stressful events relating to these factors: homelessness, being sacked or made redundant, breakdown of marriage and running away from home.

The odds of being dependent on drugs in the year before coming to prison were six times greater for those who were living off crime than for those who were working before coming to prison. Other factors associated with drug dependence before prison were previous criminal convictions, having been expelled from school, having run away from school, homelessness and serious money problems.

3. PRISON HEALTH IN SCOTLAND - A HEALTHCARE NEEDS ASSESSMENT

L Graham 2007

Background
The national strategy for the Management of Offenders was launched in 2006 .The statutory bodies of Community Justice Authorities, in partnership with other agencies, were tasked with taking the lead on its delivery. The nine Offender Outcomes outlined in the strategy reflect the central belief that better health and wellbeing can contribute to a reduction in the rate of re-offending. Such a contribution is ambitious and complex but must offer, co-ordinate and sustain services to support people who are normally hard to reach and who have multi-layered needs.
Decisions on policy development, planning and delivery of health care require to be based on up-to-date, robust and comprehensive information on the health needs of the population being served. The previous comprehensive review of prisoner health in Scotland was over four years prior to the assessment undertaken by L Graham and it was considered to be both desirable and timely to undertake a further review at that time.

Aim
To contribute to the evidence base for the planning and provision of health and health care for Scottish prisoners.

Objectives
- To describe the population of Scottish prisoners and their health problems
- To make comparisons with the health of the general Scottish population.
- To compare with the health problems of prisoners elsewhere in the UK
- To describe the services and health care standards designed to meet the need for health care.
- To describe current service provision.
- To identify gaps and how to address them

Methodology
This assessment utilised epidemiological, comparative and corporate methods. As there was a requirement for reporting in a relatively short time frame, a pragmatic approach to data collection was taken, using the most up-to-date existing data possible. Where necessary, this was supplemented with primary data analysis. Assessment of data quality was also made. The findings were then triangulated
Where information gaps existed, these could be substituted or extrapolated from other appropriate sources. It also allowed data validation between differing sources. This then allowed an overall picture to be constructed and inferences to be drawn.
The decision as to which clinical areas to study was agreed through discussion within the Health and Care Directorate and was based on what were thought to be areas of greatest concern. Thirteen 'domains' were selected, Alcohol Problems, Tobacco Use, Drug Problems , Blood Borne Viruses, Asthma, Diabetes, Epilepsy, Coronary Heart Disease, Accidents and Injury, Sexual Health, Dental Health, Dyspepsia and Mental Health.

For each domain, a series of prevalence indicators were devised along with matching prescribing indicators.

Results In Respect Of Mental Health

14% of prisoners had a history of psychiatric disorder, with the highest prevalence of 36% in HM Prison, Shotts.

0.6% of Scottish prisoners overall were recorded as having schizophrenia and 0.2% with bi-polar disorder.

0.4% of prisoners were recorded as having anxiety/depression.

7.3% of prisoners had a previous history of self-harm, including attempted suicide, ranging from 23% in HM Prison, Inverness and 0% in HM Prison, Castle Huntly.

A snapshot from PR2 in May 2007 showed 67 (0.9%) prisoners were on ACT2Care (at risk of suicide or self-harm), with the greatest proportion in HM Prison, Cornton Vale (2.7%) Table Ten (see p35). 12.2 In 2004, there were 140 recorded attempts at self-harm and 26 attempted suicides, a fall from levels in 2002 of 328 and 83 respectively [21].

19% of prisoners self reported feeling depressed on a daily basis, 25% felt unhappy and 24% did not feel hopeful about the future [17]. 12.3

In 2006, there were 45 transfers under the Mental Health Act (Scotland) 2003, nine more than in the previous year. This Act came into force in October 2005.

Conclusions In Respect Of Mental Health

It was not possible to determine a global figure for the prevalence of mental health problems in Scottish prisons. G-PASS recorded 14% of prisoners as having a history of psychiatric disorder. Low prevalence rates were noted for specific diagnoses such as schizophrenia (0.6%), bi-polar disorder (0.2%) and anxiety/ depression (0.4%). These rates contrast markedly when triangulated with other data sources and with corporate views on the burden of mental health problems in Scottish prisons. A large study of prisoners in England found rates of schizophrenia 20 times that of the general population (eg 9% male remand/36% female remand), higher rates of depression (overall one in four compared with one in 20 in the general population) and very high levels of personality disorder (approximately two out of three prisoners overall). Anxiety levels were similar to that in the general population (at approximately 10%). It would therefore

be expected that rates of mental health problems would be broadly similar in Scottish prisoners. This is supported by high levels of prescribing of drugs for specific mental health problems, ie depression and psychosis. One drug for depression was prescribed at rates 10 times that in the community and another for psychosis at 20 times the community rate. There, however, must be caution in absolute direct comparison due to differing prescribing preferences.

Deaths from suicide are relatively low and have fallen over the past few years. Transfers under the Mental Health Act(s) have risen slightly in the previous few years to a rate of just under one per week. A recent audit [3] showed evidence of acutely mental ill people being admitted to prison, and evidence of some delays in finding a hospital bed. On the whole, however, most patients were cared for timeously. A recent internal audit of cases on MDMHT files reported 480 patients, approximately 1 in 15 of all prisoners.

Services and strategies have been implemented over the past few years to address suicide and self-harm. These have proved very successful. Although screening for suicide and self-harm takes place from the moment of admission, less evident is the efficacy of screening for mental health problems. Following the launch of the SPS Positive Mental Health Policy in 2002 [4], multi-disciplinary mental health teams are in place in every prison, along with specialist mental health nurses. However, there is evidence of delays in referral for initial assessment, delivery of a limited range of interventions, limited advocacy services, and that throughcare on release is not always planned. Although there is an established forensic service, from both psychiatrists and psychologists, these are geared to the assessment of and addressing risk. Provision of services such as psychological (the talking) therapies are very limited. The limited snapshot of MDMHT case load (1 in 15 prisoners) would suggest that service provision is not fully matching need.

A more in-depth needs assessment of mental health problems should take place.

4. SEVERE MENTAL ILLNESS IN 33 588 PRISONERS WORLDWIDE: SYSTEMATIC REVIEW AND META-REGRESSION ANALYSIS

Seena Fazel, Katharina Seewald 2012

Background

High levels of psychiatric morbidity in prisoners have been documented in many countries, but it is not known whether rates of mental illness have been increasing over time or whether the prevalence differs between low–middle-income countries compared with high-income ones.

Aims

To systematically review prevalence studies for psychotic illness and major depression in prisoners, provide summary estimates and investigate sources of heterogeneity between studies using meta-regression.

Method

Studies from 1966 to 2010 were identified using ten bibliographic indexes and reference lists. Inclusion criteria were unselected prison samples and that clinical examination or semi-structured instruments were used to make DSM or ICD diagnoses of the relevant disorders.

Results

The systematic review identified 109 samples including 33 588 prisoners in 24 countries. Data was meta-analysed using random-effects models, and the researchers found a pooled prevalence of psychosis of 3.6% (95% CI 3.1–4.2) in male prisoners and 3.9%

(95% CI 2.7–5.0) in female prisoners. There were high levels of heterogeneity, some of which was explained by studies in low–middle-income countries reporting higher prevalences of psychosis (5.5%, 95% CI 4.2–6.8; *P* = 0.035 on meta-regression). The pooled prevalence of major depression was 10.2% (95% CI 8.8–11.7) in male prisoners and 14.1% (95% CI 10.2–18.1) in female prisoners. The prevalence of these disorders did not appear to be increasing over time, apart from depression in the USA (*P* = 0.008).

Conclusions
High levels of psychiatric morbidity are consistently reported in prisoners from many countries over four decades. Further research is needed to confirm whether higher rates of mental illness are found in low- and middle-income nations, and examine trends over time within nations with large prison populations

5. SPS ANNUAL PRISONER SURVEY

Background
Mental Health & Well-being Prisoners were asked questions on mental health by way of an instrument known as the Warwick-Edinburgh Mental Wellbeing Scale.

The Survey is focused intentionally upon the core elements of prison life: living conditions, family contact, healthcare, relationships and atmosphere. The Survey also seeks views on such issues as perceived safety, bullying, drug use and mental health. As it is completed in a relatively short timeslot it purposely avoids detailed questions on complex issues.

Methodology

The Survey is distributed to all prisoners and all establishments within Scotland. In this sense, the exercise is a census. The survey has been run since 1990 and in 2013 achieved an overall prisoner response rate of 60% (n=4137). Of these, 94% were male and six per cent were female. The majority of respondents were Scottish (88%), with a minority of respondents stating they were from another ethnic background. The 2013 Survey fieldwork covered the period May to June 2013. Establishments were given the option either to distribute the questionnaires or have the research team do so. Prior to these visits, posters were displayed in prominent areas in the prison informing prisoners and staff of the Survey and the day it would take place in their establishment. The evening prior to the Survey, each prisoner was given a leaflet informing them of the Survey and its aims. On the day of the Survey, prisoners were issued with a survey form by a member of the Survey Team or prison staff. After being given the chance to complete the questionnaire in the privacy of their cell, the completed forms (sealed in an envelope) were personally collected by a member of the Survey Team or prison staff. This methodology helped ensure that when handing out the forms each prisoner was given a brief explanation of why the Survey was taking place and had an opportunity to ask questions.

The survey was translated in to 6 other languages and interpreters were used on the day of the survey to capture information.

Results

As many as 85% reported 'I've been able to make up my mind about things', 79% said they were thinking clearly, and 77% said they were 'dealing with problems well'

OPTIONS APPRAISAL OF RESPECTIVE METHODOLOGIES

Study	Title	Resource required	Cost (Estimate)	Advantages	Disadvantages
1	Clinical Survey e.g. Prevalence of psychiatric morbidity among remand prisoners in Scotland Davidson et al 1995	Psychiatrists conducting interviews equating to 1 Clinician time x 1 year Administration. Analysis and write up	£250k	Comprehensive. Specific. Gold Standard.	Cost Time to complete.
2	Survey e.g. Psychiatric morbidity among prisoners in England and Wales. Singleton et al 1997	Face to face interviews by a survey team with prisoners over a three month period in a number of different establishments Administration and write up	£200k	Specific to mental health disorders Use of comparative data with individuals in households	Cost Time consuming Engagement/ training of a survey team – not clinicians
3	Triangulation of existing data e.g. Prison Health in Scotland - a healthcare needs assessment Graham, L 2007	Researcher Part Time for six months Administration Analysis and write up	£50K	Specific to Scotland Short Time Frame	Generic - not specific to mental health Used existing data Pragmatic approach to data collection
4	Systematic Review and Meta-analysis e.g. Severe mental illness in 33 588 prisoners worldwide: systematic review and meta-regression analysis Fazel et al 2012	Not applicable	nil	Current reference source that we could continue to utilise as useful comparative data from a	Results may not be directly applicable to Scotland

				global perspective	
5	SPS annual prisoner survey e.g. SPS 2013	Questionnaire A survey team Administration and write up	£50K	Specific to Scotland Good response rate (60% in 2013) Tried and tested approach to data collection in Scottish Prisons Credible and recognised as a source of robust prisoner information	Relates to a point in time Limited number of questions that may be added

Conclusion

This paper has been prepared to enable the Advisory Board to consider a number of previous approaches to data collection that may be applied when determining the best options for the mental health needs assessment that has been recommended by the Mental Health Workstream.

The aim of this exercise is to ensure we are ultimately better able to determine appropriate resources to meet service needs both now and in the future.

The Advisory Board may decide either to utilise the information that can be derived from the studies shown, such as that described by Fazel which is relatively recent, 2012 or to apply one of the methodologies previously applied such as Singleton in 1997 where a team of researchers interviewed directly 3563 prisoners. Alternatively a combination of approaches to collate fresh data could be used using an exercise similar to that of Graham in 1997 and comparing it with the data sourced by Fazel.

Appendix 4 - Workforce Comparisons

a. Forensic Community Mental Health Team

Forensic Community Mental Health Team – Glasgow Area – Mental Illness Service

Patient Number	:	55	Half are informal
Male	:	54	
Female	:	1	

Medical

2.5 wte Consultants
Juniors on placement – variable

Nursing

1 Senior Charge Nurse	Full time
5 FCPNs - Band 6	Full time
6 wte senior nursing staff	

Occupational Therapy

1 Senior Occupational Therapist	Full time
2 days of a middle grade OT	
1 Technical Assistant	Full time
2.4 wte OT staff	

Psychology

1 Consultant	Full time
1 Junior Psychologist	Full time
1 Psychology Assistant	Full time
3 wte psychology staff	

Social Work

Each patient is followed up by the Directorate Social Worker for three months following discharge. Thereafter Social Work colleagues are pulled from the local CMHT.

There are no attached MHOs. Instead MHOs are drawn from the local CMHT.

Ancillary Services

The Forensic Community Mental Health Team accesses Addictions Services and CMHTs for Clozapine clinics and physical health monitoring.

Beds are typically accessed via IPCUs on prior agreement with IPCU staff.

On occasion there is recall to low- or medium-secure Services within Glasgow. The Forensic Community Mental Health Team does not have direct access to any beds.

b. Clyde - Mental Illness Service

Patient Number : 27

Medical

1 full-time Consultant
Juniors on placement
1.0 Consultant wte

Nursing

1 Senior Charge Nurse	Full time
4 FCPNs - Band 6	Full time

5 wte senior nursing staff

Occupational Therapy

1 middle grade OT	1 day per week

0.2 wte OT staff

Psychology

1 Consultant	Full time

1 wte Psychologist

Social Work

2 Social Workers	Full time

2 wte Social Workers

c. Glasgow and Clyde Forensic Learning Disability Service

Patient Number : 18

Medical

1 full-time Consultant
Juniors on placement
Consultant wte

Nursing

3 FCPNs – Band 6 Full time
3 wte senior nursing staff

Occupational Therapy

None

Psychology

1 Consultant Full time
Band 7 Psychologist 2 days per week
1.4 wte psychology staff

Social Work

None

Additional Comments

There is one nurse manager who oversees the whole Community Service for NHS Greater Glasgow and Clyde Mental Illness and Learning Disabilities. She also has responsibility for chairing Health MAPPA meetings.

d. Community Mental Health Team – North East (Ne) Sector

The North East Sector of Glasgow has a population of 177,649. There are four resource centres in this area; namely, Springpark Resource Centre, The Arran Centre, Auchlinlea Resource Centre and the Anvil Centre. At a recent Service review the resource centres were recognised as having very different profiles. The number of resource centres will be decreased from 4 to 3 when a Service review occurs in the near future.

Springpark Resource Centre

Medical
1 full-time Consultant
2 part-time Consultants (0.6 wte each)
2 ST doctors Full time
2 SpRs Full time
6.2 wte doctors

Nursing
5 Band 6 nursing staff Full time
5 Staff Nurses/CPNs Full time
1 Healthcare Assistant Full time
11.0 wte nursing staff

Occupational Therapy
1 Band 6 (0.8 wte)
1 Band 5 Occupational Therapist Full time
1.8 wte Occupational Therapy

Psychology
Previously 1 full-time Consultant; 1 full-time Band 7
2.0 wte – usual psychology staffing level
Currently, due to staff shortages:

Consultant Psychologist
0.3 wte
0.5 wte Clinical Psychologist
Sessional top-up

Social Work
3 Social Workers Full time
3.0 wte Social Workers, one of whom has MHO status

Admin
4 Band 4 admin assistants Full time
1 Band 3 admin assistant Full time
5.0 wte Admin Assistants

Clozapine and health check clinics are run at Springpark Resource Centre. Addiction input is used from local Services. The CRISIS team also has input as required. The patients use their own General Practitioners in the local area.

e. Psychiatric and Nursing Provision in Scottish Prisons 2012

Prison	Establishment Size	MH Registered Nurses	Prisoners per Nurse*	Psychiatric Sessions per week	Prisoners per Psychiatric Session
Aberdeen	170	2	85	0.5	340
Addiewell	700	4	175	1	700
Barlinnie	1250	7	179	3	417
Cornton Vale	309	9.5	33	4	77
Dumfries	195	1	195	1	195
Edinburgh	860-920**	4.5	198	2	430-460
Glenochil	750	3	250	3	250
Greenock	255	4	64	1	255
Inverness	130	3	43	1	130
Kilmarnock	649	7	93	1	649
Low Moss	720	5	144	3	240
Perth & Castle Huntly	Perth- 528 capacity, Castle Huntly – 285	5.5	148	5	161
Peterhead	142	0	N/A	0.5	284
Polmont	763	6	127	3	254
Shotts	540	3	180	2	270

* Mental Health Registered Nurses and Learning Disability Nurses Combined
** Average population of 890 used

The number of prisoners per mental health and learning disability nurse, and per psychiatric session varies markedly between prisons. Each prison is unique and mental health needs will vary depending on proportion of remand or sentenced prisoners, long or short term sentences, males and females, and young offenders. Discussion within the group suggested however, that these figures arose largely from historical factors and did not arise from any formal needs assessment. In the absence of a formal needs assessment and a comparison with community mental health teams no comments can be made on the adequacy of these ratios. No establishments had any provision from clinical psychologists and only two had occupational therapists. Lack of mental health staff and fully functioning multi-disciplinary teams were highlighted in the Mental Welfare Commission Report into Prison Mental Health Services in Scotland (2011).

Appendix 5

SIGNPOST TO MENTAL HEALTH SERVICES

If your relative or friend is admitted to custody either on remand or while serving a sentence and you have concerns about their mental health, you can access mental health services.

There is a dedicated mental health team working within the prison that have responsibility for looking after the mental health needs of prisoners. You can access a member of nursing staff based in the mental health team to discuss your concerns. Your relative or friend will then be looked after appropriately with your concerns in mind.

Institution

Contact details

Appendix 6 - Standards

Link to the Standards for Prison Mental Health Services Publication (http://www.rcpsych.ac.uk/pdf/Standards%20for%20Prison%20Mental%20Health%20Services%20Publicationhome.pdf)

Quality Network for Prison Mental Health Services Information Sheet

The Quality Network for Prison Mental Health Services was launched in 2015 with the aim to facilitate quality improvement and change in prison mental health settings through a supportive network and peer-review process.

The network adopts a multi-disciplinary approach to quality improvement. A key component of our work is the sharing of best practice; by listening to and being led by frontline staff and patients. The network serves to identify areas for improvement through a culture of openness and enquiry; the model is one of engagement rather than inspection.

Members are expected to use the results of reviews to develop action plans to achieve year on year improvement. They are also expected to share their results throughout their services as well as with key stakeholders, including health and local authorities and those making referrals to their services.

Participating services are able to benchmark their practice against similar services and demonstrate the quality of care they provide.

Quality Network for Prison Mental Health Services is part of the College Centre for Quality Improvement.

The Review Process

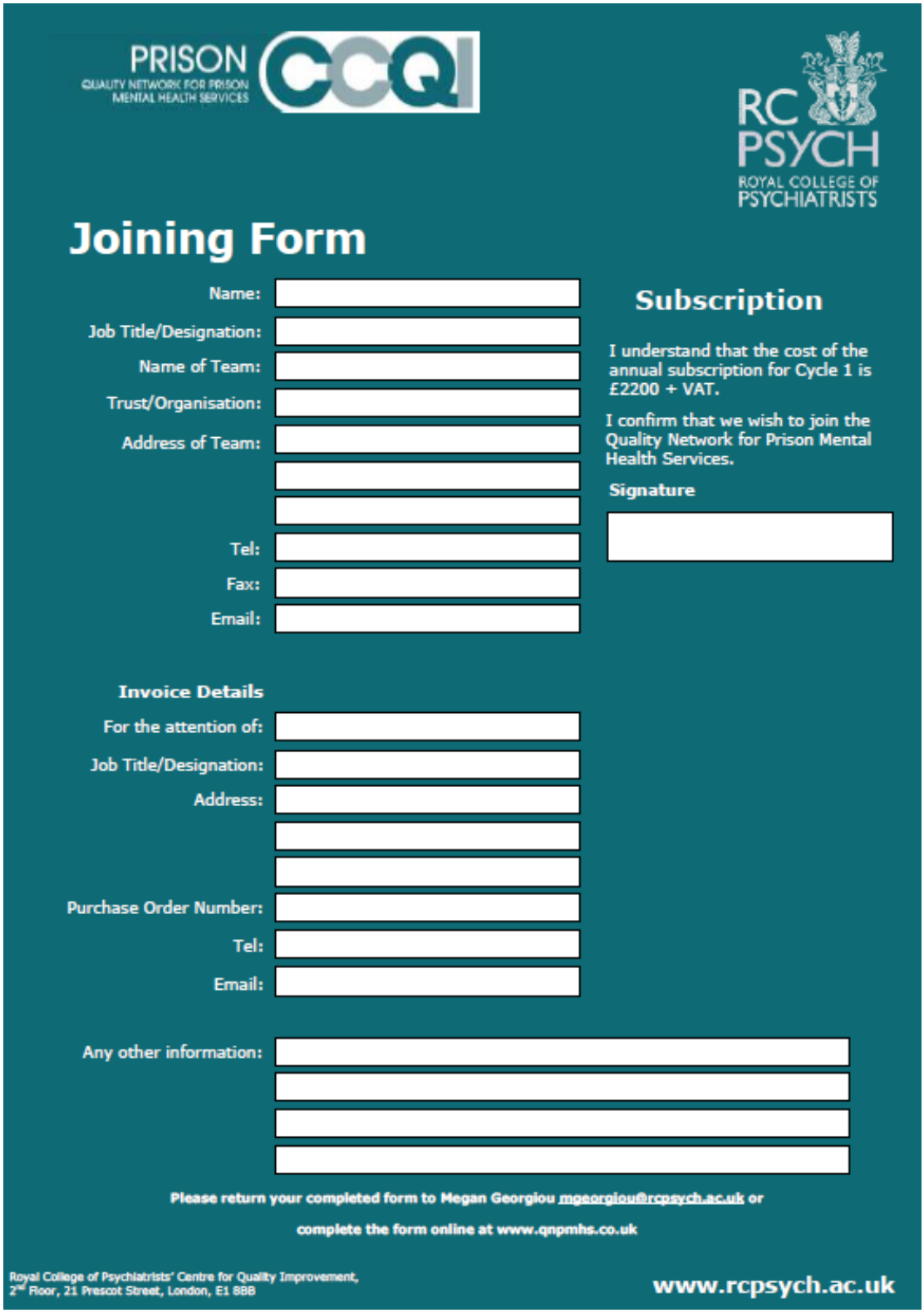
The pilot year will follow a cyclical review process, with **self-reviews** commencing in **autumn 2015.** Pilot services will be sent a welcome pack during the summer which will ask them to select a review date, and also two other services in which to review. Each service will receive a **certificate of membership** to confirm their involvement with the Quality Network for Prison Mental Health Services.

Peer-review visits will be scheduled between **January and May 2016** and members will be able to attend **training** on becoming a lead or deputy lead reviewer later this year.

Each service will receive a **report** following their peer-review visit which will provide feedback and scoring against each of the standards and also highlight the key achievements and challenges for their service.

At the end of the Cycle, all members will be invited to an **Annual Forum** to hear the key trends from the year and to watch a number of topical presentations. This would be a good opportunity to network and share good practice. An **annual report** would be published shortly after the Forum to enable services to benchmark their practices against others and see how prison mental health teams are performing generally.

Link to Quality Network for Prison Mental Health Services Joining Survey 2015 (http://www.rcpsych.ac.uk/pdf/Questionnaire.pdf)



PRISON QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES

QCQI

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Joining Form

Name:

Job Title/Designation:

Name of Team:

Trust/Organisation:

Address of Team:

Tel:

Fax:

Email:

Subscription

I understand that the cost of the annual subscription for Cycle 1 is £2200 + VAT.

I confirm that we wish to join the Quality Network for Prison Mental Health Services.

Signature

Invoice Details

For the attention of:

Job Title/Designation:

Address:

Purchase Order Number:

Tel:

Email:

Any other information:

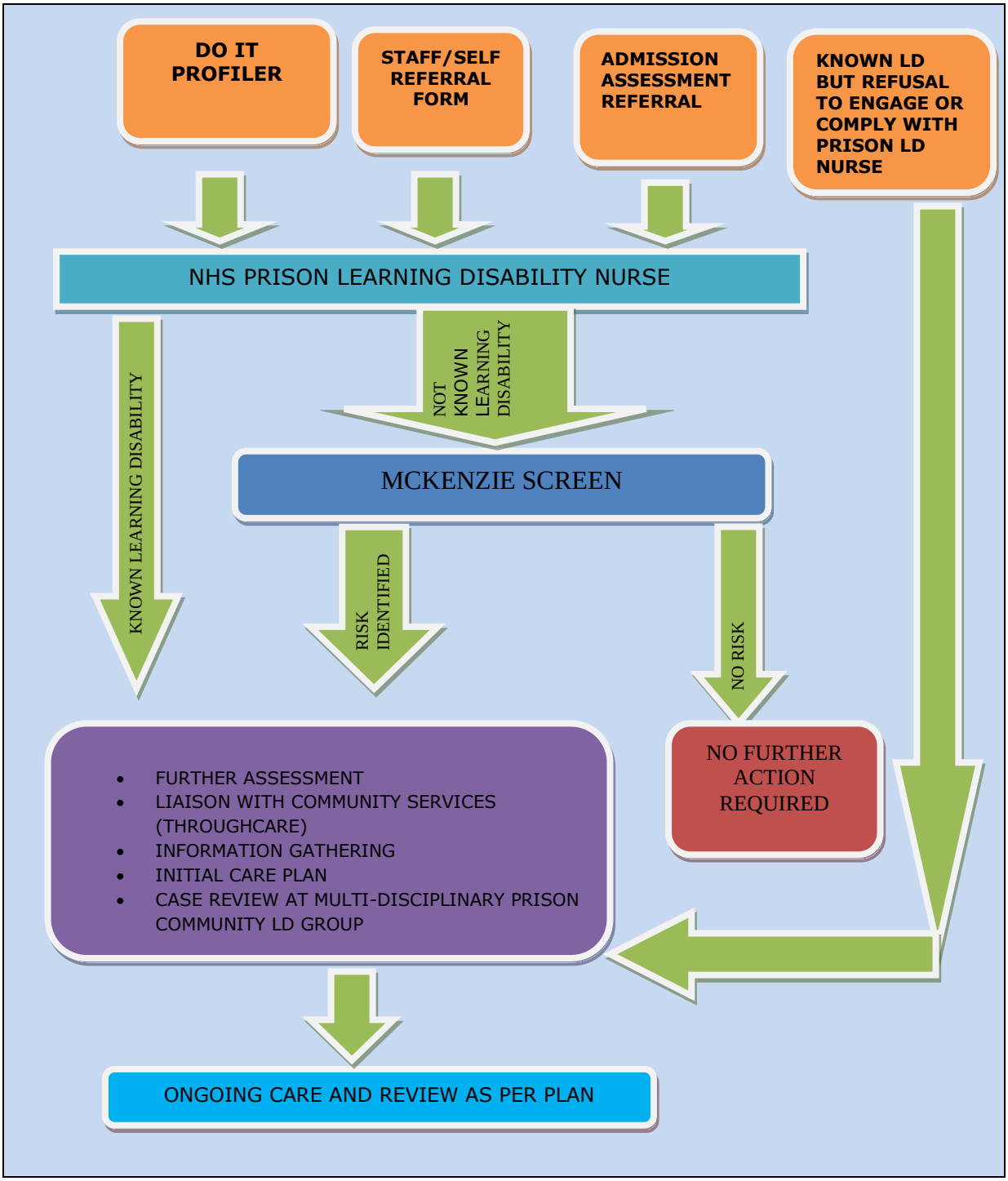
Please return your completed form to Megan Georgiou mgeorgiou@rcpsych.ac.uk or complete the form online at www.qnpmhs.co.uk

Royal College of Psychiatrists' Centre for Quality Improvement, 2nd Floor, 21 Prescot Street, London, E1 8BB

www.rcpsych.ac.uk

Appendix 7

FORTH VALLEY PRISONS LEARNING DISABILITY PATHWAY



Appendix 8 – Learning Disability Directory

This directory of Learning Disability Services is for the benefit of Prison HealthCare staff who, with the consent of a prisoner, can contact the local area professional to establish:

a) whether the prisoner has a definite learning disability
b) who has had contact with the prisoner and what this has entailed
c) whether the local learning disability service can assess the prisoner, or provide some input

Surname	Forename	Job Title	Organisation	Address	Address 1	Address 2	postcode	Telephone	Email
Bowden	Keith	Consultant Clinical Psychologist	NHS Forth Valley	Major's Loan		FALKIRK	FK1 5QE	01324 614349	kbowden@nhs.net
Douds	Fergus	Lead Clinician - Learning Disabilities	The State Hospital			CARSTAIRS	ML11 8RP	01555 842045	fdouds@nhs.net
Doyle	Mike	Chartered Forensic Psychologist	NHS Fife	Lynebank Hospital	Halbeath Road	DUNFERMLINE	KY11 4UW	01383 565 210	mdoyle@nhs.net
Field	Andy	Charge Nurse	NHS Ayrshire & Arran	CFMHT, Upper Recreational Hall	Ailsa Hospital, Dalmellington Road	AYR	KA6 6AB	01292 513731	andy.field2@aapct.scot.nhs.uk
Bantwal	Ashwin	Consultant Psychiatrist	NHS Highlands	Drumossie Unit	New Craigs Hospital	INVERNESS	IV3 8NP	01463 253 697	ashwin.bantwal@nhs.net
Bommu	Kathik	Consultant Psychiatrist	NHS Lothian	65 Morningside Drive		EDINBURGH	EH10 5NQ	0131 4464481	kbommu@nhs.net
Bhatti	Graeme	consultant Psychiatrist	NHS Dumfries & Galloway	Nithbank		DUMFRIES		01387 244339	gbhatti@nhs.net
McClements	Ricky	Forensic Practitioner	NHS Lanarkshire	Kirklands Hospital	Fallside Road	BOTHWELL	G71 8BB	01698 855 509	Ricky.McClements@lanarkshire.scot.nhs.uk
McKenzie	Amanda	Chartered Clinical Psychologist	NHS Grampian	Elmwood	26 Cornhill Road	ABERDEEN	AB25 2ZH	01224 557 152	amanda.mckenzie@nhs.net
Ramsay	Louise	Consultant Forensic	NHS Glasgow &	Douglas Inch	2 Woodside Terrace	GLASGOW	G3 7UY	0141 211 8000	louise.ramsay@ggc.scot.nhs.uk

		Psychiatrist	Clyde						
Seymour	Julie	Assistant Team Manager	NHS Borders	Westgrove Annex	Waverly Road	MELROSE		01896 824 609	julie.seymour@borders.scot.nhs.uk
Watt	Zoe	Forensic Community Team Leader	NHS Tayside	Craigmill Centre	Strathmartine Hospital	DUNDEE	DD3 0PG	01382 831 975	zoe.watt@nhs.net

APPENDIX 9

NO-ONE KNOWS RECOMMENDATIONS

1. A review of the information that accompanies prisoners into prison and on release should be conducted. The review should include the quality and content of the information as well as the effectiveness of the 'flow' of information to and from various locations.

Update
No progress made from the perspective of learning disabilities, but this is an area of need for all mentally disordered prisoners, not just those with a learning disability.

2. User-friendly tools for screening defendants for learning difficulties and learning disabilities should be developed and agreed for use across the criminal justice system.

Update
A national group has been established to look at the needs of mentally disordered offenders and those with other health problems detained in police custody, this group is being chaired by Dr Gordon Skilling, Consultant Forensic Psychiatrist. Discussions have already occurred in this group about whether screening for learning disabilities can form part of the wider health assessment of those held in police custody (in keeping with work taken forward by McKinnon and Grubin in England). This group has carried out a review of current practice across all NHS Board areas, looking at the whole pathway of mental health care in police custody (including pre and post custody). Screening has been a part of that. What is evident is that there is no consistent approach to screening.

3. Screening and, where appropriate, diagnostic assessment of people for learning difficulties and learning disabilities should be undertaken routinely and systematically prior to their arrival in prison.

Update
It is not possible to provide a "diagnostic assessment" of all detainees prior to their arrival in prison and instead as per point 2 above the most practical solution is to develop a screening tool (with reasonable specificity) which can be administered to all detainees in police custody, as part of their initial health screen. It was agreed however, to follow the SPS lead and to see if the "Do-It Profiler" tool which does not provide screening for LD per se, BUT as part of a thorough assessment will flag up prisoners with complex needs, will be sufficient in allowing such individuals to be more formally assessed for LD *and* learning difficulties. The learning disability subgroup considered that this may be better than superficially screening all prisoners.

4. Referrals from staff of prisoners they are concerned about should be recognised and encouraged, with clear routes for such referrals established at every prison.

Update
HMP Glenochil has developed a pathway(see Appendix 7) for the referral of individuals with suspected learning disabilities. A pilot programme is to take place which would provide accessible information (regarding the prison regime, routine and services) to all prisoners with learning disabilities and learning difficulties.

5. Multi-disciplinary approaches to supporting the needs of prisoners with learning difficulties or learning disabilities should continue, though some route for this other than through Integrated Case Management or Act to Care (such as mental health review meetings) should be explored. NHS Forth Valley Prison health care staff are also concurrently developing its Prison LD pathway which has also provisionally recommended use of the McKenzie Screening Tool should the DO-IT –PROFILER not have a successful evaluation.

Update
The Scottish Prison Service has commenced a pilot of the "Do-It Profiler" screening tool in the three prisons within the NHS Forth Valley area. The do-it tool will provide a comprehensive assessment of the problems and needs that each prisoner has, including "learning disabilities/difficulties". An evaluation of the do-it tool will have to occur before any decision is made about whether it will be rolled out across the whole prison estate in Scotland.

6. Clear protocols for information-sharing, and for confidentiality in information-sharing, should be disseminated and practiced throughout the prison estate.

Update
This issue relates to processes for all prisoners, not just those with a learning disability. The Scottish Accord for Sharing of Personal Information (SASPI) covers the sharing of information in conjunction with locally devised protocols

7. Prison regimes should be fully accessible to the entire prison population. In particular every prisoner should have full access to information, to offending behaviour programmes, and to opportunities for education, training and employment.

Update
Under the Equalities legislation prisoners in Scotland already have full access to offending behaviour programmes and where modifications to programmes need to take place there is a free flow of information and advice from NHS professionals working within learning disability services. Access to "easy read/accessible" information across prisons continues to be a problem. Within HMP Glenochil a pilot programme is to take place which would provide accessible information to all prisoners with learning disabilities and learning difficulties. This is being supported by Supporting Offenders with Learning Disabilities (SOLD). Final edits are being made to a completed leaflet. If this is successful it should be rolled out across the prison estate. The outcome of this programme should be followed and progress tracked if implemented across the prison estate.

8. A matrix of support for prisoners with learning difficulties or learning disabilities, including access to community-based support services, should be available in every prison. The matrix should specify referral routes and areas of staff and departmental responsibility.

Update
This item again relates to systemic issues within the prison affecting all prisoners, not just those with learning disabilities. Referral routes for access to community based support services should be the same for all prisoners. Part of the LD pathway being devised in Forth Valley has a link with the local Community Learning Disability Team through the development of a Prison multidisciplinary LD team, to enable provision of specialist support where required, however issues have arisen around the recruitment of a Part time Clinical Psychologist for this project. In Forth Valley Prisons access to Speech and Language

therapy has also enabled health care to develop easy read/accessible information leaflets and posters regarding local provision

9. National standards should be agreed for levels of care and support for offenders with learning difficulties or learning disabilities while in custody and upon release.

Update
No national standards have been agreed in relation to the specific care and support of prisoners with learning disabilities and learning difficulties in custody and upon release. As in this Implementation Report as a whole, it is recommended that the Royal College of Psychiatrists prison mental health services standards (Appendix 6) are adopted.

10. All prison staff should undertake specific disability awareness training on learning difficulties and learning disabilities and how these issues may manifest themselves in the prison environment.

Update
If the do-it profiler is rolled out across the prison estate all prison staff will undertake learning disability and learning difficulty awareness training, as this is an integral part of the do-it programme. Initial training for trainers has taken place and 2 officers identified in Glenochil to take this forward.

11. Staff responsible for specific areas of work, such as education and health care, should receive specific training on learning difficulties and learning disabilities.

Update
As per item 10.

12. Information about learning disabilities and learning difficulties, as well as referral routes and community-based supports, should be advertised and easily accessible on the Scottish Prison Service's staff intranet.

Update
A learning disabilities directory has been updated, providing SPS with information about who to contact within each Health Board's learning disability service, if there is a specific query about a prisoner with a learning disability.

13. Details of work that prison staff are most proud of and examples of good practice should be identified, built upon, and disseminated routines across the prison estate.

Update
No information available.

14. The Scottish Prison Service's Disability Equality Scheme should draw more attention to the specific needs of prisoners with learning difficulties and learning disabilities and reflect this more thoroughly in its Action Plans.

Update
No information available. The NPHN Advisory Board should consider if it wishes to take this forward with the SPS.

15. The Inspectorate of Prisons for Scotland and Social Work Inspection Agency and/or HM Inspectorate of Education for Scotland should conduct a joint thematic review on the care and treatment of prisoners with learning difficulties and learning disabilities.

Update
No information available. The NPHN Advisory Board should consider if it wishes to take this forward with the Inspectorates.

16. The Scottish Commissioner of the Commission of Equality and Human Rights should investigate the Scottish Prison Service's compliance with the terms of the Disability Discrimination Act 2005.

Update
No information available. The NPHN Advisory Board should consider if it wishes to take this forward with the Commissioner.

17. A cross-departmental working group should be convened to address the needs of offenders with learning difficulties and learning disabilities throughout the criminal justice system in Scotland. The group should include, among others, the Community Justice Authorities, representatives of the Scottish Executive, and relevant representatives from criminal justice social work, education, employment, and social exclusion.

Update
A cross-departmental working group has not been convened, but the subject of offenders with learning disabilities tends to be a standing item of business at the Scottish Parliament's cross party learning disabilities group which has representation from a wide variety of stakeholders. The Scottish Government has invested money into this area, providing funding for Supporting Offenders with Learning Disability (SOLD), a group whose main aim is to develop and improve pathways for people with learning disabilities at each step of their journey through the Criminal Justice System. The Government has also commissioned research with the Scottish Consortium for Learning Disabilities (SCLD), examining the journeys of people with learning disabilities through the steps of the Criminal Justice System.

Appendix 10 – Competencies

Expected Competencies of Psychiatrists working in Prison

1. Medical Degree
2. Member of the Royal College of Psychiatrists
3. Fully registered with GMC
4. Certificate of completion of training in Forensic Psychiatry or another branch of Psychiatry with training in the appropriate competencies (see below).
5. Appointment as a Consultant Psychiatrist
6. Alternatively a Psychiatrist in training under the supervision of the Consultant Psychiatrists within the Prison setting.
7. Experience and training in the following (competencies):
   - Working in prisons and with prisoners
   - Working in low, medium and high security facilities
   - Community management of forensic patients
   - Criminal Courts
   - Court Diversion Schemes
   - Mental Health Tribunals
   - Preparation of reports
     - Parole Boards Reports
     - Court Reports
   - Care Programme Approach
   - Multi Agency Public Protection Arrangements
   - Mental health legislation, in particular regarding transfer of mentally disordered offenders to Hospital.
   - Assessment of risk of self harm and familiarity with Act to Care system
   - Assessment and management of risk of harm to others
   - Understanding of Prison Case Management System
   - Understanding of prescribing issues within prison
   - Knowledge of the voluntary sector working with prisoners