NHS
National Institute for
Mental Health in England

Offender Mental Health Care Pathway

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Foreword

The Government is committed to ensuring that individuals who suffer from mental illness have their needs met. This includes people who have come into contact with the criminal justice system, whether this be at the point of arrest, whilst in prison, or when living back in the community after release.

"Changing the Outlook: A Strategy for Developing and Modernising Mental Health Services in Prisons"- December 2001, sets out the future development of prison mental health services so that services more closely match those that would be available in the community.

A substantial investment has been committed between 2003 and 2006 to mental health in-reach services – these are similar to Community Mental Health teams 94 prisons are now in receipt of funding to develop this service. The NHS Plan gave a commitment to have 300 extra staff providing mental health services to prisoners by the end of 2004 – this target has been reached. NHS investment in mental health services for prisoners totalled £10 million in 2003/04 and is set to double to £20 million a year by 2005/06. This is taking place alongside the wider plan to move the commissioning of all healthcare services in public sector prisons to local Primary Care Trusts by 2006.

We are now in a position to make progress on two fundamental aims of mental health care for prisoners. The first is that no-one with acute severe mental illness should be in prison. The second is that prisons should be safe places for people with mental health problems and that suicides should be increasingly prevented.

As a result of the implementation of Changing the outlook, and significant investment from the NHS, demonstrable improvements in the mental health care available to prisoners can now be seen. However, it is clear that contemporary mental health services need to be able to bridge the gap between prison and the wider community i.e. before and after, or ‘end to end’.

This care pathway document lays down valuable best practice templates to guide providers and commissioners mental health services for those involved in the criminal justice system. It is based on the best evidence currently available, sourced from both literature and innovative clinical practice.

John Boyington
Director Health Partnerships

Professor Louis Appleby
National Clinical Director Mental Health

The offender mental health care pathway is intended to guide the practice of people who directly deliver services, and support decision making for those who commission them.

A wide base of evidence was used in the development of the care pathway. Whilst it would not be appropriate to include all of that background data here, providers and commissioners are encouraged to read ***"Offender mental health – a case for change"*** which makes clear the level of need for contemporary mental health services prior to, inside, and on release from prison.

The best practice tables that make up most of this document, are intended to act as a broad framework for end to end management of offender's mental health needs. A framework for practice and commissioning is clearly useful, but should be matched to tools and resources for implementation.

A number of tools have been developed to support the implementation of the care pathway, details of these are included in this document following the best practice tables. Additionally, regional prison mental health leads have been appointed to work in each National Institute for Mental Health in England (NIMHE) development centre, the contact details of these staff, along with other key contacts, are included at the end of this document.

ACCT	Assessment, Care in Custody and Teamwork – prison care planning system currently being piloted
ASW	Approved Social Worker
CARATs	Counselling, Assessment, Referral, Advice and Throughcare services – for drug treatment in prison
CBT	Cognitive Behaviour Therapy
CJDT	Criminal Justice Drugs Team – part of Criminal Justice Intervention Programme currently being introduced nationally
CJIP	Criminal Justice Intervention Programme aimed at reducing drug related offending
CJLS	Criminal Justice Liaison Service
Cmht	Community Mental Health Team
CPA	Care Programme Approach
CPS	Crown Prosecution Service
DAT	Drug Action Team
DTTO	Drug Treatment and Testing Order
GP	General Practitioner
HCC	Health Care Centre
HMP	Her Majesty's Prison
IMR	Individual Medical Record ***(superseded by the clinical record 'CR')***
LD	Learning Disability
MDT	Multi-Disciplinary Team
MH	Mental Health
MHPIG	Department of Health Mental Health Policy Implementation Guide
Nacro	National Association for the Care and Resettlement of Offenders
NHS	National Health Service
NIMHE	National Institute for Mental Health in England
NSF	National Service Framework
NTA	National Treatment Agency
OASys	Offender Assessment System
PCT	Primary Care Trust
PSO	Prison Service Order
RMN	Registered Mental Health Nurse
RSU	Regional Secure Unit

Offender Mental Health Care Pathway

Templates for Good Practice

Contents:

Key Phase: Pre-prison

Elements	Who Is Involved?	Key Points/Objectives	Pertinent Questions	Policy Reference and Good Practice
Police Custody – point of charge (MH) • Referral for MH/risk assessment to Criminal Justice Liaison Service • Initial MH/risk assessment • If on CPA contact Care Co-ordinator • Mental Health Act assessment for prisoners likely to require NHS admission • Initiate care plan or review CPA plan • Use suicide/self harm warning form and/or PNC to communicate risk • Link with Criminal Justice Drug Team if prisoner on DTTO	Custody Sergeant/Senior Custody Officer Criminal Justice Liaison team – assumes relevant inputs from ASW, RMN, psychiatrist, psychologist, LD specialist Criminal Justice Drug Team Prisoner/detainee Links with Care Coordinator if on CPA	• To facilitate early detection of offenders with mental health problems and divert out of criminal justice into NHS system for appropriate care and treatment • Identify whether prisoner is on CPA / is suffering severe mental illness or needs to be assessed under the MH Act • To identify and reduce suicide risk • To provide ongoing MH support and care if prisoner is to go to court and pass on relevant information to the court based RMN nurse	• Are police custody sergeants trained in mental health awareness, including suicide risk assessment and management? • Is suicide/self harm warning form and/or PNC used to communicate risk? • Are written protocols in place between agencies and teams to share information? • Is the CJL team networking with all relevant agencies to enable the provision of integrated care and support? • Is the CJL team liaising with the CJ Drugs team re co morbidity issues? • What about links with the family?	References: 1, 5, 40, 42
Police Custody – point of charge (Drugs) • Drugs test made available to court • Triage assessment by Criminal Justice Drug Team (CJDT) • Obtain background information • Harm reduction and interventions initiated • Initiate Care plan • Link with CJL team if prisoner is at risk of self harm, or has MH problems/history	Custody Sergeant/Senior Custody officer Criminal Justice Liaison team if presenting with MH problems or MH history Criminal Justice Drug Team Prisoner Links with DAT, probation, housing, voluntary agencies	• To reduce drug related offending by moving prisoners through criminal justice interventions into the drug treatment system • To identify if prisoner is on DTTO • To determine if appropriate for arrest referral or enhanced arrest referral treatment programme • To carry out drug testing for offenders charged with trigger offences • To offer an integrated approach if the prisoner is at risk of self harm or has MH problems • To offer ongoing support if prisoner is going to court	• Is the CJD team networking with all relevant agencies to enable the provision of integrated care and support? • Is the CJD team liaising with the CJL team re co morbidity issues? • What access is there to local support groups to provide additional support?	References: 11, 12, 13, 28, 40, 41
Court • MH referral from the defence, CPS, clerk of the court or magistrate to court MH nurse • MH court assessment by court Mental Health nurse	Defence, CPS, clerk of the court or magistrate Prisoner Court MH nurse Psychiatrist Psychologist LD specialist	• To provide oral or written evidence to the court regarding the mental health of the prisoner to determine whether court diversion, adjournment, remand or a custodial sentence should apply • To minimise the number of court	• Is the specialist a report provided by CJL team members or is it subject to a referral system, which can add, further waiting time in remand? • Is there a robust system in place to	References: 1, 5, 40, 41 • Criminal Justice Liaison Schemes • Prison Liaison/link nurse • Avon and Wiltshire MH CJLS prison liaison nurse

• Further specialist reports may be requested by the court • CJDT provide information and progress reports to court • Prisoner remanded in custody or sentenced • Identify potential risk of suicide/self harm	Care Coordinator if prisoner on CPA Criminal Justice Drugs Team Probation Escort staff, families, solicitors	appearances, reduce waiting time in remand and prevent undue stress • To pass on relevant MH information to the Care Coordinator (if on CPA) or prison, if the prisoner is to go to prison	ensure that relevant MH information is passed onto prison reception staff if the prisoner is to be transferred to prison custody?	who links with the Care Coordinator and prison service pre and post prison • HMPs Liverpool and Belmarsh both have liaison nurses
Transfers between Court, Custody, prison or bail hostels • Identify potential risk of suicide/self harm, substance misuse or MH problems during transfers	Prisoner Custody Sergeant Senior Custody Officer Prison Escort Staff Prison Reception Staff Criminal Justice Liaison team Criminal Justice Drug Team Prison Liaison nurse	• To notify receiving prisons of prisoners who may be at risk of self harm, suicide, substance misuse or MH problems • To record actions taken during pre/inter-prison custody period to keep prisoner safe • To share relevant information between agencies	• Does the CJL team have a dedicated prison liaison nurse? If not, who is responsible for ensuring that there are proper linkages with the receiving prison, escort staff or bail hostels to pass on relevant MH information from the criminal justice interventions?	References: 1, 6, 11, 12, 13, 16, 17,30, 37, 40, 41

Key Phase: At Reception

Elements	Who Is Involved?	Key Points/Objectives	Pertinent Questions	Policy Reference and Good Practice
Health Screening • Background information collected: - Medical records from GP - CPA plan from Care Co-ordinator - Suicide/Self Harm Warning form PER and verbal handover from prison escort - Relevant information from CJL team/care co-ordinator - Relevant substance misuse information passed on from CJD team • Health screening carried out • Refer to MH nurse for immediate assessment when MH screening triggers are present giving all relevant	Reception health care staff Prisoner Prison escort Criminal Justice Liaison team Care Coordinator if on CPA Criminal Justice Drug Team GP	• To assist in identifying prisoners, who, on their reception into prison, may have health related problems that will require some form of healthcare input during their first days in prison. • To bring to notice individuals who would benefit from further specialised assessment. • To carry out health screening in a private room preferably in the first night unit • Healthcare problems being screened include: - Immediate physical health needs - Injuries - Serious mental illness - Suicide risk • To provide a direct access to secondary mental health care (In-reach team) and continuity of care for prisoners who are on CPA	• Have ligature points been removed from holding rooms in Reception? • Does the health screening take place in a private interview room? • Is the interview room located in the first night centre? • Are there dedicated competent health care screening staff? • Are the following MH screening triggers present? - MH psychiatric history/treatment - Self-harm history - On anti-psychotic or antidepressant medication - On murder or manslaughter charge • Do prisoners currently on standard or enhanced CPA prior to prison get referred directly to the In-Reach team?	References: 2, 3, 4, 6, 11, 12, 13, 16, 17, 18-23, 27, 29, 32, 34, 37, 39 References: 28, 35, 36

background information collected • Refer direct to In-Reach team for prisoners who are on standard or enhanced CPA or drug withdrawal, refer to clinical substance misuse team for assessment and treatment • For positive screen of alcohol or drug withdrawal refer to detoxification unit and detox nurse for assessment and treatment				
Mental Health Assessment (triage) • MH assessment carried out taking into account IMR, background information, current medication • Devise care plan for prisoners with mild to moderate mental health problems in conjunction with wing staff, primary care team and other agencies as necessary. • Allocate a care co-ordinator based on the wing • If prisoner is presenting with acute MH symptoms, refer to In-reach team • Refer to visiting specialists eg psychiatrist for further MH assessment • ACCT prison care planning process initiated for those at risk of self-harm or suicide • Any relevant information regarding potential risk shared with first night unit staff	Mental Health Nurse Prisoner Primary care team Wing staff /unit manager Personal officer In-reach team Health Care Centre First night officers Visiting specialists eg psychiatrist, psychologist, LD specialist	• To carry out a MH assessment on prisoners who have been identified at particular risk from the health screening process • To refer to the appropriate health team so that a care plan and treatment can be delivered on the wing where possible • To provide continuity of care • To initiate the prison wing care planning process (ACCT) for prisoners who need additional care	• Are there written protocols in place to manage the health care needs of the prisoner following the health screening? • Are wing staff trained in the role of care co-ordination? • Are there sufficient staff with appropriate skills to carry out a triage mental health assessment and plan and provide care?	References: 3, 4, 6, 16, 17, 25, 32, 34

Key Phase: First Night and Induction

Elements	Who Is Involved?	Key Points/Objectives	Pertinent Questions	Policy Reference and Good Practice
First Night Unit • Relevant health screening information passed on to First night unit officers • Cell-sharing risk assessment • Prison accommodation compliant with Safer Custody guidance PSO2700 • Information shared with induction staff • Any self-harm or suicide concerns identified on "Concern and Keep Safe" form • Triage assessment carried out by trained assessors through ACCT prison care planning process • Severe symptoms of mental illness referred to In-reach team or Health Care Centre	First night officers Prisoner Reception staff Induction unit officers	• To provide greater opportunity to identify and provide appropriate care for prisoners at heightened risk of self-harm and suicide • To provide a safe physical environment • To provide information and support to the prisoner to help reduce anxiety	• Is there a dedicated first night unit? • Is it staffed with trained dedicated first night officers? • Are shared cells used as a safeguard? • Is there a clinical substance misuse unit? • Are increased supervision and reviews provided for at risk prisoners in single cell accommodation? • Is there access to safe cell accommodation? • Are listeners provided with access to the first night area? • Is there access to a family hotline? • Are the ACCT assessors given MH supervision by the In-reach team? • Are there clear written protocols in place regarding referrals to the in-reach team or admission to the Health Care Centre? • Are First night officers trained in mental awareness? • Is a doctor available to prescribe for withdrawal symptoms	References: 6, 11, 12, 13, 16-23, 25, 27, 29, 37 • Extended shift times in unit to allow dedicated time with prisoners • Information in different languages and formats • Prominent information on display re Samaritans, Listeners, peer support schemes • Late unlocking for access to specialist staff • Access to OASys database providing information regarding past and present risks of harm • Access to prescribing for withdrawal symptoms
Induction Unit • Full multi-disciplinary assessment of prisoner's needs carried out • Prisoners follow induction programme. Length varies from 3-5 days • All relevant information passed onto Wing staff/personal officer and primary care team including	Induction unit officers Prisoners Multi-disciplinary prison staff Wing officers Nominated Personal Officer Primary care team	• To complete a comprehensive assessment of the prisoner's needs and level of risk so that appropriate care and support can be provided • To provide orientation to the prison • To reduce anxiety levels	• Is all information relating to self-harm and risk shared and passed onto the wing staff or nominated personal officer? • Is information regarding any mental health problems passed onto the wing based primary care team? • Are First night officers trained to identify severe mental health problems and risk of self-harm and	References: 6, 11, 12, 13, 16-23, 27, 29, 37 • Induction staff support toolkit • Self Harm management training package • Good access to listeners on the induction unit • Dedicated First Night and Induction Units at HMPs Birmingham, Eastwood

ACCT documentation where applicable • Any self-harm or suicide concerns identified on "Concern and Keep Safe" form • Triage assessment carried out by trained assessors initiating ACCT prison care planning process • Severe symptoms of mental illness referred to In-reach team or Health Care Centre			suicide? • Is the induction programme available to those admitted to the Health Centre, vulnerable prisoners following stabilisation or detox programmes for prisoners with substance misuse problems? • Is there help for maintaining links with family and arranging visits? • Is there a local prison Suicide and Self-Harm Prevention Strategy in place?	Park, Winchester, Wandsworth, Felton and Leeds

Key Phase: Prison Wing (1)

Elements	Who Is Involved?	Key Points/Objectives	Pertinent Questions	Policy Reference and Good Practice
Primary Care Team • Relevant care plan information and ACCT documentation regarding self –harm or suicide passed onto wing and primary care from the induction unit • Devise care plan and allocate a care co-ordinator for prisoners with mild to moderate mental health problems identified by Reception MH assessment • Accept new prison staff referrals and carry out initial MH assessment • For mild to moderate mental health problems, initiate care plan and regular reviews with wing based staff • Manage chronic diseases on the prison wing eg psychosis, bipolar disease, depression following assessment and advice under clinical	Wing officers/unit manager Prisoner Personal officer Primary care team which includes a primary mental health nurse, medical officer/GP Reception staff MH Assessment nurse Detox/drug worker/CARATS In-reach team Visiting specialists eg psychiatrist, psychologist, LD specialist All care plans to have residential staff involvement, where prisoner is on ordinary location Most care plans will be jointly managed by residential staff and primary care staff Some care plans may be jointly managed by primary care and	• To support staff to develop an environment that supports mental health and well-being • Identify prisoners with MH and substance misuse disorders • Manage prisoners with common MH disorders eg depression, anxiety disorders, sleep problems, somatic complaints, chronic tiredness, alcohol related problems • To refer appropriately for assessment, advice or treatment • Provide information and guidance for those who provide regular care for prisoners with MH problems • Contribute to the multi-disciplinary work to prevent suicide	• Is the prisoner information kept on the wing? • Are clear written protocols in place regarding appropriate routes of referral for all MH problems? • Are wing staff given support and training regarding suicide prevention, self-harm, first aid, care planning, medication side effects? • Do prisoners have access to: specialist counselling eg bereavement, abuse • anger management • anxiety management • self harm management (developing alternative coping strategies) • cognitive behavioural therapies eg reasoning and rehabilitation, enhanced thinking skills • Sex Offending Treatment programme?	References: 6, 7, 10, 16-23, 24, 25, 30, 32, 33, 34, 35, 36, 38 • Ref. 14 South East Region Multi-media abuse awareness training kit • Ref 15 – Praxis Distance learning package for CBT • Ref 15 – Recruitment of GPs for HMPs Acklington and Castington • Prison Healthcare skills toolkit • HMP Wandsworth have developed a clinical pathway for substance misuse • HMP Holloway offer crisis counselling and art therapy • HMP Brockhill offers self harm management group teaching alternative coping strategies and using art & music therapy

supervision from In-reach team • If evidence of severe mental illness, risk of self-harm, non-compliance with treatment or medication, refer direct to In-reach team for assessment • Refer to visiting specialists for further assessments and advice • Detox discharge screening information forwarded to wing staff and primary care team. Follow up treatment plan provided by CARATs/drug treatment nurse • ACCT documentation initiated for identified risk of self harm or suicide	in-reach teams. May be jointly managed between primary care staff and CARATs/drug treatment nurse			• MH primary care nurses • Personal officer schemes
Purposeful day/Therapeutic day activity • Range of therapeutic interventions to be accessed are identified as part of the appropriate assessment and care planning process eg CPA, ACCT, drug treatment planning, sentence planning	Prisoner Wing staff Personal officer Primary care staff Health Care Staff In-reach staff Occupational, art, music, social therapists Gym instructors Education centre staff CARATs Various support groups Chaplain	• To provide a wide range of activities and therapies at different levels of intensity and support to meet individual prisoner MH need and improve MH functioning • To provide a non-threatening therapeutic environment so that prisoners can identify specific problems and obtain suitable interventions for them. • To access the full range of prison facilities available • • Therapeutic day activities preferably located in dedicated unit not in Health Centre	Mental health is particularly affected by environmental factors. Do prisoners have access to: • Regular physical exercise and fresh air? • Art and music therapy? • Anti-bullying strategies? • Depression prevention – cognitive behaviour therapies, spiritual reflection? • Acquiring skills including daily living? • Flexible approach re peer support? • Contact with family and friends? • Regular time out of the cell? • Access to in-cell hobbies/diversion? • Specific support groups eg self-harm, post detox or alcohol group work?	References: 16-23, 25, 30, 32, 33, 35, 36, 37, 38 • Ref 15 - HMP Risley MH Drama Group • Relaxation and aromatherapy • Acupuncture • Healthy Living • HMP Brixton Day Care unit

Key Phase: Prison Wing (2)

Elements	Who Is Involved?	Key Points/Objectives	Pertinent Questions	Policy Reference and Good Practice
In-Reach Team (Secondary Care) Referrals • From Primary Health team or Health Care team following initial MH assessment • From Reception if prisoner is on standard or enhanced CPA prior to prison • From ACCT assessor team following risk assessment of self-harm or suicides risk • From clinical substance misuse team unit if positive risks present during programme or on discharge screening **Assessment** • MH assessment of need and risk carried out. Multidisciplinary assessment may be required for complex cases **Options following assessment** • Refer back to primary care or health care with advice and support to develop a care plan • Place prisoner on standard or enhanced CPA following the multidisciplinary care management process, initiate care plan of interventions and act as Care Co-ordinator during prison sentence • For prisoners on standard or enhanced CPA prior to prison: - Liaise with local Community Care co-ordinator, facilitate visits, respond in crisis and	Prisoner In-Reach team. Primarily nurse led but should include access to multidisciplinary sessional inputs from clinical psychology, Occupational therapy, general psychiatry and other therapeutic disciplines Primary care team/mental health nurse Health Care staff Reception staff First night officers Induction unit staff CARATs Probation Social Services Wing officers/personal officers Local Care Co-ordinator	• To provide a multidisciplinary specialist assessment and treatment service similar to the CMHT model in the community • To provide treatment and care for those prisoners with severe, complex and enduring mental health problems whose needs require standard or enhanced levels of CPA. This would include - Functional psychoses - Severe depression - Personality disorder - Prisoners requiring interventions under the Mental Health Act - Integrated care of co-morbidity between behavioural, substance misuse and mental disorders • Regular multi-disciplinary reviews of medication • To provide advice, support and training on the management of mental health problems to all relevant prison areas and prison staff disciplines. (See left column) • To liaise with Care Co-ordinators regarding the ongoing management of prisoners already on CPA • To assume the role of Care Co-ordinator for prisoners whose mental health assessment of needs meet CPA criteria • To accept transfers of care for out of area prisoners on CPA • To admit to the Health Care Centre when prisoner's MH level of risk to self or others cannot be managed on the wing • To facilitate early NHS transfers • To liaise with NHS staff regarding the continuity of care for prisoners being discharged back to the prison • To liaise with all key external agencies regarding pre-discharge planning	• Are there agreed written protocols in place to ensure appropriate referrals are made to the In-Reach team? • Are there mechanisms in place to help identify prisoners who should be on CPA? • Are there effective links with CMHT Care Co-ordinators for new prisoners currently on standard or enhanced CPA? • Are CPA care plans regularly and formally reviewed? • Does the In-Reach team offer the following range of person centred evidence based interventions: - Cognitive Behaviour therapies - Stress and anxiety management - Counselling - Self harm minimisation - Suicide prevention - MH promotion - Medication administration and awareness of side effects - Solution focused approaches - Task centred interventions - Drug and alcohol education - Symptom management - Relapse prevention management - Carer assessments and support • Is there an integrated approach in place between different programmes to provide seamless care in addressing the complex needs of prisoners with comorbidity problems of mental	References: 6, 9, 10, 11, 12, 13, 16-23, 24, 25, 27, 29, 30, 32, 33, 35, 36, 37, 38, 39 42 • Prison In-Reach Collaborative

deliver interventions - Accept transfers of care for out of area prisoners or prison transfers • Arrange admission to Health Centre if prisoner in crisis • Where appropriate refer to NHS for specialised inpatient care See Acute Episode pathway for: • Admission to Health Care centre • NHS transfers and discharges See Pre- Discharge pathway regarding In-reach inputs		• Provide support to families	illness, self-harm, substance misuse or personality disorder? • Does the In-Reach team provide training and education programmes to health care and prison staff to improve their mental health awareness and skills?	

Key Phase: Acute Care (Prison)

Elements	Who Is Involved?	Key Points/Objectives	Pertinent Questions	Policy Reference and Good Practice
Admissions to 24 hr Health Care Centre • Referral for admission • IMR and relevant background documentation eg CPA , ACCT sent to HCC • Initial assessment screening to ensure appropriate admission • Carry out comprehensive MH assessment • Review medication • Review care plan • Refer to NHS for transfer to specialised acute inpatient care • Initiate multi-disciplinary discharge planning upon admission	Direct referrals primarily from In-Reach team, psychiatrist, medical officer, induction unit officers, first night officers, clinical substance misuse team, CARAT Team, Subject to local protocols Health Care Centre Team including trained MH nurses In-Reach team Visiting NHS general or forensic psychiatrist Primary Care Team Prisoner Link with primary and in-reach teams and involve those with a role in the prisoner's care	• To provide 24 hour support, supervision, observation and short term intensive care to stabilise: - prisoners with an acute and severe psychiatric crisis - Prisoners recovering from life threatening self-harm, drug overdoses or suicide attempts - Prisoners in acute crisis due to co-existing complex morbidity problems • To provide a crisis resolution model of care – problem solving approach • To minimise the length of stay	Is accommodation free of obvious ligatures and/or are patients housed together for mutual support and risk reduction? Are there agreed written protocols in place regarding the Health Care Centre's role and purpose, its admission criteria, and range of interventions? Prisoners admitted with schizophrenia pose high risk of suicide, violence or neglect. Are there proper mechanisms in place to ensure prompt action, close supervision in a secure place, good clinical, and medication management? Does observation policy and practice reflect current evidence about suicide risk? Are there service level agreements in place with local mental health services regarding psychiatric inputs and responses?	References: 6, 7, 10, 11, 12, 13, 16-23, 26, 27, 29, 32, 35, 36, 37, 38, 39

Health Care Centre Interventions • Named nurse in HCC providing continuity of care and linkage with primary and secondary teams • Intensive support • Medication management • Improving resilience • Relapse prevention • Crisis planning	Health Care Centre Team including trained MH nurses In-Reach team Visiting NHS general or forensic psychiatrist Primary Care Team Prisoner	• To actively engage prisoners in treatment programmes • To provide an actively managed care programme • Access to regular specialist psychiatric assessment • Access to range of therapeutic day activity and therapies where appropriate	Are there trained MH nurses in the HCC? Is there access to therapeutic day activity during the prisoner's stay? Is there access to regular specialist psychiatric assessment?	References: 6, 7, 8, 10, 29
Discharge from HCC to Wing • Multi-disciplinary pre - discharge meeting involving all with a role in the patient's resettlement and care, including handover to ACCT wing care plan where appropriate • Information regarding crisis, interventions, discharge care plan and relapse prevention shared prior to discharge • Transfer of care back to care co-ordinator • Discharge follow up provided as agreed in care plan	Health Care Centre Team including trained MH nurses In-Reach team Drug treatment nurse Wing officer, personal officer CARAT CARE Coordinator	• Following the stabilisation of the prisoner's mental health, to discharge the prisoner back to the wing under the care of the care co-ordinator or in-reach team member • To provide continuity of care • To discharge the prisoner back to the same wing whenever possible to minimise stress • If discharge to another wing is necessary, to ensure that all relevant information is shared with the wing officers and personal officer who will be involved in the prisoner's future care	Is the prisoner being discharged back to the same residential wing? Is the written discharge plan agreed and shared with the prisoner and care co-coordinator/in-reach team and/or ACCT case manager (where appropriate) prior to discharge? Is the Care Co-ordinator in the Community kept informed of any admissions and outcomes? Is follow-up for prisoners on CPA provided by in-reach within 7 days of discharge back to the wing?	References: 6, 10, 16, 17, 32, 33, 35, 36, 39

Key Phase: Acute Care (NHS outside prison)

Elements	Who Is Involved?	Key Points/Objectives	Pertinent Questions	Policy Reference and Good Practice
Transfer to NHS • Pre-referral assessment: - Collect all relevant background information, IMR, CPA care plans, sentence plans - Obtain patient consent re information sharing - Physical examination - Psychiatric assessment of risk • Referral made to NHS specialist unit • Exchange of relevant information • Arrange assessment visit • Admission accepted pending availability of NHS bed • Advice and support provided by NHS unit while waiting transfer • Transfer of prisoner to NHS • CPA Co-ordinator invited to regular MDT care planning reviews	In-Reach team Health Care staff Psychiatrist of receiving unit CPA Co-ordinator Prisoner Wing staff Sentence planning officer Probation officer Solicitor Relatives Court GP (if registered) Forensic team of receiving unit Prison escort staff	• To provide speedy assessment and smooth transfer to specialist or secure NHS facilities for prisoners whose mental health problems or comorbidity problems are so severe that their mental health requires treatment in hospital. • To obtain admission for prisoners requiring detention under the Mental Health Act • In-reach team to facilitate and liaise with receiving NHS unit • CARATs	• Are there written referral criteria agreed with specialist NHS units for urgent and non-urgent transfers? • Is ongoing support and advice provided by the NHS receiving unit for the care of prisoners on the transfer waiting list?	References: 6, 8, 10-13, 24, 26, 29, 30, 32, 35, 36, 39 • HMP Holme House In-Reach team assessment provides direct access to local RSU obviating the need for an assessment visit - local agreed policy • Broadmoor High Secure hospital has a dedicated waiting list support CPN providing support and advice to facilities managing the care of patients waiting for admission
NHS discharge back to same prison • MDT pre-discharge case conference • Discharge plan shared with relevant prison staff involved in prisoner's care and treatment prior to discharge • Copy of assessments, and relevant documentation passed back to prison • Prisoner transferred back to prison • For prisoners under section 117 of the MH Act, agree Section 117 needs, arrange CPA and aftercare services • Post discharge follow up and support from transferring NHS unit	As above If Section 117 applies also include local Approved Social Worker and MH Trust representatives	• Following the stabilisation of the prisoner's mental health, to discharge the prisoner back to prison under the care of the care co-ordinator or in-reach team member • In-reach team to facilitate and liaise with transferring NHS unit • To provide continuity of care • To discharge the prisoner back to the same prison and wing whenever possible to minimise stress	• Does the discharge plan include : - Risk factors for relapse - A crisis plan - What to do if prisoner relapses after transfer back to prison? • Is a copy of the discharge plan received by the receiving prison prior to the prisoner's transfer back to prison? • What follow up is offered to the prison by the transferring NHS unit?	References: 6, 10, 16, 17, 30, 32, 33, 35, 36, 39
NHS discharge to another prison • As above but ensuring that all background information, CPA and IMR are passed onto Reception staff of receiving prison	As above	As above	• Are all relevant MH information and documentation passed onto the receiving prison Reception and Health Care Centre prior to the prisoner's transfer?	As above

Key Phase: Through care and Pre-Release

Elements	Who Is Involved?	Key Points/Objectives	Pertinent Questions	Policy Reference and Good Practice
Sentence Planning • Multi-disciplinary assessment of need • Sentence plan developed • Regular multi-disciplinary care plan review meetings • Summaries of planned through care circulated • Further assessments (may include psychiatric report) made	Sentence planning manager Healthcare manager Senior medical officer In-Reach team leader Probation officer Prison social worker Chaplain Psychologist Education manager Prisoner Family CARATs	• To reduce future offending, provide support to prisoner and family, help achieve better social functioning and prepare for release • To provide effective through care that responds quickly and seamlessly to changing need. • To ensure that information regarding the prisoner's mental health and/or drug treatment needs, prognosis and likely pattern of relapse is fully incorporated into the sentence planning process	• Is healthcare input and relevant information routinely incorporated into through care processes? • Does an appropriate member of the healthcare team attend the multi-disciplinary through care planning meetings? • Is the information being shared with the prisoner's permission?	References: 10, 11, 12, 13, 16, 17, 28, 30, 32, 35, 36
Pre-release healthcare planning **For prisoners on CPA** • Multi-disciplinary/agency CPA pre-discharge team meeting arranged • CPA Aftercare plan developed and circulated prior to release • Copy of CPA plan given to prisoner • Transfer of care agreed with Care Co-ordinator • Notify GP and provide summary of relevant MH details, CPA and aftercare plan • If prisoner under Section 117, send copy of aftercare plan to PCT and Social Services **For prisoners with substance dependence** • Similar process to above. However the Criminal Justice Drugs team (if in place) or CARATs (if not) has the lead responsibility for planning release and providing a	In-reach team Primary care mental health nurse Personal officer, prisoner Care Co-ordinator in community Criminal Justice Mental Health liaison worker/link worker CARATs, police Criminal Justice Drug Team Community Substance Misuse team NACRO, family Employment officers Housing Voluntary support agencies/mentors AND All those involved in the prisoner's care whilst in prison All those who will be responsible for the prisoner's aftercare If prisoner subject to Section 117 of MH Act need to involve PCT and Social Service representatives Information to GP	• To have appropriate arrangements in place for on-going integrated aftercare of prisoners with mental health, substance misuse or comorbidity problems in the community prior to the prisoner's release. The timing of pre-discharge meetings is subject to locally agreed policy. • To provide seamless continuity of care as part of the pre-release process	• Is support provided to the prisoner in registering with a GP if he does not have one? • Is there a locally agreed policy regarding the timing of the pre-discharge meeting and transfer of care to the Care co-ordinator and Community Mental Health Team? • Does everyone involved in the prisoner's aftercare receive a copy of the prisoner's CPA aftercare plan prior to his release? • Does the prisoner receive a written copy of his CPA Aftercare plan before being released? • For prisoners on enhanced CPA, do Aftercare plans take into account the heightened risk suicide in the first 3 months and make specific reference to the first week after release?	Reference: 1, 6, 8, 10-13, 18-23, 24, 26, 27, 28, 30, 32, 41 • Mental Aftercare Association in inner London • Revolving Doors • HMP Leeds piloting a Custody plan

dedicated aftercare service				
Unplanned release for prisoners on CPA • Contact Care Co-ordinator • Agree interim aftercare arrangements and revise CPA plan • Contact key external agencies, fax CPA care plan and risk information • Forward copy of all relevant information to key aftercare contacts • Early multidisciplinary care plan review date organised by Care Co-ordinator with all involved in prisoner's aftercare	Immediate contact with: GP, Care co-ordinator, In-Reach team, acute psychiatric service (if admission required), Probation service, Criminal Justice Liaison team or prison liaison worker, police mental health liaison officer, Social Services, Criminal Justice Drug Team, CARATs	In cases where prisoners are released unexpectedly (criminal proceedings discontinued, bail) • Put in place emergency plan of action to ensure continuity of care after release • Agree early multidisciplinary care plan review date	• Is there an agreed local protocol for appropriate actions to be taken in the event of unplanned releases?	References: 6, 10-13, 26, 27, 28, 30, 35, 36, 39

Key Phase: Prison Transfers and Aftercare

Elements	Who Is Involved?	Key Points/Objectives	Pertinent Questions	Policy Reference and Good Practice
Prison transfers **For prisoners on CPA** • Contact receiving prison In-Reach team and give verbal summary of prisoner's MH needs and current care plan • Fax through CPA care plan and relevant risk factors • Notify care-co-ordinator of transfer and new contact details • Complete prison transfer sheet • Forward casework files, IMR, CPA and prison documentation to receiving prison Reception prior to transfer • Notify GP • For prisoners at Risk of Suicide and/or Self Harm	In-Reach teams of both prisons Health Care staff Personal officer Psychiatrists for both prisons Care-Co-ordinator Prisoner Family GP Receiving prison Reception Prison Escort Staff Health care staff in both prisons CARATs in both prisons Prisoner Family GP Receiving prison Reception Prison Escort Staff	• To ensure that effective continuity of care is provided to prisoners with mental health, substance misuse or comorbidity problems as part of the prison transfer process • To ensure that all key information regarding the prisoner's mental health, substance misuse or comorbidity is promptly passed on to the receiving prison • To provide effective supervision for transporting at risk prisoners between prisons	• Are prison escort staff given MH and suicide awareness training? • Is refresher training given to Prison Escort staff every 3 years? • Does the receiving prison Reception receive all the necessary CPA forms, care plan and prison documentation prior to the prisoner's arrival?	References: 6, 10-13, 18-23, 26, 27, 29, 32, 39 References: 35, 36

• Contact receiving prison reception staff and give verbal summary of current care plan **For prisoners with MH or drug problems** • Complete prison transfer sheet providing a summary of key issues and care plan • Forward casework files, IMR, and prison documentation to receiving prison Reception prior to transfer • Notify GP				
Aftercare **For ex-prisoners on enhanced CPA or at particular high risk of self-harm or suicide** • Initial follow up contact within 7 days of release • Intensive support for first 3 months post release as per aftercare plan **For ex-prisoners on standard CPA** • Follow up contact and support as per CPA aftercare plan **For ex-prisoners with mild MH problems** • Ex-offender makes GP appointment **For drug related ex-offenders** • Dedicated aftercare service provided by Criminal Justice Drugs team (if in place) as per aftercare plan • Alternatively CARATs provide short term post release support (up to 8 weeks)	In-Reach team Prison MH Liaison worker to provide additional support needed immediately after release. May be attached to Criminal Justice Liaison team, community forensic team or CMHT Care Co-ordinator All agencies identified in aftercare plan NACRO Voluntary support groups and mentors Samaritans Criminal Justice Drugs team CARATs GP Probation Police Social Services Community Substance Misuse Team Substance Misuse Nurse	• To provide on-going integrated and effective aftercare for prisoners with mental health, substance misuse or comorbidity problems • To provide a flexible aftercare service which is responsive to the complex aftercare needs of high risk ex – prisoners • To provide seamless continuity of care for ex-prisoners on CPA • To reduce drug dependency • To reduce future drug related offending • To provide support to ex-offenders and family • To help ex-offenders achieve better social functioning	• Is there follow up within 7 days of release for ex-prisoners on enhanced CPA or at high risk of self-harm or suicide? • Is an enhanced level of support being provided to them within the first 3 months of release? • Is there a dedicated prison MH liaison nurse who can provide: - effective liaison between the criminal justice system, prison in-reach and community mental health services - facilitation of transfers and resettlement - Additional support to vulnerable ex-prisoners in the first 3 months after being released from prison?	References: 1, 6, 10-13, 18-23, 26, 27, 28, 30, 32, 33, 39 • Dedicated prison MH Liaison nurse/workers References: 28, 35, 36, 40, 41

CARE PATHWAYS REFERNCE LIST

Reference Number	
1	Anderson, J. (Oct 2003) Mental Health Criminal Justice Liaison Service – slide presentation Avon and Wiltshire Mental Health Partnership NHS Trust
2	Brooker, C., Repper, J., Beverley, C., Ferriter, M and Brewer, N (Dec 2002) Mental Health Services and Prisoners: A Review ScHARR, University of Sheffield
3	Carson, D. and Grubin, D. (Oct 2003) Reception Health Screen. University of Newcastle, Department of Forensic Psychiatry
4	Carson, D., Grubin, D and Parsons, S. (Oct 2003) Report on New Prison health screening arrangements: The results of a pilot study in 10 prisons. University of Newcastle, Department of Forensic Psychiatry
5	Department of Health (1992) Review of Health and Social Services for mentally disordered offenders and others requiring similar services HMSO London
6	Department of Health (1999) National Service Framework for Mental Health Modern Standards and Service Models. London Department of Health
7	Department of Health (2002) Mental Health Policy Implementation Guide
8	Department of Health (2002) Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision
9	Department of Health (2002) Mental Health Policy Implementation Guide: Community Mental Health Teams
10	Department of Health (2002) Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide
11	Department of Health (2002) National Suicide Prevention Strategy for England. London Department of Health
12	Department of Health (May 2003) Safer Prisons: A National Study of Prison Suicides 1999-2000 by the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness
13	Department of Health (2003) National Suicide Prevention Strategy for England – Annual report on progress
14	Department of Health/Prison Health (2003) The Prison Health Newsletter - Issue 12
15	Department of Health/Prison Health (2003) The Prison Health Newsletter - Issue13
16	HM Prison Service Safer Custody Group (2003) The ACCT User Handbook
17	HM Prison ACCT documentation
18	HM Prison Service Safer Custody Programme (14th Oct 2003) Report for the Strategy Steering Group
19	HM Prison Service Safer Custody Programme (25th Nov 2003) Papers of Care at Risk Prisoners Steering Group
20	HM Prison Service Safer Custody Programme - Care of at Risk Prisoners Project Briefing for Area Managers and other Key Stakeholders
21	HM Prison Service Safer Custody Group (2003) Suicide Prevention Strategies: Guidance on preventing prison suicide and reducing self-harm; the role of Samaritans; and safer custody cell protocols
22	HM Prison Service Safer Custody Group (Oct 2003) Draft Guidance on Managing Prisoners who Self-Harm
23	HM Prison Service Management Board paper PSMB11203/1 Suicide and Self-Harm Prevention Strategy Revisited
24	HMP Holme House (Jan 2004) Mental Health Prison In-Reach Team Operational Policy
25	Liebling, A. (Nov 2003) Legitimacy, Prison Suicide and the Moral Performance of Prisons. Cambridge University Prisons Research Centre and slide presentation
26	NICE (Dec 2002) Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care
27	NIMHE (Oct 2003) Preventing Suicide: A Toolkit for Mental Health Services
28	National Treatment Agency (Dec 2002) Models of Care Parts 1 and : Framework for Developing Local Systems of Effective Drug Treatment in England
29	Office for National Statistics (1997) Psychiatric morbidity among prisoners
30	Paton J and Jenkins R (Editors) (2002) Mental Health Primary Care in Prisons. London, Royal Society of Medicine
31	Pringle, M (July 2003) Mental Health: The Primary-Secondary Care Interface Paper for Department of Health
32	Prison Health Task Force and Policy Unit (2001) Changing the Outlook. A Strategy for Developing and Modernising Mental Health Services in Prison
33	Prison Health Task Force and Policy Unit (2002) Health Promoting Prisons: A Shared Approach
34	Prison Health Task Force and Policy Unit (2002) Developing and Modernising Primary Care in Prisons

35 Prison Service Order 3550 (20/12/00) Clinical Services for Substance Misusers
36 Prison Service Order 3630 (12/02/02) Counselling, Assessment, Referral, Advice and Throughcare services
37 Prison Service Order 2700 (04/11/02) Suicide and Self-Harm Prevention
38 Stoddart, Y (April 2003) Regional Overview of 2003/2004 Prison Mental Health Plans within the North-East and Yorkshire Areas. Northern Centre for Mental Health
39 The Care Programme Approach Association (Feb 2001) The CPA Handbook
40 *http://www.nta.nhs.uk/programme/national/CJ_intervention_summary.doc*
41 *www.drugs.gov.uk/NationalStrategy/CriminalJusticeInterventionsProgramme*
42 Department of Health (2000) The NHS Plan

SUICIDE PREVENTION – ASSESSMENT, CARE IN CUSTODY AND TEAMWORK (ACCT)

The ACCT Approach is short for `Assessment, Care in Custody and Teamwork'. A case management system aims to identify individual need and offer individualised care and support to prisoners in advance, during and after a crisis. It replaces the current F2052SH risk management system. Integral to the ACCT approach are:

- identifying and training a multi-disciplinary team who will respond quickly to prisoners identified as in crisis and help identify their needs
- putting in place regular support for this Assessor team and clear lines of communication/referral to health care/mental health care
- Identifying case managers (Unit Managers, SOs, POs) and providing them with appropriate skills training.

The contact person is Jo Patton, HM Prison Service, email – jo.patton@hmps.gsi.gov.uk

USER INVOLVEMENT IN PRISON MENTAL HEALTH SERVICE DEVELOPMENT

Work is currently underway to produce and pilot a service user involvement strategy for prison mental health services. It is expected that the pilot will be complete, and the strategy ready for national implementation by April 2005. Key contact is Alison Longwill, Women and Prison Mental Health Programmes Lead for NIMHE West Midlands, email – alison.longwill@nimhe.wmids.nhs.uk

PATIENT AND PUBLIC INVOLVEMENT

As prisoners receive NHS-commissioned services, they will need to have access to the appropriate systems of patient involvement, redress and associated support mechanisms, such as Patient Advice and Liaison Services (PALS) and Independent Complaints Advocacy Services (ICAS). PCT Patient and Public Forums will also need to ensure that health services provided to their local prison population form part of their remit and PCTs will need to look at how to engage prisoners in the wider patient and public involvement agenda. As a start to this work, the joint DH/Prison Service Prison Health Team is leading work with policy leads in the DH and the Prison Service, Commission for Patient and Public Involvement in Health and the Healthcare Commission to explore how these mechanisms can work effectively in the prison environment and ensure that they mirror, as far as is possible, those available to patients in the community. Key contact is Susannah Nisbett, email – susannah.nisbett@dh.gsi.gov.uk

COMMISSIONING

The transfer of commissioning responsibility for all healthcare services to PCTs is already taking place in the development network of 18 PCTs and 33 prisons, and will be completed across the public sector prison estate by April 2006. The tasks for commissioners of mental health services will include developing a depth of knowledge of the needs of prisoners both during and after their imprisonment, applying the whole system approach of the NSF to the prison environment, managing the market to deliver appropriately the full range of primary, secondary and tertiary services, evaluating effectiveness and value and revising the Prison Health Delivery Plan accordingly. Representation of the needs of prisoners in all aspects of the work of Local Implementation Teams is encouraged.

The NIMHE London Regional Development Centre has developed a pilot commissioning programme. The objective is to build up commissioning

expertise for mental health and this will include Prisons. The contact person is Jim Symington, Programme Director London Development Centre for Mental Health, email - jim.symington@londondevelopmentcentre.org

B.M.E. (BLACK & MINORITY ETHNIC GROUPS)

It is of key importance that mental health services in prison meet the needs of people from black and minority ethnic groups. Work has begun to produce a prison mental health BME strategy that will be implemented nationally via the NIMHE Regional Development Centres. The contact person is Lynn Emslie, Service Development Manager for NIMHE South West, email – lynn.emslie@mhsw.nhs.uk

INVOLVEMENT OF THE RDCS

There are currently a number of mental health policy, training and educational initiatives within HMPS and/or associated units, e.g. the Safer Custody Unit, which are in the process of being implemented at various locations and by numerous stakeholders throughout the country. Currently there is not a co-ordinated approach or national framework of priorities for the delivery of these initiatives. It is suggested that RDCs should form 'Regional Prison Mental Health Forums' in order to co-ordinate and monitor these national and regional initiatives. The development of a regional forum, comprising a number of these stakeholders is seen as an efficient and hopefully effective way to assess, plan, resource and manage the implementation of these priorities in the prison establishment within their region. The contact person is Mary Munday, Programme Lead for NIMHE South East, email – **mary.munday@sedc.nhs.uk**

MENTAL HEALTH AWARENESS TRAINING

Collaboration between the NHSU and Bournemouth University has led to the development and production of a mental health awareness-training package. The programme is targeted towards meeting the training needs of prison

discipline staff, particularly those involved in escort and reception duties. The contact person is Damien Mitchell at the NHSU. damien.mitchell@nhsu.org.uk

RECEPTION SCREENING

Prison Health, in conjunction with the University of Newcastle, has developed new screening arrangements for detecting immediate health needs of prisoners on their first reception into custody. The new triage-based screening procedure consists of an initial short screen by health care staff to identify any immediate risk of significant health need. If a prisoner screens positive for one of four categories: mental health; suicide and self-harm; physical health; substance misuse; a further assessment using evidence based protocols is carried out by an appropriate member of the primary care team. The new arrangements have been successfully piloted and rolled out across the prison estate. The contact person is Susannah Nisbett, email - susannah.nisbett@doh.gsi.gov.uk

MANAGEMENT OF SELF HARM

Mental Health Strategies, a long established management consultancy who specialise in working alongside providers of mental health care, were commissioned by Prison Health to develop a self-harm toolkit of relevance to custodial settings. In line with the overarching guidance emerging from the National Institute for Clinical Excellence, the objective of this package is that it be applicable across a range of prison environments by both clinical and non-clinical staff. The main theme being that individual risk should be managed in an appropriate manner with safeguards for protecting prisoners and supporting staff based on robust up to date evidence.

The first draft of the toolkit was reviewed in April 2004, with the production of the final draft being scheduled for the end of June 2004. The final format will include a CD-ROM and hardcopy, with primary contents being awareness,

management, interventions, and staff support. Key contact is Steve Stanley, email – solutions@mentalhealthstrategies.co.uk

WING-BASED MENTAL HEALTH LIAISION OFFICER ROLE

Mental health awareness training aims to give all staff a basic understanding of mental health and of mental disorders that are commonly found in a prison context. A longer and more detailed version of training (3 days) is available for staff who wish to play a more active role – equivalent to a `psychological first aider'. These staff, which may be called `Mental Health Liaison Officers' are trained and provided with on-going support in order to be able to:

- talk to a prisoner about whom there is concern
- estimate risk and advise on whether to open an ACCT Plan
- facilitate appropriate referral to health care/mental health care
- liaise with health care staff to ensure that residential staff are advised about how best to manage prisoners with mental health problems on the residential unit' liaison

There is no requirement for establishments to create this special role for a minority of their staff. Establishments with a high level of mental heath need may prefer to train all their staff to this level. Another option that is open to establishments and individuals is to combine the roles of ACCT Assessors and Mental Health Liaison Officers, as there is a great deal of overlap between their roles and training. Key contact is Dave Knight, email – **dave.knight@nhsu.org.uk**

Name	Title / subject	Contact
Sean Duggan	National Lead, Prison Mental Health.	sean.duggan@dh.gsi.gov.uk
Richard Jordan	National Deputy Lead, Prison Mental Health	richard.jordan@dh.gsi.gov.uk
Yvonne Stoddart	SUBJECT – development of the prison mental health care pathway	ystoddart@ncmh.co.uk
Jim Symington	SUBJECT – best practice in commissioning prison mental health service	jim.symington@londondevelopmentcentre.org
Lynn Emslie	SUBJECT – best practice in meeting the needs of prisoners from BME backgrounds	lynn.emslie@mhsw.nhs.uk
Alison Longwill	SUBJECT – service user involvement	alison.longwill@nimhe.wmids.nhs.uk
Mary Munday	SUBJECT – establishing prison mental health regional forums	mary.munday@sedc.nhs.uk
Damian Mitchell	SUBJECT – mental health awareness training	damian.mtichell@nhsu.org.uk
Susannah Nisbett	SUBJECT – reception screening, PPI	susannah.nisbett@dh.gsi.gov.uk
Steve Stanley	SUBJECT – management of self harm toolkit	solutions@mentalhealthstrategies.co.uk
Jo Patton	SUBJECT – assessment, care, custody and teamwork	jo.patton@hmps.gsi.gov.uk

Regional prison mental health leads

Alison Longwill	West Midlands	alison.longwill@nimhe.wmids.nhs.uk
Carl Finch	East Midlands	carl.finch@tsha.nhs.uk
Jim Symington	London	jim.symington@londodevelopmentcentre.org
Lynn Emslie	South West	lynn.emslie@msw.nhs.uk
Mary Munday	South East	mary.munday@sedc.nhs.uk
Robert Jayne	Eastern	robert.jayne@nemhpt.nhs.uk
Steve Trenchard	North West	steve.trenchard@nimhenorthwest.org.uk
Yvonne Stoddart	North East	ystoddart@ncmh.co.uk

Prison mental health central team

Sean Duggan	National Programme Lead	sean.duggan@dh.gsi.gov.uk 0778 9653 182
Richard Jordan	Deputy National Programme Lead	richard.jordan@dh.gsi.gov.uk 0784 1164 998
Circe Teasdale	Senior Programme Administrator	cire.teasdale@dh.gsi.gov.uk 020 7972 3929

Credits

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