

TOO LITTLE TOO LATE:

an independent review of unmet mental health need in prison

Kimmett Edgar and Dora Rickford



The work of the Prison Reform Trust aims to create a just, humane and effective penal system. We do this by inquiring into the workings of the system; informing prisoners, staff and the wider public; and by influencing parliament, government and officials towards reform.

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Foreword

There is no more distressing a mismatch in our criminal justice system than mental illness and prison. Would anybody prescribe for a mentally ill person the kind of environment that a prison needs to be, let alone the kind of environment that actually exists in our oldest and most unsuitable prisons? Yet this mismatch is what tens of thousands of prisoners experience – 70% of our prison population with two or more diagnosed mental illnesses is the estimate.

That mismatch is not theoretical: the stories of distress cover a whole spectrum which at one extreme includes self-harm and even suicide; it certainly includes prisoners enduring in their cells what can only be described as inner torment with nobody on hand equipped to assist them.

It is not theoretical either for those who staff our prisons: they would be the first to say that the training of a prison officer is not a training in mental health care, and that they often find themselves quite out of their depths, sympathetic and yet powerless.

It is not theoretical for the families and friends of prisoners, who watch helpless, knowing that the health of someone they care about is suffering, and will suffer more.

It is not theoretical – and here lies the origin of this report – for those charged as Independent Monitoring Board members with monitoring fairness and respect for those in custody, who express in the stories they tell and the reports they write their sense that the prison system is not managing to deal with this very serious issue at the heart of its life. They say that not out of any disdain for the compassion and attentiveness of staff or the quality, often the improving quality, of the work of the inreach teams provided by primary care trusts and others. They say it because they see the deep mismatch between needs of individuals and the response of a system not equipped to help.

The National Council for Independent Monitoring Boards was therefore very glad to be approached by the Prison Reform Trust with an offer to research the experience of boards and present a report that would make public in a more systematic way what their monitoring of establishments reveals about this distressing problem. A particular aim was to provide Lord Bradley in his review of mental health services for prisoners with further data and insights. The council gladly encouraged PRT to prepare questions for chairs of boards that would invite them to amplify what they had often already said in their annual reports. This report is the outcome of their investigation.

On behalf of the council I therefore express my appreciation to PRT and to the Worshipful Company of Mercers who supported this research and the publication of its results. The council is also grateful to those boards who found time in the heavy commitment they already make to their monitoring work to respond to PRT's questions. I want to pay tribute to PRT's research team who have brought these findings together in a form that is both readable and penetrating; they deserve our warmest thanks.

In the end, however, the thanks for which they hope – and we hope – is some improvement in what our society is able to offer for mentally ill people who become involved in crime. It is a serious irony that while the abolishing of large asylums had the worthy aim of establishing care in the community, the failure to establish that care with sufficient resources has led to so many mentally ill people being confined in establishments which were never intended for them. If what is presented here in story, statistics and conclusions can do a little to address that irony it would indeed express more powerfully than any words of mine our thanks to those who have brought such issues into the light of day.

A handwritten signature in black ink, reading "Peter Selby". The signature is written in a cursive, flowing style with a large initial 'P'.

President of the National Council for Independent Monitoring Boards
December 2008

Acknowledgements

The Prison Reform Trust is grateful to the National Council for Independent Monitoring Boards, and to its president, Peter Selby, for supporting us in undertaking this applied research. We thank the chairs of Independent Monitoring Boards in prisons throughout England and Wales who took great care to respond to the survey. The report would not be possible without the detailed information they provided. The Prison Reform Trust takes responsibility for the final text. Individual respondents are not named in the report. We do however name the prisons where good practice was described so that their work can be properly acknowledged and hopefully replicated.

The authors would like to thank Prison Reform Trust trustees Dr Adrian Grounds, Dame Ruth Runciman and its director Juliet Lyon for editorial comments on drafts of this report.

The Prison Reform Trust gratefully acknowledges the support of the Worshipful Company of Mercers, who generously enabled us to conduct this unique, independent review of unmet mental health need in prison.

1 Introduction

Independent Monitoring Boards perform a vital function in prisons, monitoring fairness and respect for people in custody. Appointed by the Secretary of State for Justice, they provide an independent perspective on the treatment of prisoners and the conditions in prisons. The National Council of Independent Monitoring Boards recently analysed annual reports and identified prisoners' unmet mental health needs as a foremost concern of boards across England and Wales.

In earlier reports, the Prison Reform Trust turned to the National Council of Independent Monitoring Boards for their views on the impact of prison overcrowding, and on young adults in prison, a 'lost generation'. Concerned about the imprisonment of people who are mentally ill, PRT approached the National Council again in June, 2008. Its president, Dr Peter Selby, wrote to the chair of each board asking them to write to the Prison Reform Trust about mental health need in the prison which they monitor.

The Prison Reform Trust, supported by the Mercers' Company, analysed the feedback from board members. This report draws on their views and sets them in the context of current research and policy. All told, information was received from 57 boards, representing the following types of prison:

Dispersal	1
Women	7
Foreign national	1
Local	22
Open	1
Training	22
Young offender	8
Total	57

The structure of this report is based on the specific areas cited in Dr Selby's letter:

- diversion
- reception
- resources
- transfers
- treatment
- prisoners with learning disabilities
- prisoners with a dual diagnosis
- particular groups at risk
- patient involvement
- peer support and involvement of the voluntary sector
- families
- resettlement
- coordination.

In many instances, boards submitted the stories of individual prisoners, without giving their names, to illustrate their points. Some of these accounts have been reproduced here to show the extent of problems faced by people who are mentally ill in prison and the burden on staff who work with them.

Over half of the boards reported that they frequently saw prisoners who were too ill to be in prison. Other prisoners have a history of enduring mental health problems and engage in persistent, low-level offending. Subjecting them to a cycle of short prison sentences does nothing to enable them to get their lives in order.

The main findings of this review can be summarised briefly.

Boards reported that many prisons lack the resources to conduct full psychiatric assessments of those they receive. Mentally ill people often arrive in prisons without sufficient information about their needs. Too few prisons have specialist trained staff. Many people who have serious mental illnesses end up on segregation units, because normal location is far too stressful. IMB chairs also reported concerns about the number of prisoners who have learning disabilities and are excluded from many day to day activities.

Co-ordination between services for substance misusers and mental health in-reach teams is often poor, with the consequence that people with dual diagnosis are often not provided with an integrated service.

On release, prisoners with mental health problems often need accommodation, drug misuse services, health care and support for physical and mental illness, and social services. When vulnerable people are released from prison with no after-care arrangements in place, the predictable outcome is that the person is often returned to face a subsequent prison sentence. Remanded prisoners released directly from court are particularly likely to fall through the net.

The principle of equivalence, to which the Government is committed, holds that people in prison should have access to an equal standard of healthcare as in the community. Only one in six of the boards rated the resources available for mental health care in their prison good or adequate.

The report makes a number of recommendations, among which are:

- A national network of court and police diversion and liaison schemes should be established, with performance targets and sustainable funding.
- Every prison should have learning disability specialists, providing a better assessment service, improved conditions and treatment, and follow-up support.
- Prison resettlement units and probation officers should alert Local Authorities of their duties to assess the needs of vulnerable prisoners at an early stage well before they are released from prison.

2 Diversion

This board is concerned about the large number of prisoners resident in health care who have mental health problems. It appears that the courts are disregarding the mental health issues of defendants and sending them to prison rather than to a more appropriate mental health environment.

(Board chair)

Diversion and liaison schemes, usually funded, where they exist, by primary care trusts, cover police stations, the courts and prisons. These are intended to identify mental health problems early, ensure that appropriate help and treatment is provided to people who are charged with, or convicted of, offences, and divert those who are mentally ill from the criminal justice system to an appropriate NHS mental health service.

Responses from Independent Monitoring Boards revealed a picture of patchy and sometimes inadequate diversion services, mentally ill people slipping through the net, and a criminal justice system which is poorly equipped to provide for their needs.

Findings on diversion

Are there people in the establishment you monitor who you think could have been diverted at police stations or courts into a range of health or social care services rather than entering custody?

- Of the 41 boards who provided information in response to this question, over half felt that they frequently saw prisoners who were too ill to be in prison.
- 22 boards responded from training prisons. There should be very few people with serious mental health problems in these prisons. If they were not identified and diverted at the police station or in courts, at the very least their problems ought to have been picked up in a local prison so they could be transferred from there. Of the boards in training prisons, over 40% said they came across people who should have been diverted from prison. This suggests that overcrowding pressures have reduced the effectiveness of mental health screening at local prisons.

A number of boards attempted to pinpoint the main reasons that courts would send people with mental health problems, inappropriately, to prison. The most common explanation was that care in the community has failed: an under-resourced mental health service in the community had resulted in large numbers of people with serious mental illness being drawn into the criminal justice system.

One board suggested that courts are not receiving sufficient information about a defendant's mental health prior to sentencing. Others cited inadequate mental health training for police and courts, and poor coordination between agencies at the earliest stage of a person's contact with criminal justice.

The board at a medium-sized local prison stated that the mental health inreach team (MHIRT) was receiving, on average, a referral every day. Another board at a local prison explained that they often see mentally ill prisoners who are serving comparatively short sentences. They felt that courts use the prison as a default option, but spells of imprisonment do not address mental health problems. In their view, diversion should be used not only for those with serious mental health problems, but also for people whose mental health underlies persistent lower level offences.

One board drew attention to the apparent lack of diversion for offenders who breach conditions:

One particular area of concern relates to those prisoners who have enduring mental health problems, and who breach their license conditions. They seem, very rapidly, to be returned to prison rather than to be referred to defined NHS mental health service provision where, from a medical perspective, they should probably have been in the first place.

The impact of sending mentally ill people to prison

Many boards also described the main effects of requiring prisons to hold people who should be the responsibility of the health service. In custody, their mental health is likely to deteriorate, and prison staff must devote disproportionate resources to looking after these individuals.

One board wrote to say that, in their view, local prisons were particularly damaging for people who were severely mentally ill:

Whether or not a prisoner is diagnosed as requiring treatment under the Mental Health Act, it is immensely unsatisfactory that he should continue to be detained in a busy local prison. The numbers and the turnover of prisoners in [this prison] are such that the disproportionate time and effort which must be devoted to highly disruptive individuals adversely affects the remainder of the regime. Discipline staff do not routinely receive training to cope with irrational and extreme behaviour. Such prisoners requiring psychiatric treatment should be promptly transferred to appropriate institutions, whilst those not assessed as needing treatment ought to be in a custodial setting free from the overwhelming everyday pressures faced by busy local prisons.

Behaviour symptomatic of mental illness is sometimes treated in prison as a disciplinary rather than a medical matter. Prison Service Order 1700 (segregation) explicitly states that prisoners at risk of self-harm or suicide 'should only remain in segregation in exceptional circumstances'. It further states: 'if the mental health of the prisoner is so at risk as to suggest that they will be totally unable to cope with segregation then they should not be kept in the segregation unit.' This policy follows a judgement by the European Court of Human Rights (*Keenan v United Kingdom*, 2001) which found that a lack of psychiatric advice about Mark Keenan's confinement in segregation, and ineffective monitoring of his condition, amounted to a breach of Article 3 (inhuman or degrading treatment or punishment).

A board chair at a local prison summed up the problem in these terms:

Too often we observe prisoners whose extreme, often bizarre, behaviour patterns present serious control problems within the prison. Such prisoners usually end up in the segregation unit, where their disruptive behaviour often continues. A mental health assessment will be obtained, but all too often this concludes that the prisoner suffers from a personality disorder which is not amenable to psychiatric intervention . . . We note in this context that the absence of any power to treat a prisoner compulsorily means that those exhibiting bizarre behaviour have to be controlled by techniques of restraint rather than medication, altogether a more degrading and less humane response.

In the community, people with severe mental illness detained under the Mental Health Act, receive in-patient 24 hour nursing and medical care. Any seclusion imposed comes under the Code of Practice, Mental Health Act 1983 (Department of Health, 2008: 123), which states that seclusion should be used as a last resort and for the shortest possible time. It should not be used as a punishment or threat, as part of a treatment programme, because of shortage of staff, or solely to manage a risk of suicide or self-harm.

I have become increasingly concerned at the number of prisoners with mental health problems who are being moved from one segregation unit to another either because they are not suitable for normal location or because they refuse to locate anywhere except the "block". At HMP - - -, we have received one such today. His notes say that he has a diagnosis of a severe mental illness, and he was designated as a "three man unlock" at the previous prison because of his violent tendencies. Given no prior warning he was put on the van this morning (on what must have been the hottest day of the year) and, unwilling, brought to us. We have no hospital wing at [this prison] - - -.

A young female who . . . had a mental age of a young adolescent, because of each prison wishing a respite from her activity was sent to [this prison], where she was retained in the segregation unit for over 28 weeks. Despite the attempt to move her on and also attempts to have her sectioned, this prisoner was given all the care and attention by officers and management who were not trained to be nurses or mental health care staff.

A small number of prisoners who should have been diverted at police stations end up in [prison] when they should not, e.g. a prisoner who had a clinically assessed mental age of between two and five years of age. He was cared for in the CSU [care and separation unit] and his toileting and washing needs were met by nurses until he was transferred out of the prison.

The failure to divert people from the criminal justice system is clearly damaging to them, but staff, too are affected. The Prison Governors' Association and the Prison Officers Association have voiced concerns about professional compromise, as their members are required to care for people who need mental health treatment and social care.

Two boards described the effects on staff:

At various times during its relatively short operational life, [this prison] has had the majority of its care and separation unit (18 beds) and its hospital (12 beds) occupied by prisoners with mental health problems. These prisoners often require continuous bed watch and three man unlock so the workload on staff is enormous.

Our concerns are not only for the prisoner and his medical mental health care in prison but the real impact on the officer staff who deal with these conditions on a continuous basis and the stress and strain this generates for them when they do not have the training or support we feel should be available to them.

[An older] man is withdrawn and unable to look after himself. He almost certainly has an organic dementia. He is an IPP prisoner who is quite unable to cooperate in any courses even if they were available and this means that he will remain in prison indefinitely unless somebody intervenes. Before sentencing he was known to social services because he was neglecting himself. The board is so concerned about him that we have written to the minister. The other example is an 80-year-old confused man who also is unable to look after himself. We do not yet know whether he was known to social services but it seems likely. He has a five-year sentence for indecent exposure which is not surprising since he continually takes his clothes off. Neither of these men should be in prison.

At the moment, a woman in her 70s [is here] who constantly breaches restraining orders from the courts not to harass. The woman is fixated by what she sees as injustices against her by police, courts, solicitors - no amount of talking helps. She refuses accommodation in the health care centre, but is seen daily by health care staff. She will not cooperate in the production of psychiatric reports. We believe prison is not the place for such a woman.

Context

In 2004, Dr Adrian Grounds estimated that, at any one time, up to 3,700 prisoners had a mental illness severe enough to require transfer to an appropriate NHS mental health service (Davies, 2004). In September 2008, Michael Spurr, Operational Head of HM Prison Service, told Today that 10% of the prison population was seriously mentally ill (BBC Radio 4, 2008). The scale of the problem shows the lack of diversion schemes and, more widely, the failure of mental health care in the community and the limitations of

hospital provision. In addition to these people, defendants who have a history of enduring mental illness and engage in persistent, low-level offending should be referred, where possible, to mental health support in the community. People with learning disabilities should be referred to social care services.

The most recent detailed survey of psychiatric morbidity in prison was conducted in 1997-1998 (Singleton et al., 1998). That research found that 90% of prisoners have common mental health problems, such as anxiety, depression, or neuroses. Their mental health needs often fall below the threshold required to access treatment in the community; and their offending is less of a serious risk to society and more of a persistent nuisance. Part of the background to the use of prison for these offenders is a failure to identify, or treat, common mental health problems in the community.

The majority of prisoners with mental health problems report that they were not receiving basic support from community services prior to imprisonment. It is clear that the holes in the safety net of services are too large for this group, so that they fall through into the criminal justice system easily and repeatedly.
(Revolving Doors Agency, 2007)

Nacro surveyed court diversion and criminal justice mental health liaison schemes for mentally disordered offenders in England and Wales (Nacro, 2005). The survey showed that staffing levels had decreased over the previous year in a quarter of the schemes; and 30% cited inadequate staffing as a barrier to efficient operation. Some areas of the country were without any coverage.

Treating mentally ill people – rather than locking them up in jail – works to reduce the risk of reoffending. The Home Office had funded successful pilot schemes in diversion in the 1990s. In a 2002 study by David James and colleagues, the reconviction rate of people who had been admitted to hospital from courts was 28%, half the reconviction rate of people of a similar age and offence who were sent to prison.

From these results, there is no justification for the view that diversion to hospital is a 'soft option' or that it fails to offer public protection. On the contrary, these results indicate that it may constitute an effective means of crime reduction in those suffering from mental illness.
(James, 2002)

Independent Monitoring Boards have previously spoken out about failures, earlier in the criminal justice process, to divert prisoners who are seriously ill. In its annual report, the board at Portland Young Offender Institution wrote:

The board presses for meaningful liaison between agencies at an early stage of a person's contact with the criminal justice system. An early assessment of need and a more appropriate treatment method being found without resort to a custodial sentence.

Part three of the Mental Health Act 2007 covers patients involved in criminal proceedings. The courts can use section 35 to remand an accused to hospital for a

report and for treatment under section 36. Section 37 enables them to admit a sentenced offender to hospital for treatment. Section 38 allows for an interim order for six months to evaluate response to treatment.

In the last 10 years, the courts have become more likely to impose prison, and less likely to make use of mental health services. In 1996/7, 268 people were remanded to hospital for a report under section 35, as compared to 118 in 2006/7, a drop of 56%. The use of section 36 (remanded to hospital for treatment) fell from 33 in 1996/7 to 19 in 2006/7. There was a slight increase (2.5%) in the use of Section 37 orders, from 754 in 1996/7 to 773 in 2006/7. These figures show that courts have not made sufficient use of these sections, particularly when they remand defendants to custody.

In that 10-year period, there was a rise in the number of people appearing before the courts, but the total number of people sent to NHS and independent hospitals from the courts remained fairly constant. The number sent to NHS and independent hospitals from the courts and prisons remained at about 1,900, while prison numbers increased by 41%, from 55,256 in 1996 to 77,982 in 2006 (NOMS, 2007: Table 8.1).

A much-neglected means for diverting mentally ill people from the criminal justice system at the court stage are community sentences with mental health treatment. Revolving Doors Agency reported:

Sentencers are not using the mental health treatment requirement of the community order or suspended sentence orders. The mental health treatment requirement has been used for less than 1% of all requirements issued – just 725 were issued in England and Wales in 2006, out of a total of 203,323 requirements.
(Revolving Doors Agency, 2007)

Courts rely on information being provided to them in a timely way. There are some new initiatives to speed up the process of providing them with the information they need. But the courts can only transfer a patient under the Act if a bed is available. They have no powers to enforce this. Otherwise they must adjourn the case or send the person to prison for further assessment.

The evidence from the boards who responded to the survey shows that, hidden behind prison walls, the challenge of managing people with serious mental health problems consumes disproportionate resources of an over-stretched Prison Service which is not equipped to manage severe mental illness. In the past, some boards voiced strong objections to the use of segregation to hold mentally ill people, and this survey has provided ample evidence that the practice continues.

3 Reception

Admission procedures in individual receiving prisons can be good, but if information from the community or sending prisons is poor or non-existent then the health care professional has to rely on information given by the prisoner. This could be scant or misleading due to the stigma attached to mental health issues.

(Board chair)

Reception is a vital stage for prisoners as they pass into the care and control of the Prison Service who take on responsibility for their safety and welfare. The importance of receiving accurate and detailed information about each prisoner, from the courts, other prisons, probation, and health services cannot be over-stated. Reception processes have different purposes in different types of prison. In large local prisons, over 50 people might be received into the prison on a typical working day, whereas fewer than a dozen new arrivals can be received each month by some long-term training prisons.

Findings on the reception process

Are you satisfied that initial assessments, first night and induction processes take proper account of mental health needs?

- Half of the boards responding said that they were satisfied with the reception process at their prison.
- One in six boards felt that the reception process was inadequate at identifying people with mental health needs.
- In addition to the problems discussed below, some boards reported that in their prison:
 - the information received with the prisoner was of variable quality
 - escorts arriving late could result in a hasty process
 - reception was conducted in English only, creating problems for assessing many foreign national prisoners.

Among the most positive responses, some boards singled out staff for praise:

Induction staff are carefully chosen and in our experience include some of the most caring and experienced officers in the prison. There are numerous examples every day where officers have done that little bit extra to help a newly arrived prisoner.

Another stressed that as a small prison, they were able to provide sensitive, individual attention.

One of the central concerns about the initial screening is the extent to which it relies on self-reported problems. Another board highlighted a tension between the induction staff and the inreach team, as the latter described the induction assessments as 'tick-box'.

A second concern is the level of training required accurately to assess mental health problems. One board wrote:

Induction staff say that recognition of mental health care needs on the wing is '90% instinct'. They say that quite frequently it is other prisoners who first alert them to cases which require attention.

A third concern is an imbalance between assessment and treatment. Someone who is moved from one prison to another over several months might have to endure half a dozen assessments of their mental health needs without ever receiving any treatment for needs that had been identified earlier.

Good practice in reception and induction which was described by boards includes:

- screening everyone carefully
- excellent communication between different groups in the prison
- continuous availability of mental health specialist care.

Problems in reception and induction identified in these responses include:

- lack of specialist mental health practitioner on reception to conduct early screening
- late arrivals mean that some prisoners are not seen by mental health specialists
- provision of specialist mental health practitioners overwhelmed by level of demand
- poor communication between different groups in the prison (e.g., reception and health care)
- tensions between different departments within the prison
- a reliance on self-reported mental health problems
- substance misusers in no state to make best use of time on reception.

Context

Reception into prisons has rightly been the focus of much attention by the Department of Health and the Ministry of Justice, due in part to a heightened risk of suicide during this time. Following an evaluation of suicide prevention measures (Liebling et al., 2005) there has been a general improvement in first-night services. However, a recent study by the Sainsbury Centre for Mental Health (2008a) identified problems with screening prisoners' mental health on arrival:

- the screenings they observed were brief, typically only five minutes
- many prisoners arrived without any medical notes
- the numbers arriving varied, making it difficult to predict the resources required to conduct assessments
- some prisoners were adamant that they did not want to discuss their vulnerabilities on reception
- many prisoners felt frustrated at having to undergo repeated assessments.

A particularly alarming finding, however, was that a lack of communication within prison (and between prisons) meant that problems were likely to remain hidden if they were not picked up in reception:

For all prisons, screening was largely a 'one-off' event, taking place at reception. Many of the prisoners would have experienced at least one previous screening and perhaps several if they had been transferred between establishments before. In spite of this, when we reviewed medical notes we found that it was not uncommon for there to be no indication of mental health problems on previous screening questionnaires, even when it was clear from other sources that there was a history of mental health problems. (Sainsbury Centre for Mental Health, 2008a)

The boards who responded to the survey expressed concerns about the lack of information that arrives with the prisoner. This means that those conducting assessments rely on prisoners to provide mental health care histories. In some prisons, boards felt that reception areas had too few people who were professionally trained in mental health awareness. A few boards recognised the improvements made by new safer custody measures.

4 Resources

We believe this study is aimed at the wrong area - the one body that cannot do anything about it - HMPS and through that the board. This study should be directly aimed at the policy making bodies within the DoH and the Treasury who control the purse strings.
(Board chair)

The principle of equivalence, to which the government is committed, holds that people in prison should have access to an equal standard of health care as the community. The Department of Health undertook responsibility for prison health care in 2006. Inreach teams have been established in over 100 prisons, with new investment. Primary care trusts (PCTs) now have a central role in commissioning mental health care in prisons.

Findings on resources for mental health care in prison

Do you think prison and health care staff now have the resources, capacity and training to respond to the range of mental health needs?

- One in six of the boards who provided information believed that the resources for mental health in prison were adequate or good.
- Of the 49 boards providing relevant information over half – 53% – felt that resources were inadequate.

A few boards highlighted recent improvements in resources. One board listed a range of areas in which mental health care was well-resourced. The inreach team covered mild to moderate mental illness. They provided assessments, delivered treatment, and ensured continuity of care by planning for discharge and linking with the community mental health teams.

Boards held different views about what constitutes a good level of capacity. For example, one prison was reported to have consultant psychiatrists on duty for three sessions per week – two of which were conducted by forensic psychiatrists; in another prison, the consultant psychiatrist visited weekly and was available on call; yet a third board wrote approvingly that a consultant psychiatrist visited for one session per week; and another stated that a psychiatrist visited once every five or six weeks. The level of demand differs not only by the size of the prison, but also by the proportion of prisoners who have severe mental health problems. Nonetheless, the responses indicated that board members held diverse ideas about the level of provision that would be adequate.

The level of resources in any prison is partly based on its function, and partly on historical funding levels. There are three types of provision: level three usually applies in busy local prisons, which are judged to require 24 hour full coverage; level two have extended cover

(from eight am to nine pm) and level one has cover from eight in the morning until five pm. The problem with these levels of resource is that overcrowding pressures have increased the demands on prisons with levels one and two, and there are now prisoners there who require 24 hour cover.

Some boards made a direct link between the recent improvements and the involvement of primary care trusts in commissioning: 'Since the . . . PCT took over responsibility for the prison's medical service, there has been a much better quality of service . . .'

As stated above, a board could feel that provision had improved, yet not consider it adequate. A chair of the board at a women's prison wrote:

I have spoken to the chaplaincy team – they felt one of the good things to come out of the closing health care centre at [this prison] is that the mental health nurses are now working out on the wings where they are needed. They also stated that progress is being made but never enough to deal with the numbers and complexity. This last point I think is to do with the number of self-harmers.

One board stated that a newly built health care suite was in use by a visiting inreach team, but the team was not based in the prison, limiting options for treatment. Another stated that the resources provided in the prison by the PCT had not addressed the delays in obtaining psychiatric assessments or transfers to NHS care.

Eighteen boards identified problems in the resources for mental health care, ranging from moderate to severe. For one board the problem was not specifically in funding, but in maintaining staff: 'In May 2008, the health care team had seven vacancies out of 18 posts.'

One response explicitly stated that the shift in commissioning to PCTs had not resulted in an adequate provision of mental health care. They added that the mental health staff in the prison were subject to a high turnover, with the consequence that the level of treatment actually delivered suffered. Another board stated that although the level of resources was currently under review, they did not expect that any additional funding would be adequate. But a third took a different perspective, drawing attention to a dilemma at the heart of the question. They asked whether it was sensible to put more resources into prisons, when mental health care and social services support in the community are seriously under-resourced.

At a local prison, a board referred to the unpredictability of the level of demand for services, depending on who arrived from court each day. They felt that the unexpected shifts in levels of need caused delays in getting treatment (or even assessments) for prisoners with common mental health problems, such as anxiety or depression. A board at a training prison cited resource problems that arise from caring for seriously ill prisoners, as they consume a disproportionate amount of staff time. Five boards stated that there was a lack of 24 hour cover at their prison. Although seriously disturbed people should not be held in a prison that does not have 24 hour psychiatric care, it was clear from the responses that this sometimes occurs, due to population pressures.

A small number of boards acknowledged that there was a difference of opinion within the establishment, with some staff taking the view that the service was well-equipped and others feeling it was seriously deficient. In part, the opposing views could reflect changes over time: reflecting improvements introduced through the involvement of the PCT. However, others believed that the level of need had also increased dramatically over the past few years. They cited the views of prison staff who felt that there are many more prisoners with mental health problems, and the problems are far more complex. One of these boards made the point that, if over two-thirds of a prison population have mental health problems, and an inreach team can work with 40 or so, an enormous number of prisoners are being denied the treatment they need.

A chair wrote to express disquiet:

From the IMB's point of view, every board member could give numerous examples of prisoners that we have met during applications, during the IMB induction talk, during observations of adjudications etc, where we felt that the prisoner had some type of mental health issue. We normally do not know if that prisoner is receiving treatment, but our feeling is that there is a problem here which is larger than current clinical definitions embrace.

Findings on training

Working with this group of prisoners asks prison officers to develop a different type of relationship. In turn this presents challenges to the other prison functions of security and control. This leads to tensions and misunderstandings.

(Board chair)

Eighteen boards (over one in four) cited a concern about the provision of staff training in mental health. Some were concerned about a lack of specialist training for mental health professionals, for example, the absence of a mental health nurse with awareness of learning disabilities or geriatric mental health. Boards also voiced concerns about inadequate numbers of staff on reception who were well-trained in assessing serious mental illness.

Most boards focused on prison officers, and the importance of training them in recognising and responding to mental health problems. The good practice cited was training provided for wing staff by the inreach team, and (in other prisons) the involvement of the PCT in delivering mental health training (boards from Eastwood Park and Mersyside).

The Listener scheme offers good training to prisoners who volunteer for this post in prison. It enables stress and mental health to be taken account of. Why is this training not a compulsory element for all prison staff who have care of (and power over) those who are constrained by custodial sentence?

Seven boards felt that while training in mental health was desirable, staff were under too much pressure in other ways to be released for training. One felt that officers were not trained, while on the opposite end of the spectrum, another was confident that mental health awareness training had been very successfully provided for prison officers. One board drew particular attention to the lack of training for officers in learning disabilities. Finally, one chair suggested that members of Independent Monitoring Boards should receive mental health awareness training.

An institution which holds acutely mentally ill people needs, at a minimum, adequate staffing. Yet, in most prisons, severely mentally ill prisoners are unlikely to benefit from sufficient numbers of specially trained prison nursing and medical staff. Although wing staff do their best to work with mentally ill prisoners, they often lack basic knowledge about mental illness and cannot provide the appropriate care. Managing disruptive and ill prisoners takes prison staff away from their core duties and, because training of staff is often inadequate, officers are not equipped to respond to needs of people who are mentally ill.

Mental health training is not mandatory for prison officers and must compete with other priorities such as control and restraint techniques, race equality, security, learning disabilities, and other topics. In a prison inspected in 2004, inspectors found that strip clothing and blankets were still routinely being used in the in-patient facility. Staff 'did not appear to know that this was no longer acceptable' (HMCIP, 2004a: para 1.100).

Good links between health care staff and wing staff have an impact on safety of prisoners. Daily contact with prisoners enables wing officers to support them, observe fluctuating states of mind and mood, and refer them to specialist care. The project evaluation on the impact of new suicide prevention procedures, assessment, care in custody and teamwork (ACCT), on prisoners at risk showed that ACCT is more effective when health care and residential staff are involved (Shaw, et al, 2006).

Context

The equivalence principle means that prisoners should receive an equivalent standard of care as they could have in the community. Department of Health guidance (2002a) suggests that a typical community mental health team with a caseload of 350 (half with complex problems) should have three to four community psychiatric nurses, two to three social workers, a minimum of one psychologist, support worker and administrator and two full time psychiatrists. Prison populations have much higher rates of psychiatric morbidity, and therefore far greater investment is needed.

The Sainsbury Centre for Mental Health estimates that a typical prison for sentenced men with a population of 550 would require 11 whole time equivalent specialist mental health staff (SCMH, 2007). Yet another study found that the average size of an inreach team in 2006 was three whole time staff (Steel et al., 2007). The Sainsbury Centre for Mental Health concluded that current inreach provision was less than one-third of what would be required to provide an equivalent level of service.

A review by the Chief Inspector of Prisons cited the Health Care Commission's assessments of commissioning arrangements, covering 23 PCTs and 26 prisons. The review showed that prison mental health was a low priority for the PCTs. Asked to identify their priority areas, only three mentioned mental health (HMCIP, 2007: para 2.13). GPs interviewed for the review suggested that much of the primary mental health care need in prison remained unmet.

The inreach team must include a qualified forensic psychiatrist. But the Chief Inspector found that inreach teams had inadequate resources:

MHIRTs were mainly nurse-led and staffed by RMNs [Registered Mental Health Nurses], with variable access to other health professionals from their trusts. Most lacked the support they would have had in the community and some felt professionally isolated. (HMCIP, 2007: para 1.19)

Professor Charlie Brooker and colleagues found that over half of all health providers in prison assessed the mental health service as average or poor (Sainsbury Centre for Mental Health, 2008b, 27).

In addition to general under-funding, a recent report by Policy Exchange, 'Out of Sight, Out of Mind' (2008) drew attention to regional variations among prisons, with Yorkshire and Humber, and the north of England relatively high in prison mental health investment, and low investment in the east Midlands and southwest England. Equally, there are disparities by the type of prisoner, with spending on mental health care for women offenders particularly low.

The Policy Exchange report also judged that budgets are not being spent in the most efficient way. They estimated that £2.1 million of the allocated £20.4 million is not used due to shortfalls in recruitment. Money was not being spent in line with policy objectives. Policy Exchange estimated that up to one-third of inreach caseloads have neither a serious mental illness nor a personality disorder.

Another problem identified by Policy Exchange is that the original concept for the inreach teams was to work with people with serious mental illness. However, much mental illness in prison is associated with substance misuse (Farrel et al., 2002). Subsequent studies have found high levels of co-morbidity between neurotic disorders, personality disorder and substance misuse in prisoners (Sheeran and Swallow, 2007). As a result, inreach teams have been pulled in too many directions, with a blurring of boundaries between primary and secondary mental health care and a feeling of 'mission creep' (Policy Exchange, 2008: page 23).

5 Transfers

The strategy and protocols set up for transfer of mentally ill prisoners to forensic beds or secure NHS accommodation are lengthy and complicated as stated in this report. Prisoners appear to take up beds for assessment for terms of six to eight weeks then are returned to prison, one may question if this is appropriate as prisoners who are ill are taking up assessment accommodation rather than being placed in appropriate accommodation to meet their actual mental health needs.
(Board chair)

A prison is not a hospital. For the purposes of the Mental Health Act, prisoners who exhibit severe mental distress, need treatment and care, who have capacity but do not consent to take medication, need to be moved to NHS provision to receive treatment. To arrange for a transfer, the prisoner needs to be assessed, and then a suitable NHS facility must be found. The Department of Health piloted a waiting time limit for transferring seriously ill prisoners of 14 days between an assessment and their placement in a hospital.

Findings on transfers from prison

Are transfers to outside health care managed in a timely and therapeutic way?

- Of the 49 boards providing relevant information, just over half reported serious delays in arranging for transfers.
- Another 13 felt that transfers were generally slow.
- Fewer than one in four felt that transfers were done in a timely and therapeutic way.

To highlight the positive findings: boards who were satisfied with the timing of transfers described a variety of practices that improved the process. These were:

- Therapeutic work with the patient leading up to the transfer, and full cooperation with the children and adolescent mental health services team (CAMHS) who are accepting the patient.
- Better communication and good links with the NHS providers – both locally and regionally – a proactive approach by the prison.

We find that once assessments are made and a prisoner is accepted for outside health

care, transfers take place more quickly than used to be the case, perhaps because the prison is proactive, e.g. in asking what information is needed and providing it without delay rather than waiting for requests for information.

However, 25 boards reported that there were serious delays or that arranging for transfers was very difficult. One of these provided a list of problems that caused delays in transfers:

There are long delays awaiting NHS beds – the mental health inreach team are robust in their assessments but referrals to forensic beds and NHS secure beds are delayed. There are a number of reasons:

- When the consultant psychiatrist refers, there has to be a further visit for another assessment from the unit referred to which takes some time to be put in place even if it is considered urgent.
- The clinical director cannot refer direct (as if he was in the GP practice he could within the community).
- Acceptance by the NHS for funding is complicated therefore some PCTs do not wish to pay for this bed causing many delays. The funding system should be reviewed as this is the major problem for delays. Sometimes months.
- Although the Prison Health transfer system has been tightened up – time reduced for transfer when notice is issued and records show this has greatly improved – within the time scales – this does not give an accurate reflection of prisoners with serious mental health problems not being appropriately treated adding to a deterioration in their health and any rehabilitation.

Two boards suggested that administrative delays lengthened the time a prisoner would have to wait for a transfer even when a bed had been found:

A prisoner can only be transferred when a movement order has been signed, but such an order will only be issued when a place has been allocated. If a place becomes available at very short notice – as can happen – it cannot be taken up without a movement order. The logistics of obtaining such an order rapidly are an unwanted complication.

A consequence of administrative delays in arranging transfers is that prisoners are left in limbo, as illustrated by the following individual account.

The transfer of prisoners to an outside mental health care establishment is only actioned when a prisoner has been 'sectioned'. However, once 'sectioned', this does not necessarily mean a quick transfer as this depends on the availability of accommodation which is often at a premium. The psychiatrist will not 'section' anyone unless they know they have a date for a placement in an outside establishment. As illustrated by a recent case, the board expressed concern that a prisoner with mental health problems had been kept for an undue length of time, firstly in segregation and then in the prison hospital, whilst awaiting transfer to an outside psychiatric unit.

The use of segregation for prisoners who ought to have been diverted from prison has been highlighted earlier in this report. Delays in arranging transfers can also result in the misuse of segregation units.

Prisons are not equipped to deal with acutely ill people. Example: a sentenced prisoner was sent to our establishment in January 2008, section papers were signed June 2008 and he is still in the health care centre under a three man unlock all these months later. At times, against medical advice, he has been housed in the segregation unit because he needed restraint. The decision was taken at a governor level. Was it cheaper for the Prison Service to keep him in seg rather than the health care centre? What were the criteria used to make this decision?

(Board response dated 27 August)

Another problem, mentioned by one board, was arranging for suitable transport when a transfer had been agreed. Other boards described the impact of delayed transfers on the work of the mental health teams:

Transfers on discharge to outside health care are sometimes difficult and, although staff may be sympathetic to the prisoner's needs, it is very time consuming for the appropriate contacts (often requiring many phone calls) to be made. The system requires simplification. It would also appear to us that budgetary constraints are working against the prisoner/patient's best interests.

Both prison and health care staff often struggle to cope with prisoners who suffer from a wide range of mental health problems. However, of particular significance is the delay, often extended, in sectioning a prisoner under the prison estate. These delays result in a disproportionate level of involvement for staff with regards to time, patience and commitment.

The process of arranging a transfer can also require good cooperation between prisons, where one prison has a good in-patient unit which can care for the patient until the transfer to NHS services can be arranged. For example, one board responded that:

Transfer to prison establishments with the suitable 24 hour care and facilities can be unpredictable and rely on only two other local prisons to assist.

The reliance of some prisons on other prisons to care for a patient until a transfer can be arranged may not actually obtain treatment for the prisoner, as illustrated by three responses. The first board expressed confidence that patients with serious mental illness were transferred to the in-patient unit at a second prison (prison B).

The board at prison B responded:

It is extremely difficult to access outside health care when the need is mental rather than physical. The need has to be severe, and the wait is considerable.

The third stated that transferring a patient to the NHS was done through prison B, and could not be relied on:

Transfers from the specialist health unit at HMP 'B', which serves [this prison], continue to depend on the identification of a suitable unit/bed/ resource and on funding from the appropriate PCT, both of which result in frequent, lengthy delays. Often the commissioning PCT will want to assess the prisoner for themselves which again contributes to the delay in transferring the prisoner to a suitable resource.

Clearly, moving a patient needing psychiatric care from one prison to another is delaying the solution, rather than resolving the problem.

A severely disturbed young offender was sectioned at [YOI] and moved to [HMP] on December 21 2007. An attempt to get him admitted to [a] psychiatric unit failed as they refused to take him. His release date was [imminent] and there was a real concern that he was not in a safe or fit mental state to resume life within the community. Eventually, as a result of the concerted efforts of the prison staff and the IMB he was visited by a psychiatrist and subsequently moved to a private unit until a place became available in an NHS facility.

Context

According to the principle of equivalence, prisoners who meet the criteria for treatment in hospital under the Mental Health Act should have the same access to a hospital place and standard of care as those people in the community.

Ideally, the prison should be able to arrange a transfer:

- a. accurately identifying everyone for whom NHS services are appropriate
- b. gaining the input of the patient about his/her wishes
- c. having available a range of options to transfer the patient to (including, for example, medium secure places and community mental health care)
- d. consistently achieving transfers within the time limits
- e. not holding the person in segregation pending their transfer.

The problems with transfers (delays, lack of available places, disputes about eligibility or which PCT is responsible) highlight the 'prisoner or patient' gulf. There is a huge gap between what happens to a severely mentally ill person in a prison and one who falls ill in the community. Prison health care staff have to jump a series of bureaucratic and time consuming hurdles to get assessments (which have to be repeated if the prisoner is moved) and securing agreement to funding from the PCT and a bed from the NHS before the transfer can take place. A duplicate, almost parallel, system operates between prisons. Prisons with inpatient facilities may act for a cluster of prisons with reduced health care

cover. The prisoner will need to be assessed and wait for a place in this prison hospital before being assessed again for the NHS transfer.

The long delays in achieving transfers from prison are well recorded and Department of Health guidance on procedure (now revised 2007) and political interest has had some effect in increasing the numbers of transfers since 2004. Guidance states that disputes about funding should not hold up the process and advises on how to resolve problems for finding an appropriate second medical opinion.

A Department of Health audit in 2006 showed that at any one time there were 282 prisoners awaiting initial psychiatric assessment. That is not the end of the process. Professor Charlie Brooker (Lincoln University, 2007 slide presentation) cites prisoners who were awaiting a second psychiatric assessment after transfer had been agreed. Professor Brooker commented that 'relatively large' numbers of people in Prison Service care were not deemed suitable for transfer under the Mental Health Act because of their 'clinical profile, personality disorder, re-referral to appropriate security level, and awaiting decision to accept'.

The Chief Inspector of Prisons reported that although there has been a 20% decrease in the number of people waiting for a transfer for more than 12 weeks from assessment, assessments can be delayed, for long periods, until a bed becomes available (HMCIP, 2007: para 2.20).

The main role of inreach teams is to work with prisoners who have severe and enduring mental illness. As most, if not all, of these should be cared for by the NHS rather than the Prison Service, the inreach team mandate implies that arranging for transfers should be a major part of their work. In addition, time limits for transfers have been set. If they find it difficult to arrange transfers for those who require one, then this role will monopolise their time and reduce their effectiveness in working with the majority of prisoners with mental health problems.

The evidence gathered from Independent Monitoring Boards responding to the survey demonstrates that transferring a prisoner who is seriously mentally ill to appropriate NHS services is cumbersome and often results in intolerable delays. An obvious solution to many of these delays is to improve the functioning of diversion from custody, far earlier in the criminal justice process.

6 Treatment

No problems with medication but psychological input is limited.
(Board chair)

The extremely high prevalence of mental health problems in prison suggests that providing good quality mental health treatment should be a high priority for the NHS, through its primary care trusts, and mental health inreach teams. The wide range of mental health problems among prisoners requires a diverse, multi-disciplinary response, including, for example, counselling, cognitive behaviour therapy, psychotherapy, specialist substance misuse support, mental health and social care. All of this should be provided at all prisons, in addition to the appropriate use of medication.

The principle of equivalence suggests that, at a minimum, the prisoner should have available: a full range of treatments and therapies, access to a second opinion, advice about effects of medication and informed consent to treatment.

Findings on mental health treatment

Do you have any concerns about the availability of medication or help via “talking therapies”?

The difficulty for boards in responding to this question is that few members are medically qualified.

- Almost half of the boards providing information about treatment said that they had no concerns about treatment in their prison.
- Over a third of those providing information cited problems with talking therapies.
- Seven boards commented on problems prisoners had in obtaining medication. (Some overlap with problems with therapies).

Four boards commented on problems prisoners had in obtaining medication. A board chair wrote about prescribing practices:

The unchallenged view within health care is that prisoners try it on all the time. A lot of the drugs we are talking about have similar effects to illegal substances and doubtlessly have a currency within the prison. OK, health care staff have to be careful but they never seem to give anyone the benefit of the doubt and . . . often seem very uncaring.

Another said medication was available but there were delays in obtaining it. Problems arose when there was no pharmacy on site and the prison depended on services from a neighbouring prison. Others described situations in which the prison GP prescribed a different medication from that which the prisoner had been given in the community. It seemed that the different prescribing patterns applied in particular to people coming into prison who had been substance misusers. Transfers between prisons also led to gaps in prescribing practices, with some prisoners having to re-start the process of receiving the medication they needed, each time they went to a different prison.

It appeared that prisoners were most likely to tell board members about problems with medication when changes were not explained to them:

Several prisoners have complained to an IMB member that medication they have been on in the community has been withdrawn in prison. They said no explanation was given for the withdrawal . . . It gets further complicated by the fact that many of these drugs have side effects and if a prisoner was stabilised on one drug they may have withdrawal symptoms/adverse reaction/need restabilising when put on another or it's withdrawn altogether. This may not be explained properly to the prisoner.

Another board member made the point that differences in prescribing practices also affect the prisoner after release, if the community GP changes the medication again.

A problem which is not unique to prisons is missed appointments. However, the prison environment may present particular challenges for people with mental illness. Some boards questioned whether these obstacles were fully taken into account by mental health services and uniformed staff in their prisons.

When prisoners failed to attend appointments, it may highlight hidden problems which may not be picked up by health care staff. The prisoner might not have understood, or been able to manage, the procedures for getting to the health care centre. Some may have unidentified learning disabilities. They may be seriously depressed and be unable to motivate themselves. Whether the health care staff recognise the problem of non-attendance and have a method of addressing it will illustrate the extent to which resources are being used effectively.

The subject of prisoners who did not attend their appointments was highlighted by two boards. In one, almost one in three medical appointments were missed. That board observed that some of the prisoners were not capable of attending appointments without help. The board's response to PRT described a prisoner who missed six appointments during the 54 days they were in the prison. There was no evidence that anyone other than the board attempted to find out why this prisoner, who was hearing voices and in a state of distress, had failed to attend.

The Mental Capacity Act 2005 - fully implemented from October 2007 - applies to people in prison. It provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves.

Concerns regarding follow up of appointments by inreach workers to prisoners who miss appointments, were highlighted recently when a prisoner found dead in his cell was found to have missed three appointments which had not been pursued.

Twelve boards wrote with concerns about the provision of talking therapies. Few, however, gave specific details; most commented merely that therapy was limited or 'inadequate'. One suggested that therapy was available for only a small number, and another commented that waiting lists were too long. Another board chair said that in their prison, talking therapies had lapsed due to 'mis-management'.

As stated in the introduction to this section, the high proportion of prisoners who have mental health problems suggests that the population will present a wide variety of disorders, requiring diverse forms of treatment. This view was echoed in the response of a board member:

The manager tells us that more and more complex mental health cases are coming through the system. The health team at [this prison] would, we believe, class themselves as generic. The manager tells us there are times when a 'crisis' team should be used, but there is no funding for such an arrangement.

A board at a small open prison stated that their manageable size enabled them to provide a more sensitive and personal service. All staff knew the prisoners well enough to identify changes in mood or behaviour and to provide support.

Another board described the process of referring people with mental health problems, identifying a number of partners in the system:

Good and appropriate counselling has proved effective although in the case of a torture victim, repatriated from a foreign jail, it wasn't plain sailing. The counsellor provided was a bereavement counsellor and after quite a few sessions, [the patient] realised that it wasn't helping and [their] mental state was deteriorating. Once a practitioner experienced in counselling victims of torture was brought in then progress was good.

On referral, a RMN carries out a risk assessment using a nine point questionnaire. This takes about fifteen minutes. Based on this the nurse decides what action is needed, and the level of urgency required. If a full mental health assessment is required there is normally a delay of one – two weeks. The full assessment by a RMN then takes up to two hours. Following this, the prisoner will be seen by one or more of the following: doctor, inreach team, community psychiatric nurse, psychologist, Mind worker, chaplain/ counsellors. A flow chart showing the primary care mental health pathway makes the structure clear.

Context

At present, according to the Policy Exchange report (Policy Exchange, 2008), there is a lack of clarity about the roles of inreach teams; in particular, whether they should focus solely on people with profound mental ill health, or serve a broader group of prisoners who have common mental health problems, such as depression, anxiety, and personality disorders.

Part of the treatment options in the community are ‘talking therapies’, which comprise: cognitive behaviour therapy, counselling, group work, holistic methods (such as Raiki, massage and acupuncture), and psychotherapy. While it is true that not all of these are available to everyone in the community, prisons have much higher concentrations of people with mental health problems, and hence the variety of problems in prison is much greater.

The evidence on this question from boards who responded demonstrates that mental health care in prisons is still very far from an equivalent service. It is not just a question of resources: the purposes of prison include a punitive function and they are not designed to treat people who are mentally ill. As one board member wrote:

There remains an underlying and unresolved ethical dilemma about holding people with mental health illnesses in closed conditions, where providing treatment and support for them, which is similar to that available in the community, is almost impossible.

7 Prisoners with learning disabilities

Learning disabilities pose a great challenge to wing and other staff and mental health needs may not be detected in the general run of the prison. As board members we are not automatically informed of people with such needs.

(Board chair)

Personality disorders and learning disabilities can become overwhelming in a prison, but do not always seem to trigger the right specialist help. It seems obvious to us that the prison experience exacerbates these underlying problems with long term damaging effects on the individual.

(Board chair)

People with learning disabilities are more vulnerable to poor mental health and find it harder to access services because of their disability. A learning disability is not regarded as a mental disorder for the purposes of the amended Mental Health Act 2007 unless the disability is associated with ‘abnormally aggressive or seriously irresponsible conduct on his part’.

No One Knows, a programme of work at the Prison Reform Trust focused on the needs of people with learning disabilities and learning difficulties who are caught up in the criminal justice system, published its conclusions in November, 2008 (Jenny Talbot, 2008).

The proportion of people in prison who have learning disabilities or learning difficulties that interfere with their ability to cope with the criminal justice system has been estimated at 20 to 30% (Prison Reform Trust, 2007a: page 1). A study of three prisons found that just under 7% were assessed as learning disabled and over one quarter as borderline learning disabled. *No One Knows* also reported a consensus that the rate of dyslexia in prisons is about 30%. One assessment estimated that 60% of prisoners have a reading ability equal to or below that of a five-year old child.

Findings on prisoners who have learning disabilities

What support is available for those with mental health needs who also have a learning disability?

- 26 boards – over half of the boards who provided information – stated explicitly that there is no specific service for learning disabilities (LD).
- A third gave no response to the question, suggesting that greater awareness of learning disabilities is required.

The main examples of good practice in working with prisoners who have learning disabilities came from Holloway and Gloucester prisons.

- In Holloway, a multi-disciplinary learning disability steering group had been formed and had developed an action plan.
- In Gloucester, prisoners identified with learning disabilities were referred to partnership agencies from outside.

In the remaining three prisons where the board expressed general satisfaction, two regarded learning disabilities as the responsibility of health care, and one, as the responsibility of the education department.

Boards described some of the evidence that people with learning disabilities had been neglected in their prisons:

No-one questioned can remember any severely learning disabled prisoners in [this prison]. Discussions are taking place to have a LD champion. Any mildly LD prisoner is referred appropriately to Learning and Skills etc.

One board quoted a head of learning and skills in their response:

Prisons do not employ (either individually or on an area basis) educational psychologists. Prison psychologists are either clinical or forensic. Consequently there is no-one on site with appropriate specialist knowledge and expertise to diagnose learning disabilities or identify possible disorders such as ADHD [attention deficit hyperactivity disorder] or disorders on the autistic spectrum which may seriously reduce the ability of women to access and engage effectively in mainstream education and vocational training in prisons. Moreover, there is no funding to enable prisons to buy in this expertise from local education authorities and there is also no funding within the current OLASS [Offenders' Learning and Skills Service] provision for contracted education providers to provide such a service.

A recurrent theme was that there is a lack of staff who have any training in identifying or caring for people with learning disabilities, so that the problem often goes undetected. As *No One Knows* has argued, this usually means that the prisoner's needs will be neglected; and sometimes means that failures by the prisoner to comply will be punished. The following case shows both the challenges facing prisons in holding people who have learning disabilities and an example of good practice:

A young man with learning disability and evidence of possible schizophrenia and autism was experiencing pressure from other prisoners on the wing. The board objected when he was relocated to a different wing, with more limited facilities, as he was not the perpetrator. The young man had spent most of his life in special care homes where he had a very structured regime with good continuity of care.

The board member reported that an officer, normally traditional in approach, suspected that this young man was disoriented and that the bizarre behaviour he exhibited was a result of not being able to follow and understand simple instructions. The officer sought solutions for these problems. Once the prisoner understood what was expected of him, he began to comply. On the initiative of the officer, the wing created a care map, using resources in the prison to enable the young man to stay on original location despite his unpredictable and sometimes risky behaviour. The education department provided special help with activities and education and provided a mentor. Together, they created order and structure for him on the wing until a semi-secure psychiatric unit could be found for him.

The board commented that many man hours were invested in helping the young prisoner. It was very encouraging to see prison officers tackling the issue so well. The board pointed out that this was done for one out of 610 prisoners and commented that 'at least a third would benefit enormously from such attention'.

(Board response paraphrased)

Context

Despite estimates about the high prevalence of learning disabilities among prisoners, they remain a hidden group in many prisons. Learning disabilities were not mentioned in the early health commissioning strategy documents although there is now a booklet, 'Positive Practice; Positive Outcomes,' for professionals produced by the Care Services Improvement Partnership (CSIP). In the foreword, Rob Greig, National Director for Learning Disabilities, wrote:

Without ... appropriate support people may be extremely vulnerable to neglect, abuse and the risk of persistent reoffending. There is thus a shared interest between those involved in the criminal justice system, the health and social care systems and the learning disabled people themselves in ensuring the provision of high quality support.

(CSIP, 2007: page 2)

The Chief Inspector of Prisons' thematic review on mental health found that there was no prisoner on the caseload of the inreach teams surveyed for learning disabilities alone, and – more worryingly – no evidence of any attempt to engage learning disability services for prisoners with both mental illness and a learning disability (HMCIP, 2007: para 7.23/29).

Under the Disability Discrimination Act (DDA, 2005) public services have duties to ensure equal opportunity for people who are disabled and to eliminate discrimination against them. A basic weakness in this duty is that learning disabilities often go unidentified: it is a 'hidden disability'. Thus, while the Police and Criminal Evidence Act makes it clear that defendants who are vulnerable should have access to an appropriate adult, *No One Knows* found that less than a third of prisoners with learning disabilities or borderline learning disabilities said that they had received the support from an appropriate adult during the police interview (Talbot, 2008: page v).

Interviews with prisoners who have learning disabilities or learning difficulties revealed that they frequently could not access offender behaviour courses (with the likely consequence that many would spend longer in custody). They also tended to spend longer periods of time on their own with little to do. Their lived experience of prison was of systematic disadvantage, as their inability to read and understand prison information hindered them from many benefits of the prison regime, including family visits, going to the gym, choice of meals, or canteen.

Among the recommendations from *No One Knows* are that:

- all courts should be required to produce a disability equality scheme
- all criminal justice system information and interventions should be produced in 'easy read' or alternatives of the same quality
- people with learning disabilities and learning difficulties should be identified at the point of arrest and appropriate support put in place
- awareness training on learning disabilities and learning difficulties should be undertaken by all staff who come into contact with people as they enter and travel through the criminal justice system.

(Talbot, 2008: pages 78-79)

8 Prisoners with dual diagnosis

A large proportion of women who come here have mental health issues together with drug and alcohol dependency. Those with serious mental health issues are well served but it is likely that others slip through the net, especially if they are engaged in de-tox programmes.

(Board chair)

In respect of dual diagnosis, the inter-relations between physical and mental health symptoms (often found with prisoners), their treatment and costs involved are a major issue for this prison.

(Board chair)

The proportion of prisoners with a dual diagnosis is much higher than in the general public. The Social Exclusion Unit report on reducing reoffending by ex-prisoners, stated that 60-70% of people in prison had misused drugs prior to imprisonment; and over 70% of prisoners suffer from at least two mental disorders (SEU, 2002). On 13 February 2006, Lord Bassam stated that around 39,000 prisoners had a serious drug problem, almost half of the total population at the time.

Findings about prisoners with a dual diagnosis

What support is available for those with mental health needs who also have a dual diagnosis involving addictions?

Six boards felt that their prison provided a good service for people with dual diagnosis. Most of these responses included descriptions of good practice. For example:

Joint working with the juvenile substance misuse service. Any young person with a history of drug taking is referred to this service as a matter of course and picked up by them, also with input from the multi-disciplinary nursing team.

There are links with the local community team prior to release.

Seven boards provided evidence that the prison was working to provide services for those with dual diagnosis, though there were some gaps. For example, in one prison, it appears that prisoners arriving with a dual diagnosis were required first to go through drug treatment before their mental health needs were picked up by the inreach team. Although it is true that drug misuse can mask poor mental health, treating people in sequences, rather than providing an integrated service, can allow many people to slip through the net.

Better evidence of integration came from a different board:

The health care team also work alongside the CARATs team [counselling, assessment, referral, advice, and throughcare service] providing input into those with dual diagnosis.

The boards at eight prisons suggested that the service provided was inadequate. Some of these said that drug treatment was provided, but could give no evidence about the management of dual diagnosis. One of these explicitly stated that the scale of demand for dual diagnosis services meant that common mental health problems are neglected.

For prisoners with substance misuse problems, there are a range of services and programmes available within the prison although these are often over stretched and working to full capacity. How effectively such prisoners, who also present as having mental health needs, are dealt with is unclear. One would like to think that there was a multidisciplinary approach to working with such prisoners, but the board have yet to see the evidence that such co working occurs.

The boards from 12 prisons gave no evidence of any programme for people with dual diagnosis. Two of these stated that prisoners with dual diagnosis would not be admitted into the prison; another said that plans were currently being made to provide services.

A high number of boards – 25 – gave no response to the question.

Context

A psychiatrist, quoted in a toolkit produced by Rethink and Turning Point, explained:

People with a dual diagnosis are, in effect, a kind of mental health underclass. They find that their needs are not severe enough to meet the criteria of any single agency, so they can fall just below the threshold of all “helping” services . . . As a result, they have a dreadful quality of life, even though they may have six or seven major problems, they may receive either no help, or just bits and bobs of help without clear coordination.

(Rethink and Turning Point, 2004)

Further analysis of the Office for National Statistics 1997 data shows strong correlations between a severe dependence on cannabis and psychostimulants and psychosis, suggesting that much mental illness in prisons is linked with substance misuse, and needs to be treated alongside it in a coordinated approach.

Into the Mainstream, a Department of Health paper, stated that the prevalence of dual diagnosis among women prisoners had an important implication for policy: ‘Dual diagnosis should be considered as usual rather than exceptional and mental health services need to provide appropriate interventions.’

Despite this commitment, there is some evidence that, in prison, drug treatment services and inreach teams do not reach many people with dual diagnosis. For example, mental health services were commissioned without reference to CARATs teams, which were introduced in 1998 to address substance misuse. Guidance failed to make explicit how two services would work together (HMCIP, 2007: para 2.8).

The original strategy for mental health inreach of targeting services at severe and enduring mental illness overlooked the less severe combination of primary mental health need, personality disorder and substance misuse which is frequent in the prison population. Protocols between inreach teams and CARATs teams cover referrals, but not joint work. It is by accident – not design – when substance misuse specialists in prison have a background in mental health care.

The Department of Health guide states:

- *Mainstream mental health services have a responsibility to address the needs of people with a dual diagnosis.*
- *Where they exist, specialist teams of dual diagnosis workers should provide support to mainstream mental health services.*
- *All staff in assertive outreach must be trained and equipped to work with dual diagnosis.*
- *Adequate numbers of staff in crisis resolution and early intervention teams, CMHTs [community mental health teams] and inpatient settings must also be so trained.*
- *They must be able to link up with each other and with specialist advice and support, including from drug and alcohol agencies.*
- *All local health and social care economies must map need including for those in prison.*
- *Project teams must be set up and must agree a local plan to meet need which must contain an agreed local focused definition, care pathways/care coordination protocols and clinical governance guidelines.*
- *All clients must be on the CPA [care programme approach] and must have a full risk assessment regardless of their location within services.*
- *LITs [local implementation teams] should take the lead in implementing these guidelines ensuring that commissioning is coordinated across PCTs and DATs [drug action teams].*

(DoH, 2002b: page 16)

9 Particular groups at risk

This board is concerned that elderly prisoners with complex mental health and physical needs are being held in the health care centre of the prison which has neither the appropriate facilities and equipment nor sufficiently trained staff to respond to their needs.

(Board chair)

Our greatest concern is for those women who have “untreatable personality disorders” who, because they are deemed to be untreatable, cannot transfer to a hospital. They therefore remain in prison, even though their level of self-harming behaviour is often very high. Surely there is a need for more appropriate accommodation for these incredibly needy women?

(Board chair)

The Equalities and Human Rights Commission works to eliminate discrimination on the basis of age, religion, disability, gender, race, or sexual orientation. When services in prison target the most common needs of the majority population, there is a risk that specific needs of minority groups will be neglected. It is important to recognise that providing a fair service does not mean providing everyone with the same service. Service providers can use impact assessments to determine whether their policies are likely to disadvantage any particular group.

Findings on particular mental health needs

Do you have any concerns about mental health needs and treatment of any particular group within the prison population, for example children, the elderly, vulnerable women, foreign national or black and minority ethnic prisoners?

- Few boards expressed any concern about foreign national prisoners, vulnerable prisoners, offenders with a history of alcohol misuse, or black and minority ethnic prisoners.
- One-third of those responding to the question explicitly stated that they had no concerns about any particular group.
- About one in four boards raised concerns about elderly prisoners, some of whom focused on physical disabilities.

Nine boards mentioned concerns about elderly prisoners (more than any other group). In one prison, the board reported that the health care centre was being used inappropriately to house elderly prisoners:

This board is concerned that elderly prisoners with complex mental health and physical needs are being held in the health care centre of the prison which has neither the appropriate facilities and equipment nor sufficiently trained staff to respond to their needs.

Another explicitly mentioned the problem of dementia:

There are an increasing number of elderly prisoners, three of which are suffering from a severe degree of dementia. Some experienced staff on VPU wing [vulnerable prisoner unit], where the age profile of prisoners is higher, are aware of mental decline in older prisoners.

Four remarked upon a lack of programmes for people with personality disorders. One chair stated that care for people with personality disorders depended on subtle definitions:

In talking to the prison doctor it became apparent that the medical profession would classify many of the issues we, as members of the public, and many prison officers call mental health issues, as social not medical problems.

Two boards expressed concerns that people located on the prison's vulnerable prisoner unit had limited access to health care. At one prison, the inreach team provided a safer custody group for prisoners – presumably to reduce the risk of self-harm. But at the time of the response, the group was not available to prisoners on the vulnerable prisoner unit – arguably the prisoners most in need – though the board expected that the problem would soon be resolved.

In 2000, the then director general conceded that the Prison Service was institutionally racist. Within health services, a programme, 'Delivering Race Equality', was established on the basis that more needed to be done to ensure equality of access to treatment. Yet, despite these official acknowledgements of racism in public services, only two of the 57 boards who replied to the survey expressed concern about the treatment provided for people from BME groups. The National Council of Independent Monitoring Boards may wish to consider steps that could raise awareness among its members.

Two other boards mentioned black and minority ethnic prisoners, citing examples of good practice. In Gloucester and Dartmoor prisons, links had been established with a mental health support group for BME people. Other boards could explore how they might promote similar schemes in their prisons.

Context

The Prison Reform Trust report, *Troubled Inside* (2005a), discussed the specific mental health needs of five groups. Special problems in accessing mental health care in prison might arise for prisoners who:

- are from BME groups
- are elderly
- are deaf
- have a learning disability
- hold foreign nationality.

The needs of particular groups have been highlighted in different ways.

The vulnerability of women offenders is well-documented in the SEU report (2002) and in the Corston report (2007). The SEU report presented evidence about women prisoners:

- 70% of women in prison suffer from two or more mental health problems
- 37% of women in prison have attempted suicide
- 66% of women offenders report drug and alcohol abuse.

The Corston report drew attention to women offenders with particular vulnerabilities, including mental health problems. Baroness Corston suggested that the problems that lead women into conflict with criminal justice fall under three areas:

- domestic circumstances and problems such as domestic violence, abuse, child-care issues, being a single-parent
- personal circumstances such as mental illness, low self-esteem, eating disorders, substance misuse
- socio-economic factors such as poverty, isolation and unemployment.

Imprisonment, even for a short period of remand, can exacerbate the woman's problems in all of these areas. If abuse, self-harm, or depression is linked to her offending, it is very likely that her condition will worsen while she is inside (Prison Reform Trust, 2003). The Corston report made a powerful case for a drastic reduction in the numbers of women sent to prison. While the government has accepted 40 of 43 of Baroness Corston's recommendations, implementation remains slow.

There is increasing concern about elderly prisoners. At the end of March 2008, there were 6,661 men and 316 women over the age of 50 in prison in England and Wales, just under 9% of the prison population. There were 454 people over the age of 70. Over half of all elderly prisoners suffer from a mental illness, the most common being depression which can emerge as a result of imprisonment.

The Prison Reform Trust, together with the Centre on Policy for Ageing, published a report on older prisoners, *Growing Old in Prison* (2003). The report cited evidence that older prisoners are more likely than others to suffer from depression. They are also more likely to be socially isolated. More recently, a briefing paper, *Doing Time* (PRT, 2008) recommended that inreach teams should have training on the specific needs of elderly prisoners.

Mental health problems typical of older prisoners can develop unnoticed. The Chief Inspector of Prisons' review, *No Problems, Old and Quiet*, (HMCIP, 2004b) argued that the lack of a strategy for responding to the needs of older prisoners reveals a tendency to target problems that demand attention (for example, by disrupting the prison routine) to the neglect of hidden needs. In this environment, it is particularly important to devise strategies for mental health that spell out how hidden problems will be identified and treated.

A study conducted by Frank Keating, *Breaking the Circles of Fear* (Keating, 2002), suggested that treatment of people from BME communities is hampered by mutual mistrust between professionals in mental health and people from BME groups. The study concluded that too often, black people come to the attention of mental health services at a late stage and are often severely ill before they begin to receive treatment.

The Chief Inspector's thematic review on mental health found evidence that the diverse needs of prisoners – in particular, women and black and minority ethnic prisoners – were missed in prison:

Services were insufficiently responsive to diverse needs. Neither substance use nor mental health services were sufficiently alert to the different needs of BME prisoners; nor were they monitoring access effectively.
(HMCIP, 2007: 6)

The Chief Inspector expressed concern that problems identified in screening prisoners on reception were much less likely to be followed up for BME prisoners (49%) than for white prisoners (68%) (HMCIP, 2007: 59). In addition, the thematic review stated that ethnicity was not reliably reported on clinical records and there was little awareness of different health needs of different ethnic groups.

A primary function of an Independent Monitoring Board is to respond to prisoners' complaints. This role may have influenced their ability to identify particular groups who might not be able to access mental health services. Although board members routinely observe the day-to-day life of a prison, they also depend on prisoners' willingness to report problems. It is likely that the responses to this particular question reflect, to some extent, the patterns of complaints that reach the board.

The evidence provided by some boards suggests that some prisons need to focus on the particular needs of elderly prisoners, as well as prisoners with personality disorders. But boards should also consider how they can be more proactive in identifying problems for groups who are more reticent about discussing concerns with board members.

10 Patient involvement

The services are run on a consent based approach where advocacy is said to be not needed.

(Board chair)

The government has taken practical steps to enhance the extent to which patients can participate in decision-making about their treatment under the NHS. Since April 2008, patients have been able to choose from a wide range of providers throughout the country.

Choices in Mental Health, published jointly by the National Institute for Mental Health (NIMHE) and the Care Services Improvement Partnership (CSIP), sets out benefits and principles of patient choice: the principle of choice promotes integration into the community and upholds the patient's place in society. The person should have available to them a range of varied access routes to health care, together with clear information about how to access them. The principle of person centred care means that individual patients have considerable discretion about their treatment. Patients, as a group, should be enabled to provide input into policies that affect all service users.

Findings on patient involvement

What arrangements are made to enable the prisoner to have a say in his/her own treatment or use advocacy?

- 16 boards – over a quarter of those responding to the survey – did not provide information relevant to patient choice.
- 11 boards gave examples of good practice.

The good practice highlighted by 11 boards could be applied in all prisons. Examples include:

- involving the prisoners' families in decisions (Ashfield YOI, Stoke Heath YOI)
- independent advocacy regularly available (Gloucester, Nottingham Stafford)
- patients signing contracts for care plans (Everthorpe)
- a copy of the care plan provided to patient (Low Newton)
- the risk of relapse incorporated in care plan (Everthorpe)
- patient advice and liaison service (PALS) (Everthorpe, Gloucester Parkhurst)
- involvement of Mind or other relevant voluntary sector support (Low Newton)

The boards at 10 prisons stated that some attempts had been made to enable patients to have a say, but there were limitations on how well it worked in practice. For example, two of these stated that patients consent to treatment and there is no need for an advocacy service. In others, nurses served as advocates, rather than providing independent advocates.

In 19 prisons, the boards' responses to this question indicated that patient involvement and advocacy were under-developed. One wrote simply: 'all prisoners are free to refuse treatment.' Another stated that staff decide whether a prisoner is able to contribute to decisions about his treatment.

One board wrote:

The prisoner has no way of querying what is going on (nor do we) other than through the independent complaints scheme. Furthermore because of their situation they can't do what you would do on the out - change doctors or get a second opinion!

The impression from many responses is that prison mental health care has failed to develop patient involvement in comparison with efforts outside. One example of good practice was provided by the chair of the board at Dartmoor, who described plans to establish a mental health forum there.

Context

Mind defined user involvement as:

Equal citizenship; dignity and respect in mental health services; full information on treatments and rights; involvement in treatment and care; independent advocacy in every area; broad participation of users through equal opportunities employment and service delivery practices; involvement in planning, running and evaluation of services; policies to ensure it is safe to get involved; training of workers by users; practical commitment and resources for user involvement.

(Mind, 1993)

Care and treatment is likely to be more effective when patients are empowered to take control over their lives and to participate in making decisions about the treatment they will receive. Mind also suggests that services will become more effective if they take the experience of service users into account.

Medical training and practice have an increasing emphasis on a patient centred approach and skills to develop the patient's voice. Patient involvement is central to assessments, as stated in Choices in Mental Health:

After someone has reached the initial access and engagement point, his or her needs should be assessed in the spirit of partnership, through an open discussion about their current situation. At this point, possible referral to other community-based services and non-statutory support or more specialist care is agreed.

(NIMHE and CSIP: Choices in Mental Health)

However, the implementation of patient choice by the NHS has been patchy in mental health services, as described by a recent briefing by the Sainsbury Centre for Mental Health:

Mental health service users who are involved in their own care planning are more satisfied with the services they receive but . . . currently many service users and carers are not meaningfully involved.

(SCMH, Briefing 31: 4)

Research by Joan Langan and Vivien Lindow revealed a wide range in the extent to which mental health service users were permitted to have a say (Langan and Lindow, 2004). Although there was some evidence of users who were able to influence the treatment they received, the general picture was that patients were restricted to accepting or rejecting what was given. Langan and Lindow found little evidence of the use of advocates, and in some cases, patients were not informed about possible options in the treatment they were given. They, too, found that in the relationship between the service provider and the service user, user involvement could mean merely commenting on treatment, not influencing it. Few of the professionals they interviewed discussed how to elicit participation by hard to reach patients.

Langan and Lindow examined the extent to which mental health patients had a say in their own risk assessments:

Many service users were aware that they could pose a risk to other people when experiencing psychosis and they wanted help to reduce the chances of this happening.

(Langan and Lindow, 2004)

A useful tool for managing risk in the care of individuals is the advance directive, a statement by the patient, setting out their wishes in the event of an emergency. A briefing by the Sainsbury Centre for Mental Health (SCMH, 2006) describes the advance directive in detail.

The Royal College of Psychiatrists suggested a number of principles of patient involvement as the House of Lords considered proposed amendments to the Mental Health Act:

- *respect patients' past and present wishes and feeling*
- *minimise restrictions on liberty*
- *involve patients in planning, developing and delivering care and treatment appropriate to them*
- *avoid unlawful discrimination*
- *consider effectiveness of treatment*
- *consider the views of carers and other interested parties*
- *consider patient well being and safety*
- *consider public safety.*

(Royal College of Psychiatry, 2007)

These are excellent benchmarks against which to judge developments in patient involvement and choice.

The Chief Inspector's review of mental health surveyed prisoners receiving mental health care and found that:

- 57% said they had been given choice
- 48% had been asked what worked for them in the past.

Of those on medication:

- 98% knew what it was for
- 70% been told about possible side effects
- 63% knew how long it would take for medications to work.

(HMCIP 2007: para 5.22)

11 Peer support and involvement of the voluntary sector

This prison has actively promoted liaison and support from community voluntary organisations, with a number of organisations actively involved.

(Board chair)

Samaritans began to train prisoners to provide support for other prisoners who were in distress in the early 1990s (the Listener scheme). Since that time, prisons have rapidly expanded the range of opportunities for prisoners to support other prisoners. The roles now include, in addition to Listeners:

- mentors, for example Toe-by-Toe, a programme through which prisoners mentor other prisoners in reading skills
- 'Insiders', peer support for new prisoners by more experienced ones, on a meet-and-greet basis
- race representatives, prisoners providing advice about responding to racist incidents.

Findings on peer support

Do peer support schemes or voluntary organisations make a contribution?

- 20 boards did not respond to this question.
- 20 boards cited peer support schemes. Although it is clear that peer support is far more widespread than this would suggest, it may be that their relevance to mental health care is not well known.

Twenty boards were aware of peer support schemes in their prison. Although most of them cited the Listener scheme, other examples included the use of mentors and prisoners helping out with mental health day care.

Two responses (from the boards at Dartmoor and Dorchester) demonstrated the wide variety of ways that prisons have developed the idea of peer support (although not all had relevance to mental health) and described the plans to work with the voluntary sector:

Peer groups run the wing Listener scheme with training and oversight from Samaritans. There are wing reps for anti bullying, race relations and recently introduced prisoners' council, plus the new older prisoner initiative mentioned above. This latter programme has been initiated with the active involvement of Age Concern who in turn have engaged community volunteers and volunteers from the Plymouth University social work students course. Fata He, a local BME voluntary organisation, will also be working with the BME and foreign national prisoners.

(Dartmoor board)

This prison has actively promoted liaison and support from community voluntary organisations, with number of organisations actively involved.

- *Good practice road shows held in the prison with organisations displaying their services and prisoners wing by wing visiting during the day to talk to representatives.*
- *Training organisations, housing, benefits agency, volunteer bureau, local companies willing to recruit ex-prisoners many more...*
- *Chaplaincy multi faith volunteers and Imam weekly rotas.*
- *'Footprints' church all faiths service to support prisoners on release.*
- *Dr Barnardo's volunteer . . . developing services to prisoner families visiting.*
- *Prison visiting service.*

(Dorchester board)

However, one board sent words of caution against a misuse of peer support, namely, a temptation to turn to Listeners as a resource to provide mental health counselling in times of crisis.

The Listeners are a very important part of the 'loop', but it may be unfair and inappropriate to use them in a severe mental health situation. The latter cannot be left to chance but needs watertight protocols between the prison and the PCT. It is not good enough for people to try to wriggle out of their responsibilities and hope that someone else's budget will pick up the tab.

The hugely successful HOPIN (Help Other Prisoners In Need) service, introduced at HMP Stafford in 2005, where experienced prisoners help others, usually new, prisoners in a whole range of areas both at induction and during their time on the wings: this also has the benefit of reducing the demands on already stretched staff resources.

Twenty-two boards mentioned the involvement of the voluntary sector. The prisons that involve the voluntary sector made use of a wide range of organisations, including Samaritans, Mind, Alcoholics Anonymous, a bereavement counselling service, Barnardos, and PALS.

Context

In 2005, the Prison Reform Trust worked with women prisoners, the governor and staff at Holloway prison to develop ideas about what prisoners could do to help themselves, and what they could be doing to help other prisoners. The project demonstrated that prisoners could be a valuable resource for other prisoners, in a wide range of areas of need.

The programme with the most direct link to mental health is the Listeners scheme. Any prisoner in distress can ask to see a Listener, a peer trained by Samaritans to support someone in distress. However, Listeners are not meant to treat mental illness or to provide mental health counselling. In addition, Listeners maintain the principle of

confidentiality, which means that they will not contribute to case conferences or mental health reviews.

There is also a wide range of voluntary sector organisations which offer expertise in mental health. Prisons have made greater effort to link up with relevant voluntary sector agencies in recent years.

12 Family support

Families seem to be peripheral in any decision making particularly if they live a long way away.

(Board chair)

Family contact can reduce the feelings of isolation and stress caused by imprisonment. Prisons can more effectively meet the needs of prisoners for emotional support, and respond to families in a more consistent way, by:

- further development of family contact development officers
- ensuring that families are kept well-informed
- involving them in key processes such as sentence planning and suicide prevention
- conferring responsibility for family relations to a specific, accountable person, to coordinate the work with families
- initiating a family relations working group, with a remit that parallels the work of race relations management teams.

Findings on family liaison

Is any particular attention paid to the involvement of families when a relative is mentally ill in prison?

- Of the 57 boards who provided information, not one stated that families were always involved in decisions about mental health care as a matter of principle.
- Conversely, seven boards said explicitly that families were never – or very rarely – consulted about mental health care.
- 23 boards – over one in three of the boards in the survey – did not respond to the question.

One chair spoke for many boards in stating that families were ‘peripheral’ to decision-making about a prisoner’s mental health. That only two of the 57 who provided information were able to describe good practice in this area gives a strong indication that families are rarely considered in thinking about the mental health treatment of prisoners.

A number of boards cited specific problems that arose in trying to involve families. Two referred to the distance families would need to travel. Others explained that many prisoners have lost contact with their families.

Three boards identified a policy dilemma: there can be a tension between respect for the rights of the prisoner to confidentiality and communication with the prisoner's family.

Families may be approached for information on their medical history and treatment – however, informed consent must be given by the prisoner.

Another chair stated:

The inreach team tries to avoid entering into correspondence with prisoner families and would only meet with them on rare occasions.

The two examples of good practice were a policy of involving families in treatment plans, and family days at the prison:

It is often the case that close contact is kept with families – they are often invited to case conferences and are an important source of information and support.

Due to its location . . . [HMP - -] is a net importer of prisoners. The majority of its inmates are located more than 100 miles from home. Almost without exception these prisoners would like to be located closer to home. The prison is not easy to reach by public transport, so family and friends find visiting difficult and expensive. The anxiety this causes prisoners should not be underestimated. The situation is made even worse by the inadequate transport resource available for transfers, and so even prisoners who have received confirmation of a place at a prison closer to home (itself a slow and uncertain process) may have to wait months or even longer for the move to take place. They often have no idea that the move will actually happen until 24 hours beforehand. There are currently more than 40 prisoners in this situation, with one having waited more than a year. Throughout this wait they are consumed with uncertainty and the board believes this is a contributory factor to some of the 'social mental health problems' we see.

Context

The Chief Inspector's thematic report on mental health surveyed prisoners. Just over half of them had regular contact with family and friends and just over a quarter had some contact. Inreach team leads were asked if they had invited family or a friend to discuss the care plans. Only 8% of client's families had been involved in their care planning. The Inspectorate added that over half of the inreach teams said that families had been contacted, but had not been involved in decision making because of the problem of distance. The Inspectorate concluded that this was a 'low level of family involvement for a high risk group of prisoners with multiple needs' (HMCIP, 2007: para 5.29).

A recent assessment of pacts' first night in custody service by the Prison Reform Trust (PRT, 2007b) found that in the early days of imprisonment, isolation from families was often a major cause of distress. The first night service was often asked by prisoners to make contact with the prisoner's family, to provide basic information and help them to decipher prison policies. But this contact could lead to deeper involvement, for example, helping prisoners and their families to manage the problems that arise for them when a family member is sent to prison.

A second Prison Reform Trust study, *Keeping in Touch*, presented evidence from prisons in Scotland that maintaining contact with families improved the mental health of both prisoners and their families and could help to reduce reoffending. Involving families is also likely to bring practical benefits. For example, prisoners who receive visits are much more likely to have accommodation on release. The author, Dr Nancy Loucks, contended that:

Dedicated family support staff can build on relations with families to increase a family's participation in prisoners' sentence plans, rehabilitation, and resettlement. Improved welfare of prisoners and families is also likely, as better relations means better communication and information regarding risk of suicide, concerns about mental health, and drug use.

(Prison Reform Trust, 2005b: page 15)

13 Resettlement

In our experience, some people have received excellent care prior to and on discharge with one man being provided with fresh clothing and taken to a railway station a distance away in order to avoid other prisoners being discharged that morning. It would, clearly, not be possible to give everyone that level of consideration so it is vital that the NOMS concept of a seamless service should work in reality. This has staffing (and therefore resource implications). With the promise of money going to "Titan" prisons where is the funding to come from?

(Board chair)

All the prisoners are invited to an interview with health care two weeks prior to release. This provides the opportunity to address issues for those with mental health needs as well as primary care needs.

(Board chair)

Prisoners with mental health needs often face a combination of problems after release. They might need a tailored package of accommodation, drug misuse services, health care and support for physical and mental illness, and social services.

Findings

What help are people with mental health needs given to prepare for release and to ensure continuity of health and social care and access to entitlements?

- 30% of the boards who responded to this question believed that support from the community to ensure continuity of care and successful reintegration was lacking.
- One in five cited the use of the care programme approach in preparing people for release.

A major problem for people who are mentally ill and who are released from prison is the 'revolving door'. Some boards suggested that part of the problem is that the mental health needs of this group of prisoners often fall just short of the threshold, and the lack of support results in their return to prison. One chair's observation is typical:

HMP - - - is a local prison taking into custody all those committed by the courts. Many of these are part of the 'revolving door', in which prisoners serve out a life sentence, not in one stretch, but in sequential committals. They are known to the courts and are sent to prison as there is no alternative provision available. Those provisions that exist depend on a diagnosis of mental health, and where one cannot be found there is no help available, which seems to be the crux of the problem.

A number of boards made the point that the resources outside are so over-stretched that the released prisoner faces a struggle in trying to obtain treatment. A few boards argued that holding prisoners far from their home areas seriously impedes arrangements for post-release support.

An article by Paul Bowen, Kate Markus and Azeem Suterwalla stressed the importance of preparing for release well in advance of the discharge date (Bowen et al, 2008, Edgar et al, 2008). For many local authorities, 28 days is not a sufficient time period to conduct an assessment of a vulnerable person and then make the necessary arrangements to provide post-release care and support. Clearly the local authority depends on the prison to inform them of a prisoner's release date.

Only eight boards provided any evidence that the process of obtaining post-release support started in good time in their prison. In some prisons, the process was led by a resettlement or discharge board. One board stated that the process is organised jointly by the resettlement team and the inreach team. In others, health care took primary responsibility (presumably for prisoners identified as having significant mental health problems).

However, a small number of local prisons – male and female – focused on remanded prisoners. There was a clear need to prioritise arrangements for post-prison mental health care when the person leaves the prison for a court appearance and is then discharged at court. One chair, at a women's prison, wrote:

Last year it was brought to my attention that prisoners who are released suddenly from court tend not to have any care plan in place. It can take several days to arrange this with outside agencies and is impossible if it happens just before the weekend. It may be appropriate for the courts in some cases to check that for mentally ill or vulnerable prisoner a care plan has been put in place before a prisoner is released.

There were eight prisons (of 43 who responded to this question) where the board thought there were good links with the community. Three stated that because their inreach team was employed by the local mental health trust, it had good contacts with the full range of mental health care in the community. One board stated that joint care programme meetings were regularly held in the prison. One, the board at Birmingham, described a post of discharge co-ordinator who worked with prisoners held in other regions who would be resettled in Birmingham.

As stated above, the ideal way to prepare for post-release care and support was to engage a range of partners to build a coordinated, multi-disciplinary network. Four boards described how this could be done. One (the board at Holloway) said that the process involves the resettlement unit, probation services (inside and out), prisoners themselves and their families, and community organisations.

There is ... a team approach with health care, MHIRT, and OMU[offender management unit] to prepare for their release.

Contact for GP registration

Informing primary health care community teams

Housing accommodation

Benefits advisory contacts

Probation OMU

REAT [race Equality Action Team]

Prison dialogue meetings.

(Dorchester board)

The board at HMP Wellingborough explicitly mentioned prisoners who do not qualify for a care programme approach (CPA):

Patients who are not on the severe mental illness register but on the national service framework mental illness register will have a discharge summary prepared and referred to their local community mental health team. They may already be known to them or a new referral for assessment made to them. There are other patients with mild/moderate mental health issues who can be followed up by their GP. They will be discussed within the team's referral meeting that is held on a monthly basis by the prison mental health team.

A new programme, 'Mind the gap', has just been introduced which may provide assistance to more of the prisoners who have problems which fall outside the scope of medical treatment. It is funded by the charity Mind for two years. It covers patients who are referred by the PCT and inreach who do not meet the criteria for secondary care. For example, anger management, self esteem or anxiety issues will be covered. It should also be able to assist the 'poor copers' mentioned earlier. The project extends to helping prisoners who it is anticipated may have problems coping with release for the same reasons.

(Channings Wood board)

Context

Changing the Outlook stated that no prisoner with a serious mental illness would leave prison without a care plan and a designated care co-ordinator (DoH, 2001: 28). The care programme approach should link the prisoner, once discharged, to appropriate community services. Care plans should include secure suitable occupational activity, adequate housing and appropriate entitlement to welfare benefits. Care plan conferences

need to be attended by all the key professionals. Ideally, relatives and carers of the prisoner with severe mental health problems are encouraged to attend. Equivalence with the NHS requires that a severely ill prisoner should receive a follow up contact with a clinician within seven days, as their counterpart would receive in the community. Under the Health Service Act 2006, health care services to which prisoners might be entitled include: GPs, community mental health teams, community learning disability teams, and hospitals.

People coming out of prisons have rights which are often not met. Many, who are eligible for housing, community care services, and health care do not receive it. The article by Bowen and colleagues shows how prisons can access support for prisoners. They stress that discharged prisoners have the same rights to health, housing and community care services as anyone else. Local authorities are legally obliged to assess the needs of vulnerable people, prior to release from prison. To set the process going, the first step should be that the prison – which knows the probable date of release – informs the local authority that the offender is vulnerable and should be assessed (Edgar et al., 2008). However, when prisons fail to inform the local authority, or fail to contact them in time, the prisoner will be released without having arrangements in place for proper support.

The Chief Inspector's thematic review found evidence that many prisons did little to meet the practical needs of mentally ill prisoners prior to release.

Those with primary mental health needs had rare communication with resettlement teams prior to release, and referral to GPs in the community was variable. Links were also variable for the 31 clients in our sample who were approaching release. Only half recorded contact with community mental health teams within three months of the date of release, clients were not routinely involved and kept informed about resettlement planning, and information about ongoing mental health care on release was not routinely shared with other disciplines with resettlement responsibilities.
(HMCIP, 2007: para 1.37)

In addition, the prison inspectorate's survey of prisoners in contact with the inreach team in prisons found that only 38% of those about to be released had been involved in their release plans. This was particularly inefficient as – when agencies do not communicate – the prisoner is the only source of information a receiving agency has about what has been previously arranged. The original commissioning arrangements had never made clear how inreach teams were to work with prison resettlement teams or probation.

People with mental health problems or learning disabilities do not necessarily require constant and long-term mental health care and support. Not everyone who might be eligible for mental health care will qualify for a care programme approach. Even so, they might be able to access community care. It is unlawful to refuse to provide community care services to persons with mental health problems or learning disabilities merely because they do not meet the criteria for the CPA.

The ideal solution would be a single, integrated care plan. Under the National Health Service and Community Care Act (1990), assessment processes . . .

Should include the responsible housing authority and PCT where a request for cooperation is made under s47(3). This should result in one, global assessment of the prisoner's housing, health and community care needs with a single care plan that identifies all his/her needs, the services to be provided to meet those needs and the agencies responsible for meeting those needs, well in advance of the prisoner's actual release date.

(Bowen et al, 2008)

14 Coordination

NHS liaison with the prison is good when patients become prisoners – not so good the other way around. Mental health prisoners can present with complex behavioural problems and the local NHS Trust seem to think that the prison should be looking after them. There seems to be little understanding by them that a prisoner with mental health issues is still entitled to outside NHS care.

(Board chair)

Coordination within a prison refers to the collaborative work between uniformed staff, health care, the inreach team, CARATs, resettlement teams, probation, education and others. Each of these departments has links and communication with agencies outside the prison, such as social services, housing associations, probation, and the police. Prisoners are in an extremely dependent position, and often ill-informed about the communications concerning them that occur between the various departments inside prisons and agencies in the community.

Findings on coordination of services in the prison

Is there good coordination between NHS and prison staff and services?

- Over one in four boards could not provide useful information relevant to this question.

Of those who responded:

- Ten boards provided detailed descriptions of the mechanics required for improving inter-agency coordination, including which agencies are involved, how the prison makes the links, and under what circumstances.
- One in four provided evidence about a lack of coordination.
- One in four felt coordination within the prison was good.
- One in four felt that coordination with outside mental health services was good.

Good practice in promoting coordination

Few boards provided clear descriptions about how coordination was fostered at their prison. However, their responses did suggest aspects of good practice:

- proactive multi-agency teams well-established inside the prison
- governor and local PCT meet regularly
- representatives of all areas of the prison, including voluntary sector agencies, and the PCT in the health action group
- mental health care group comprising the doctor, RMNs, inreach, Mind, meets every week.

A new mental health pathway has been drawn up from reception through to aftercare. It identifies the interventions, activities, responders, and key links. This huge piece of work has been carried out by all the stakeholders – prison governors and officers, PCT staff, mental health trust staff, psychiatrist. Signs are good that extra staff/resources will be funded.
(Chelmsford board)

Problems identified in achieving coordinated services

Boards drew attention to a range of obstacles to coordination within prisons or between prisons and services in the community:

- outside services seem to lack the desire (or resources) to assist
- the prison and the PCT [have] not met for nearly two years which is very unsatisfactory
- lack of detail in service level agreement between the prison and PCT leaves vague responsibility for responding to serious mental health needs
- reluctance among prisons and medical professionals outside to share information about patients
- difficulties in communication between inreach and wing staff
- lack of clarity about the role of the registered mental health nurse (RMN) within the mental health team
- no overlap between times of staff so communication between teams is problematic.

A chair described tense relations with the providers of community mental health care:

Mental health prisoners can present with complex behavioural problems and the local NHS Trust seem to think that the prison should be looking after them. There seems to be little understanding by them that a prisoner with mental health issues is still entitled to outside NHS care.

PCT nurses do not have access to the 'Carebase' data system. Mental health trust day care staff and PCT health care staff do not have regular meetings, do not share all need-to-know information and are separately managed on different floors of the same building. The PCT staff feel strongly that they hold the fort 24 hours of the day and that mental health day care staff should be more available for mental health emergencies/incidents. Mental health staff say they are not invited to case reviews where they feel their input would be important.

One board wrote that education staff are not informed about mental health assessments. Therefore, prisoners are placed in classes without the teacher having any forewarning of sensitive areas that may increase the risk of self-harm; nor any idea of identified behavioural or emotional problems that might interfere with the person's capacity for learning.

Another board said that officers were frustrated that their job of caring for prisoners was made much more difficult due to health care professionals refusing to share information. A third described the clash of cultures inside the prison, as health care made efforts to work with uniformed staff:

Day to day working relationships appear good. However the understanding of mental health issues by both SMT [senior management team] and prison officers will need improved communications, excellent training and crucially ongoing support for the staff who deal with prisoners on a day today basis.

Context

This question about coordination encompassed, for example, uniformed staff, managers, health care staff, inreach teams, CARATs, education, chaplaincy, works, and probation, in addition to outside agencies.

The Chief Inspector found a lack of coordination between the inreach teams and wing staff, or between the team and mental health professionals outside:

A third of the 84 MHIRTs surveyed preferred to receive referrals from health care staff and almost a fifth were reluctant to receive referrals from prison staff who had no mental health awareness training. Few prisons had RMNs in the primary care team who could screen referrals or deliver primary mental health care, and links with primary care teams were not always good.

(HMCIP, 2007: para 1.19)

Obstacles to close cooperation between the inreach team and the uniformed officers are raised by the tensions between the values of health care and punishment. Alice Mills has written:

The key tasks of the prison to punish and to maintain order and control continue to conflict with notions of care and treatment, and mental health workers have experienced hostility when they are seen to 'care' for prisoners . . . or have challenged prison practices that are detrimental to good mental health.

(Mills, 2008)

Department of Health practice guidance states that if a prisoner is held on a wing, then residential staff should be involved in the care programme approach. The Chief Inspector found that inreach teams under-estimated the effect to which wing staff could contribute to case management: 'only 12% of MHIRT leads reported genuine cooperative working and CPA rarely involved residential staff.' (HMCIP, 2007: para 7.5)

Prison Service instruction 251/2002 contains guidance about the importance of sharing information with other agencies but the prison inspectorate reported a widespread belief among both health care and non health care that clinical information should not be shared (HMCIP, 2007: para 7.8) Just over half (53%) of staff interviewed who had referred individual prisoners had received some limited feedback.

Good links with agencies outside prison are needed for effective resettlement particularly if the prisoner has been transferred from his/her home area. However, continuity of care can be undermined by aspects of current policy. The PCT in which the prison is located holds responsibility for providing health care for the prisoners, even when an individual prisoner, approaching release, plans to return home to a different part of the country. In practice, the care planning for this person would either be delayed until the patient returns home, or carried out under the PCT where the prison is situated, which will have no further role in implementing the care plan (NHS, 2002).

15 Summary and recommendations

The boards who responded to the survey shed much light on the current state of mental health, and mental health care, in prisons. The diverse views expressed provide a useful and independent overview.

A significant number of prisons receive people who have a serious mental illness and for whom prison is not a suitable environment. Caring for these people places intolerable strains on prisons, and exhausts disproportionate amounts of resources and staff time. From the perspective of many boards, these prisoners should not have been sent to prison, and were not diverted when they should have been by police and court liaison services, or supported adequately by mental health services in the community.

Many prisons lack the resources they would need to conduct full psychiatric assessments of those they receive. Boards saw problems in the way mentally ill people are treated when they first arrive in prisons:

- a lack of information arriving with the person
- too often prisons must rely on information from the prisoner to build up a profile of the person's needs
- too few prisons have access to specialist trained staff who can accurately assess mental health problems at an early stage.

The shift of commissioning responsibility to PCTs has resulted in an improvement in health services; and the arrival of mental health in-reach teams has greatly improved mental health care for prisoners. However, there remains a huge gap, as the mental health needs of prisoners have expanded in numbers, severity and complexity.

There are some signs of improvement in the capacity to transfer mentally ill people in prison to suitable services outside. However, intolerable delays were reported by some boards. A wider concern is that far too often, prisons use segregation units to hold people who are seriously ill until a transfer can be arranged.

Good practice in providing treatment was reported by a small number of boards, and this included:

- thorough assessments of need
- a range of treatments available in the prison
- early planning for continuity of care after discharge
- links made to community mental health teams.

There is scope for much greater use of a range of therapies for prisoners; there is a particular need for therapy for personality disorder.

A small number of boards mentioned prisoners missing appointments, where there appeared to be little effort by the prison or health care to determine why the person did not attend. Far more needs to be done to support prisoners to ensure that they can negotiate the hoops within prison and are able to attend appointments for mental health care.

Many prisons lack any means of identifying people who have learning disabilities, and often their disabilities restrict their capacity to engage fully with the regime.

The coordination required between services for substance misusers and mental health inreach teams is often poor, with the consequence that people with dual diagnosis are often not provided with an integrated service.

A high number of boards expressed concerns about elderly prisoners; few boards appeared to be aware of difficulties that BME prisoners sometimes face in accessing mental health services.

It appeared from the responses that mental health services in many prisons have done little to develop patient involvement and choice. Although many boards said that prisoners could refuse treatment, there was little evidence that inreach teams consulted patients about the provision of care in the prison, or engaged them in decisions about their treatment.

Most prisons reporting back had expanded the use of peer support services, such as the Listeners, and some made use of an extensive network of organisations from the voluntary sector. The benefits from these developments were, as yet, far from their long-term potential.

One board spoke for many in suggesting that the prison was treating families as 'peripheral' to work intended to meet the prisoners' mental health needs. Boards felt that prison mental health care could be far more pro-active in engaging prisoners' families in decisions about the person's mental health care (with appropriate safeguards for prisoners who did not wish to work with their families).

A number of boards were concerned about a perceived tendency to release people from prison with no after-care arrangements in place, with the predictable outcome that the person was often returned to face a subsequent prison sentence.

Remanded prisoners who were released directly from court were particularly likely to fall through the net. It appears that many people in this situation were released with no mental health plan, no support, and no links set up.

One board listed the essential steps to prepare for a person's release:

- registration with a GP
- contact with the primary care trust
- as appropriate, contact with the community mental health team
- advice with housing and benefits
- a multi-faceted, problem-solving resettlement plan.

Many boards felt that there was a lack of effective coordination of services, both within the prison, and between the prison and the local community. Good practice identified included:

- multi-agency teams within the prison
- a health action group with good representation from all prison departments, the voluntary sector and prisoner representatives
- monthly meetings between the local PCT and the governor
- clarity of purpose.

Recommendations

Examining the wide-ranging evidence provided by these independent monitoring boards, the Prison Reform Trust recommends:

- The Equality and Human Rights Commission should investigate compliance with the Disability Discrimination Act (DDA) by all criminal justice services. NOMS (National Offender Management Service) should also initiate an internal review of compliance with the DDA. Work to comply fully with the DDA would highlight the need for far more efficient mechanisms for diverting mentally ill people from the criminal justice system.
- The new Care Quality Commission should monitor the extent to which equivalence in mental health care is being achieved in prisons. This could be conducted jointly with the Inspectorate of Prisons.

Diversion

- A national network of court and police diversion and liaison schemes should be established, with performance targets and sustainable funding.
- Police, court officials, and magistrates should have regular training in understanding mental illness and learning disabilities.
- Local mental health and social care services should be required to provide full and current information to courts about the resources and services in their areas.
- The 'appropriate adult' in police stations and courts must be fully resourced so that they can work with duty social workers to facilitate referrals to mental health services and social care.

Transfers out of prison under the Mental Health Act

- Under current policy (DOH Guidance 2007 page 7), when a prisoner is assessed as needing a transfer and is then moved to a different prison, they must be re-assessed before the transfer can take place. The policy causes unnecessary delay and should be reviewed.
- A more efficient structure is needed to resolve disputes between Primary Care Trusts (PCTs) over which of them is the responsible commissioner for a prisoner's mental health care.

Treatment of mentally ill people in prison

- Every prison should have learning disability specialists, providing a better assessment service, improved conditions and treatment, and follow-up support.
- When prisoners do not attend mental health care appointments, reasons for non-attendance should be rigorously explored, and then remedied.
- The Prison Service Order on segregation (1700) which permits the use of segregation for people at risk of self-harm 'in exceptional circumstances' should be tightened to eliminate the current over-use of segregation units for prisoners with serious mental health problems.
- Patient involvement, and engaging prisoners' families in treatment planning, should be high priorities for mental health inreach services.
- Every prison should expand its links to voluntary organisations outside, in particular, with black and minority ethnic groups. Mental health inreach teams should also ensure that they maintain links with the PCT's community development workers.
- Performance measures and standards should be introduced to assess PCTs on the adequacy of prison mental health care.
- Each prison should have a full complement of staff in mental health teams equivalent to the norms that would apply in the community for the prevalence and caseload of psychiatric morbidity.

Resettlement

- More should be done to provide specialist mental health and social support for people released on licence to ensure that will not be returned to prison for breaching their conditions.
- Prison resettlement units and probation staff should alert local authorities to their duties to assess the needs of vulnerable prisoners at an early stage well before they are released from prison. Prison Service Orders give guidance on this but need to be reinforced by training and support for prison officers acting as advocates for vulnerable prisoners.
- Prior to release, arrangements should be made for any prisoner needing continuing mental health care to establish registration with a GP, suitable accommodation, and a commitment from the relevant local mental health care services to provide support.
- Under current rules of residence, prisoners with mental health needs eligible for the care programme approach are not the responsibility of their 'home' PCT until they are released. When prisoners are held away from their home area, any care planning that occurs will be carried out by the area in which the prison is situated. The result can be delay and confusion and often no support for prisoners released with mental health problems. Guidance on the rules of residence need to be clarified to ensure that support services, to which vulnerable prisoners are legally entitled, are provided in a timely way.

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Annual reports of Independent Monitoring Boards across England and Wales have identified prisoners' unmet mental health need as a foremost concern. Supported by the Mercers' Company, the Prison Reform Trust initiated this review of prisoners' mental health. Dr Peter Selby, President of the National Council for Independent Monitoring Boards wrote to the chair of each board asking them to inform the Prison Reform Trust about mental health need in the prison which they monitor. This unique report draws on these views and sets them in the context of current research and policy.

In his foreword to the report Dr Selby says: 'There is no more distressing a mismatch in our criminal justice system than mental illness and prison. Would anybody prescribe for a mentally ill person the kind of environment that a prison needs to be, let alone the kind of environment that actually exists in our oldest and most unsuitable prisons? Yet this mismatch is what tens of thousands of prisoners experience.'

Too Little Too Late identifies failures and gaps in the system as well as highlighting examples of good practice and improvements in services. It makes clear recommendations for change. A proper network of court and police diversion and liaison schemes should be established. Police, court officials, and sentencers should have regular training in understanding mental illness and learning disabilities. Performance measures and standards should be introduced to assess the adequacy of prison mental health care and plans for support on release.



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