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# Changing the Outlook

## A Strategy for Developing and Modernising Mental Health Services in Prisons

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## Foreword

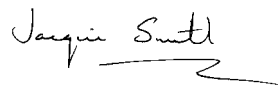
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Around 140,000 persons pass through our English and Welsh prisons each year. The current prison population is about 68,000. Surveys have shown that as many as 90% of prisoners have a diagnosable mental illness, substance abuse problem or, often, both. Among young offenders and juveniles that figure is even higher, 95%. We also know that mental illness can contribute to re-offending and problems of social exclusion. Yet, historically, neither the Prison Service nor the NHS have been as effective as they could be – and should be – in providing mental health services for prisoners, nor in recognising the particular mental health needs of specific groups of prisoners; women, people from minority ethnic groups and young people.


In England, the National Service Framework (NSF) for Mental Health was published in September 1999 and applies to all working age adults, including prisoners. This strategy is the starting point for developing and modernising mental health service provision within the prison setting. It is grounded in the NSF and in the subsequent commitments made in the NHS Plan, published in July 2000. It sets out a vision of where we want mental health services for prisoners to be in 3-5 years' time, and identifies some of the issues that will need to be addressed in getting there. It is not a "how to do it" manual which gives all the answers. We recognise the importance of partnership, and for solutions to be developed jointly and owned locally. We also recognise the need to identify good practice and for that to be disseminated among all those who work in this area, in prisons and in the NHS. We have therefore established an expert group on prison mental health, chaired by the National Director for Mental Health, Professor Louis Appleby, to oversee the implementation of this strategy and to help in the development of more detailed guidance and advice to practitioners.

Wales has issued its own All Wales Strategy for adult mental health services and the National Service Framework for Wales will follow in early 2002. Taken together, these documents will direct mental health services in Wales over the next ten years. The principles underpinning them will be applied to take forward mental health provision in Welsh prisons, working closely with the Prison Health Policy Unit and Task Force and the Prison Service.

In both countries, this represents a significant piece of work for both the Prison Service and the NHS, at a time when both organisations are already under pressure and undergoing change. But the need to improve mental health services for prisoners is urgent and important, in the interest of prisoners themselves, to improve the chances of rehabilitation and resettlement, and to reduce the risks to public safety.



Jacqui Smith MP  
Minister of State  
for Health



Beverley Hughes MP  
Parliamentary  
Under-Secretary of  
State, Home Office



Jane Hutt AM  
Minister for Health and  
Social Services  
National Assembly  
for Wales

## Executive Summary

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1. This document sets out a joint Department of Health and Prison Service approach to far-reaching development and modernisation of mental health services in prisons over the next 3-5 years, in line with the National Service Framework (NSF) for Mental Health and the NHS Plan. In Wales, the National Assembly is taking forward a similar programme with the Prison Service based on its own policy framework for mental health.
2. There is considerable evidence that, with a few notable exceptions, the way mental health services are currently organised, in terms of volume, range and quality, do not meet prisoners' needs. Ineffective and inflexible services that do not match identified health needs inevitably result in poor health outcomes for prisoners, wasted resources and de-motivated staff. There are too many prisoners in too many prisons who, despite the best efforts of committed prison health care and NHS staff, receive no treatment, or inappropriate treatment for their mental illness, from staff with the wrong mix of skills and in the wrong kind of setting.
3. Mental health services in prisons have struggled to keep pace with developments by the NHS. The NSF for Mental Health, published in 1999, set seven standards for the improvement of mental health services, covering mental health promotion, primary care and access to services, effective services for people with severe mental illness, caring for those who care for people with mental illness, and preventing suicide. The NSF makes clear that they apply equally to prisoners as to the wider community. In this, as in all other areas of health care, prisoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS. This means that, for example, there should be a move away from the assumption that prisoners with mental health problems are automatically to be located in the prison health care centre. Greater use of day care and wing-based treatments, mirroring the community scenario, offer ways in which the lives of such prisoners can be made more normal, with greater opportunities to participate in a purposeful regime and other activities.
4. We are clear that there is a range of services, offering support and treatment of varying intensity, that should be available to prisoners. These include mental health promotion; primary care services; wing-based services; day care; in-patient services; transfer to NHS facilities; and, throughcare. Combinations of these services, appropriately planned and delivered, should be able to respond effectively to the needs of mentally ill prisoners.

5. There are also wider benefits for society in general. Tackling the mental health problems of prisoners can contribute to reducing crime and re-offending rates, as well as helping to respond to the problems caused by social exclusion.
6. **By 30 September 2002 all prisons and their local NHS partners will be expected to have completed a detailed review of mental health needs, based on their existing health needs assessment work, to identify gaps in provision between what is currently available and that set out in section 3 of this document, and to have developed action plans to implement the changes needed to fill those gaps. This work should include a training needs analysis for prison staff and NHS in-reach teams.** Prisons and their local NHS partners should work together to achieve this.
7. For many prisons this will mean significant changes. It is an opportunity to take a fresh “whole systems” look at how prisons and their local health communities can work together to provide mental health services that meet prisoners’ needs while in custody, and ensure continuity of care following release. The role and contribution of the *whole prison* and of the wider health community in providing needs based care for mentally disordered prisoners will be vitally important. It will be important, also, to recognise that the development and modernisation of mental health services is just one part of a wider programme of reform of prison health, many elements of which inter-link significantly. Other planning documents are scheduled for the near future, e.g on health promotion in prisons with obvious links to mental health promotion. This mental health strategy therefore should be seen in the context of these wider reforms, each a piece of the jigsaw fitting together within the prison setting to create a comprehensive health service for prisoners. The schematic attached at Annex C illustrates the extent and integrated nature of this work programme.
8. For the NHS, too, things will change. The structural and organisational alterations being implemented as a result of the reforms set out in the *Shifting the Balance of Power* document represent a major change for the NHS as a whole. This strategy tries, as far as possible, to take into account the changes that will be occurring within the NHS over the next couple of years, though inevitably some of the detail is yet to be settled.
9. Although *Shifting the Balance of Power* means that the NHS is going through a period of some uncertainty as new structures are set up, it also offers useful opportunities to look critically at the way it is doing some of its business, including how health care for prisoners, and particularly mental health services, are provided. There needs to be a recognition that prisoners remain part of the NHS community and their mental health care, particularly for the most seriously ill, has to be provided through a partnership with the Prison Service in which the NHS makes a full and equal contribution. The NHS must be willing to work innovatively to help provide modern, effective mental health services in a prison environment.

10. The challenge of this change is great and should not be under-estimated, but the potential benefits of achieving these major shifts in service provision are just as great. There is a need to establish more clearly the baseline of current services from which to judge progress, and for relevant information on activity and health outcomes to be collected. Nonetheless we should aim, in 3-5 years, for:
  - a reduction in the number of prisoners located in prison health care centres, with resources re-deployed to provide day care and wing-based support;
  - a reduction in the average length of time mentally ill prisoners spend in those prison health care beds that remain;
  - a more appropriate skill mix among those providing mental health care, so that prisoners have access to the right range of services to NHS standards;
  - increased numbers of day care places;
  - improved wing-based services;
  - better integration between Prison Service and NHS staff, to encourage skills transfer among staff and reduce professional isolation, and to facilitate exchange of information;
  - quicker and more effective arrangements for transferring the most seriously ill prisoners to appropriate NHS facilities and receiving them back;
  - increased collaboration by NHS staff in the management of those who are seriously mentally ill, including those vulnerable to suicide or self-harm whilst they are in prison;
  - improved health and social functioning for patients.
11. This document describes the changes that will be needed at a high level. It is not intended to be a blueprint for how to get mental health services in prison X or prison Y “right”, nor is it an implementation manual. Rather, it sets the direction of travel, and raises some of the issues that will need to be addressed during the change process. There will be a need to offer more detailed advice and guidance, and to identify and promulgate good practice. To help provide that support Ministers in the Home Office and the Department of Health have agreed to set up an Expert Group chaired by Professor Louis Appleby, the Government’s National Director for Mental Health. The Expert Group will oversee the implementation of this strategy, and the development of guidance where that is needed.
12. Each prison’s needs will be different – a Category D open prison housing low security prisoners nearing the end of their sentence will not have the same needs as a big Category B local acting as reception, remand and allocation centre with several thousand persons passing through it each year. Prisons,

working together with their local NHS partners, will need to take joint responsibility for identifying, planning and managing delivery of the changes needed. This will need to include the specific needs of particular types of prisoners, such as women, minority ethnic and young prisoners.

13. A good deal of information should already be available as part of the joint Prison Service/NHS Health Needs Assessments completed in the course of 2000/01. Every prison working with its local PCT should look critically at the mental health needs of its inmates, and consider how far existing provision meets those needs. For some prisons the work already completed will have examined this in sufficient detail. For others – particularly the larger prisons dealing with the more demanding section of the prison population – additional work may be needed to take account of the key shifts in service provision envisaged in this strategy. Once this assessment work is completed, the next stage will be to draw up an action plan to deliver the required changes. This should be completed by 30 September 2002.
14. It is estimated that around half of the current Prison Service health care budget of some £90m is spent on mental health services. At present this is not being used as effectively as it could be. Reconfiguring services in line with the framework set out in this document will allow existing resources to be used most efficiently. In addition, there is some specific funding coming from the NHS – equivalent to 300 new staff over three years to 2003/04 – to support the implementation of mental health in-reach, to be targeted at prisons with the greatest need, to support the commitments made in the NHS Plan.
15. Arrangements are being put in place to help support this major programme. The Prison Health Policy Unit and Task Force will be publishing further detailed guidance and is available to offer advice and support where needed. The Prison Health Regional Task Force Teams will oversee both the planning and the implementation process for their areas; and local health communities will be expected to engage fully with the proposed changes.



# 1

## Introduction

- 1.1 It has been Government policy for over a decade that people with a mental disorder who require specialist medical treatment or social support should, wherever possible, receive it from the health and personal social services. The commencement of criminal proceedings should not prevent or delay a person's access to appropriate care and treatment. The Home Office has provided general guidance to people working within the constituent elements of the criminal justice system about how these broad principles should be put into practice. This strategy document has been drawn up to be consistent with these policies. Although there is considerable mental ill health in the prison population, the majority of mentally disordered prisoners are not so ill that they need to be detained in hospital under the Mental Health Act 1983 for medical treatment. If they were not in prison they would be receiving treatment for their mental disorders in the community.
- 1.2 Developing effective and appropriate mental health services for people in prison is an enormously challenging agenda. The level of need is very high – surveys conducted by the Office for National Statistics in 1997 indicated that nine out of every ten prisoners have at least one of the five disorders considered in the survey (neurosis, psychosis, personality disorder, alcohol abuse or drug dependence). Between 12% – 15% of sentenced prisoners have four of the five. We have a duty to provide proper care and treatment for prisoners, but prisons are struggling to do so in a custodial setting that is neither specifically designed nor primarily intended for this purpose. Equally, the Prison Service is not resourced to provide a full mental health service, and is therefore reliant on the NHS to provide the specialised services which are beyond its own capacity.
- 1.3 The Government has already determined that the way to tackle the problems in prison health care is through a formal partnership between the Prison Service and the NHS. Both the Prison Service and the NHS need to work *together* to achieve an effective and integrated service. This is perhaps particularly imperative for mental health care. The NHS cannot relinquish responsibility for patients at the prison gate: more than half of all prisoners serve sentences of less than six months, and many spend only a few weeks in jail. Then they are back out in the community, often in need of on-going NHS care and treatment for their mental health problems. Effective throughcare from first reception to release and beyond not only fulfils the Prison Service's obligation to care for those in custody, but also promotes ease of management

both while they are in prison and after release, making it easier for the NHS to fulfil its on-going duty of care.

- 1.4 For these reasons this strategy is aimed at the Prison Service and the NHS. Both will need to bring about changes to achieve the objectives set out in this document. Prisoners are part of the NHS community, and the modernisation and development of mental health care services precipitated by the National Service Framework for Mental Health must include services for prisoners.
- 1.5 This approach not only benefits individual prisoners, who will receive more effective mental health services, but can also have wider benefits for society in general. Around one third of crime is drugs related. Untreated mental disorder can be the underlying cause of a significant proportion of offending behaviour, as well as contributing to the social exclusion that is a feature of so many offenders' lives. If we can offer proper, effective treatment while offenders are in prison, we can contribute towards the Government's wider goals of reducing crime and re-offending rates as well as playing a part in tackling social exclusion.
- 1.6 Ultimately, the Prison Service has a duty to look after all prisoners with humanity in a decent environment and to help them lead law-abiding and useful lives in custody and after release. Given the very high levels of psychiatric morbidity within the prison population, an important element of fulfilling that duty is to ensure that, whether they are in custody for a few weeks or a few years, prisoners receive a level of care appropriate to their mental health needs, and to the standards of the NHS.
- 1.7 However, the purpose of this strategy is not to be an implementation guide telling the NHS and Prison Service how to get mental health services for prisoners "right". The strategy is intended to set the direction of travel, show how the National Service Framework for Mental Health and the NHS Plan can relate to prisoners, and identify some of the issues which will need to be considered in developing services. That does not mean, though, that nothing need be done until detailed guidance is issued. On the contrary, every prison needs to begin working with its local NHS partners to start the change process.
- 1.8 We recognise that there will be issues on which further advice and guidance is needed, and that will be provided in due course. To help identify and respond to these issues, and to oversee the change process, Ministers at the Department of Health and the Home Office have agreed that a special Prison Mental Health Expert Group be set up. Professor Louis Appleby, the Government's National Director for Mental Health, chairs the Group, which has already been established and has started its work. The Group includes members responsible for mental health policy in the Department of Health and the Home Office, as well as practitioners working in the field and others with experience of mental health services in custodial settings. Its overall remit is to provide advice about

the planned reforms and improvements to mental health services for prisoners. In particular, the Group will oversee the implementation of the in-reach of community mental health services into prisons as set out in the NHS Plan.

## **Wales**

- 1.9 For convenience, this document uses the terminology applying to mental health services in England but there is very close co-operation with the National Assembly for Wales in taking forward a similar programme of improvement in Wales. The National Assembly is about to issue its new Strategy for Adult Mental Health Services, which will be followed by a National Service Framework for Wales. Improvements in the mental health services in prison in Wales will be compatible with the policy framework contained in these 2 documents.
- 1.10 It is important, too, to note that a major consultation is taking place which will have far-reaching implications for the structure of the NHS in Wales. The proposals put forward by the National Assembly would result in the abolition of Health Authorities and the strengthening of Local Health Groups which would become Local Health Boards. The commissioning of mental health services is highlighted as a particular question to be addressed in the consultation and several possible models have been put forward. Radical pilot schemes are being planned to trial some of these.
- 1.11 This is a time of major change. It is clear that the structure which emerges in Wales will be significantly different from that in England, and that this will be particularly true for mental health services. The programme of prison health reform will continue whatever structural changes take place in the NHS in Wales. Whatever structures emerge, the National Assembly will expect the appropriate NHS bodies to build on the greatly improved communication and co-operation with the Prison Service, which has been achieved as the first product of prison health reforms.

## 2

# Context/Background

- 2.1 Work on improving mental health services in prisons must be seen in the context of the overall strategy for improving prison health care generally, and must operate within that framework. The Report *The Future Organisation of Prison Health Care* succinctly summarised the basic principles as follows:

*Healthcare in prisons should promote the health of prisoners; identify prisoners with health problems; assess their needs and deliver treatment or refer to other specialist services as appropriate. It should also continue any care started in the community contributing to a seamless service and facilitating throughcare on release.<sup>1</sup>*

- 2.2 Perhaps the most important recommendation made in that Report was that there should be a formal partnership between the Prison Service and the NHS at local and national level so that the two organisations could work together to implement the substantial programme of change the Report had set out. Underpinning this approach is the principle that prisoners should be able to access the same range and quality of services as are available to the general population through the NHS.

### The National Service Framework for Mental Health

- 2.3 This principle means that improvements in prison mental health services need to be based on the National Service Framework (NSF) for Mental Health, published in September 1999. Part of the Government's programme to drive up quality and reduce unacceptable variations in health and social services, the NSF sets out seven standards for the provision of effective mental health care for all those who need it, including prisoners. The standards cover mental health promotion; primary care and access to services; effective services for people with severe mental illness; individuals who care for people with mental illness; and, preventing suicide. The standards are set out in more detail at annex A. How they might be applied within a prison setting is examined in section 3 below. To help achieve the key standards, the Department of Health has established underpinning programmes covering workforce and training, research and development, clinical decision support and information. All of these can be expected to have outcomes of benefit to prison mental health services.

<sup>1</sup> *The Future Organisation of Prison Health Care* Report by the Joint Prison Service and NHS Executive Working Group, Dept. of Health, March 1999

- 2.4 Not every element of every standard will be relevant or appropriate in a custodial setting. But the Mental Health NSF recognises that Prison Service and NHS staff will need to work together to achieve the many elements that apply in prisons:

*“[closer partnership working] will have significant implications for some mental health services. Better needs assessment is likely to identify unmet or inappropriately met need, and local services will need to explore opportunities to improve mental health care for prisoners within existing resources. Improved partnership work between the NHS, local authorities and the probation service will also be required for service development and the care of service users, especially individuals with severe mental illness.”*<sup>2</sup>

### **The NHS Plan**

- 2.5 A further important element of policy in developing mental health services in prisons is the NHS Plan, published in July 2000. The Plan makes specific commitments, backed up with dedicated developmental funding, on the provision of mental health services for prisoners:

*Within the new partnerships between the NHS and local prisons, some 300 additional staff will be employed.*

- *by 2004, 5,000 prisoners at any time should be receiving more comprehensive mental health services in prison. All people with severe mental illness will be in receipt of treatment, and no prisoner with serious mental illness will leave prison without a care plan and a care co-ordinator.*<sup>3</sup>

- 2.6 A three-year programme of work to meet these commitments is under way, focusing on the establishment of multi-disciplinary mental health in-reach teams that will provide specialist services to prisoners. This is explained in more detail in Section 4 below.

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<sup>2</sup> *National Service Framework of Mental Health* Dept of Health, September 1999

<sup>3</sup> *The NHS Plan* Dept of Health, July 2000

## 3

# A Vision for Service

- 3.1 In articulating a vision for the services it will be helpful to give some examples of the themes identified in the NSF for Mental Health, and how they might be implemented within the prison setting.
- 3.2 Not every prison will necessarily need the full range of services discussed here. Prisons vary in size, type and prisoner need. A Category D open prison housing low security prisoners nearing the end of their sentence will not have the same level of need as a big Category B local acting as a reception, remand and allocation centre, with several thousand persons passing through it each year. The fundamental underlying aim must be to provide mental health services that respond to individual prisoners' needs, recognising that those with the greatest need will require the most help.

## Promoting Mental Health

- 3.3 Imprisonment is stressful, especially for first time prisoners or those on remand who have the added uncertainty of not knowing what will happen next. Home and family life worries can assume a special significance, and the loss of personal control over one's daily life can be very difficult to cope with. Prisoners serving indeterminate life sentences may have particular difficulties in adjusting. Prisoners will generally engage in varying amounts of constructive educational activity or work, depending on the type of prison, on whether they are sentenced or on remand, and on the length of sentence being served. The benefit of such purposeful activity to provide what is termed in the NHS as "meaningful days" is very considerable in terms of the physical and emotional well being of prisoners. But there are limits to how much activity a prison can provide, and there will be times when some prisoners will find themselves brooding on their problems or those of their families. There are various ways of promoting mental health:
  - recognition and acceptance that many prisoners on normal location on the wings, whilst not developing specific mental health problems, will at times feel under stress and may need extra support;
  - effective mental health awareness training for wing officers so that they can develop the competencies and confidence to identify quickly anyone showing signs of stress or anxiety, and advise on appropriate support;

- having in place policies and practices to prevent bullying, including involving inmates in the identification of bullying risk and making anti-bullying a part of induction;
  - making available counselling or other support groups – access to NHS Direct through their national phone line could help individual prisoners identify appropriate organisations;
  - the “listener” schemes that operate in most prisons, where prisoners are trained by local Samaritan branches to provide a listening service for fellow inmates, can also have an important role to play;
  - promoting, as far as is possible in a custodial setting, personal autonomy which will promote mental health and prepare prisoners for the resumption of individual responsibility on release (for example, being able to choose meals).
- 3.4 Whilst this sort of support does not constitute a specialist mental health service, its importance should not be underestimated as part of an overall response representing the kind of service that might be available to people in the community through primary care, mitigating some of the routine negative factors of imprisonment.
- 3.5 Equally important is the role of family and friends in providing support and contact with the outside world. Family contact in particular is very important and should have centre stage in approaches to promoting mental health. However, it is important to recognise too, the limits that the custodial setting necessarily imposes on what can be done, and the constraints on families themselves on the frequency of visits that they may be able to make, as well as other pressures that they may face.

**Case Study**

Mersey Care NHS Trust, the Merseyside Criminal Justice Liaison Service and John Moore’s University are working together to develop a Certificate in Higher Education course in mental health awareness for Prison Officers. The course is designed to provide students with an overview of mental illness and the knowledge to develop their skills in working with people with mental illness. HMP Liverpool, HMP Manchester, HMP Hindley and HMP Risley are all due to send officers on the course from September 2001

**Primary Care Services**

- 3.6 All prisoners should have access to primary care services, and all prisons have a responsibility to ensure that these are available, appropriate and adequate. This includes an effective level of primary mental health interventions for those who need it, tackling the majority of need and acting as gatekeeper for the specialised services. In the community around 80% of mental health care is provided through primary care services, and it is important to recognise that

the situation should be much the same in a prison setting, starting with Reception Screening when an individual first arrives in prison. Primary care should cover the range of mental health services that would be available in the community through general practice, including the diagnosis of specific mental disorders or the recognition of complex mental health problems leading to:

- the diagnosis of stress related problems which might be addressed by the wing-based support mentioned above;
- the identification of a care management plan including the prescription of appropriate medications to support a person through a particularly difficult period;
- the referral of patients to more specialised psychiatric nursing support available within the prison;
- the referral of patients to visiting specialists, eg psychiatrists or clinical psychologists, for further assessment and advice on management; and,
- chronic disease management, such as psychosis, bipolar disease, depression, or mental health co-morbidity in presence of drug or alcohol dependency.

Primary care services should also be able to identify and help those whose problems relate to more general difficulties in adjusting to prison life: coping strategies, anxiety management and some of the “talking therapies”, perhaps via appropriately trained wing staff, can help those commonly described as “poor copers”. It may be that prison primary care services offer opportunities for links to the graduate workers described in the NHS Plan

## **Wing-based Services**

- 3.7 Just as in the wider community, some of those who are identified through the prison primary care services may be assessed as needing a greater level of specialist intervention. This should not mean, however, that such prisoners automatically need to be moved from their normal location. Rather, the next level of service should focus on meeting their additional needs by providing such additional support through services based in the residential prison wings.
- 3.8 In the wider community the NHS is seeking to support and treat people in their own homes by the provision of visiting professionals – usually Community Psychiatric Nurses (CPNs) – who can provide specialist advice, support and therapeutic intervention to patients and to others who care for them.
- 3.9 Those with serious mental health problems will usually have an agreed programme of treatment and other interventions, designed to meet their specific needs, and which is regularly monitored and reviewed. The Care Programme Approach (CPA) is one of the key elements of current mental health care policies, and should extend to the prison context. Prisoners who



were on CPA before entry into prison should be able to have their programmes of treatment set out for them and continued as far as possible within the prison setting. Care co-ordinators based in the community should endeavour to retain contact with patients who have been sent to prison, and liaise with prison based staff working with the patient, in order to provide continuity of care, particularly on release. Furthermore, inmates whose clinical profile would precipitate CPA in the community should commence on CPA in prison. It will be important to ensure that there are mechanisms in place to help identify prisoners who are, or should be, on CPA.

- 3.10 CPNs can help with issues such as anxiety management, monitoring of patients on CPA, “coping” strategies, and can offer help and advice on other options, as well as acting as an advocate for patients who might otherwise have difficulty articulating their fears and concerns. They will need to play an important role in monitoring the progress of people with serious mental illness as part of their therapeutic management. They will usually be part of a local Community Mental Health Team (CMHT) providing a whole range of services, including occupational therapy, psychology and other therapeutic interventions. Social Services and, in the case of some ex-offenders, Probation Services should also be involved. In the same way, regular visits or therapeutic programmes supervised by a CPN or visiting professional may provide enough therapeutic support to a patient for them to be able to remain in their normal residential setting within the prison. It will be important, however, to ensure that links with other programmes within the prison are maintained, for example detoxification and the follow-up drug treatment programmes.

**Case Study**

At HMP/YOI Moorland the Mental Health Liaison Team (MHLT) have introduced a Crisis Card Scheme. Where an inmate with mental health problems has been assessed by the team as likely to benefit from the added reassurance of immediate access to a mental health professional, they will issue that prisoner with a card which they can show to their wing officer at any time, day or night, if they feel they are in crisis. Wing officers know which prisoners have been issued with a card, but not why, and know that if the card is produced, they must contact the Health Care Centre immediately. The MHLT aim to respond within 30 minutes. Virtually no abuse of the scheme has been reported.

**Day Care Services**

- 3.11 In the community a greater emphasis is being placed on effective interventions delivered through day care services. These have the advantage of providing more intensive support throughout what can otherwise be a long day for an individual who is unable to work or spend time in other constructive activity. As suggested in paragraph 3.3 above, it is well recognised that the lack of such activity can in itself cause a deterioration in someone with mental health

problems, so that they come to need a higher level of intervention than might otherwise have been necessary.

- 3.12 Day care offers the potential benefit of giving patients access to more specialised services. Members of a CMHT will usually provide these and patients would not have to undergo the uncertainty and de-stabilising effects of having to move to a hospital-like setting (although some, both in the community and in prison, may actually prefer to be in hospital or the health care centre (HCC), even if it is not necessarily the best place for them). The aim is to provide a non-threatening therapeutic environment, which helps individuals to identify specific problems and receive appropriate interventions for them.
- 3.13 Within the prison setting, day services should provide a varying menu of activities and therapies at differing levels of intensity of support, some in a structured day care setting, but also by making use of existing facilities such as gyms, education centres etc. Prisoners' needs can then be assessed and individualised care programmes developed that best meet those needs. Some patients will find their mental health problems effectively supported and treated by two or three sessions a week of specific therapeutic activity. Others might need to spend many of their waking hours in such a therapeutic setting, if they are unable to cope with, for example, working in one of the prison workshops or with the rigours of the normal wing routine.
- 3.14 The establishment of day care within prisons may seem a major task. But there are clear benefits: for patients, who will be able to receive the level of care they need with the minimum of disruption; and for staff, who will be able to focus on the provision of that care without the added problems that relocation to the HCC with its attendant need for night support and supervision would bring. People with serious mental illness may have difficulties with activities of daily living, such as washing, dressing, food preparation (and, in the community, practical tasks such as shopping and paying bills). Day care provides the opportunity for work with occupational therapists, who can assess individual capabilities and identify a therapeutic approach to enhance the patient's skills both in prison and after release. Social therapists, art therapists and other creative therapists can also provide valuable additional support.

**Case Study**

HMP Brixton's Day Care Unit aims to offer a wide range of therapeutic groups for prisoners from the Health Care Centre and residential wings, as well as health promotion schemes. Prisoners are referred to the Unit by staff from both mental health and primary care services, and are assessed and allocated to groups specific to their needs, which may include basic recreation and discussion groups as well as targeted sessions such as anger management, anxiety management, or detoxification support groups.

## **In-patient Services**

- 3.15 Where the range of services already mentioned is in place and working effectively, the pressure for in-patient psychiatric care should reduce. But there will inevitably be a small minority of people who will need 24-hour support, supervision and observation, either because of the severity of their mental illness or because they are going through a particular crisis and need short-term intensive care. In some respects this latter may be likened to the crisis resolution provision described in the Mental Health NSF.
- 3.16 Psychiatric in-patient services in prisons should be structured to recognise that they are mainly aimed at those with the more severe mental health problems in the local prison population. Services for in-patients should therefore be structured around engaging those who require them in active treatment programmes. The in-patient care team should include trained mental health nurses and other professionals and the service should have regular access to, and support from, local general and forensic psychiatric services in the NHS. All patients cared for in a prison in-patient facility should have an actively managed care programme and regular specialist psychiatric assessment as well as having access to the primary care services on offer to all other prisoners.
- 3.17 In-patient stays should be kept as short as possible with either patient resettlement or transfer to hospital being a focus at admission to in-patient care. Not only should day care services be used to minimise in-patient admission, but also to support patients' transition back to normal location after a period of in-patient treatment. Resettlement should always be carefully planned and managed, and involve all those who would have a role in their care. Ideally prisoners should return to the location from which they were admitted to the health care centre, unless there are other reasons to suggest that that would be not in their best interest. In this way the additional stress of having to build relationships with a new set of wing staff and inmates can be avoided. Moreover staff who already know the individual will be more likely to recognise behaviour which might indicate that a relapse or crisis may be imminent.

## **Transfer to NHS Facilities**

- 3.18 Inevitably a comparatively small proportion of prisoners will have mental health problems that are so severe that the prison system simply cannot meet them effectively. The goal for such patients must be speedy assessment and transfer to appropriate specialist NHS facilities. Such transfers require the active engagement of professionals from the proposed receiving unit and a full and free interchange of information with respect to clinical need. Where delays are unavoidable, the receiving unit should offer support and advice to the prison on how to manage the patient to prevent any further deterioration in

their well-being, especially those with acute psychosis, risk of suicide, self-harming behaviour or posing a risk of harm to others.

- 3.19 Whilst in some cases such transfers will lead to lengthy periods of hospital stay, for many the stay in a NHS facility will be short, followed by a return to prison. It is therefore essential that such transfers actively engage staff from the receiving prison so that appropriate treatment arrangements are in place to facilitate a smooth transfer which will support and maintain the improvement achieved in the NHS hospital. In that respect it is also proper that there should be an appropriate degree of follow-up and support from the transferring NHS unit.
- 3.20 It is recognised that sometimes the delays in arranging transfers to the NHS can be unacceptable. In some cases, it seems that the NHS does not always give a prisoner-patient the same level of priority as they would have in the community, perhaps in the belief that those in prison are at least in a secure environment and pose little risk either to themselves or to the public. However, prison health care staff have no legal authority to administer treatment without consent other than under common law. Thus seriously ill but non-compliant prisoners who are a real risk not only to themselves, but also to other prisoners and the staff trying to care for them, can spend months in wholly inappropriate settings receiving little or no effective treatment. The Prison Health Policy Unit is now monitoring numbers of prisoners waiting for transfer to the NHS on mental health grounds and is following up all those who have been waiting for more than three months. In addition, robust mechanisms are being agreed with Regional Specialist Commissioning Groups to facilitate difficult cases so that waiting time is kept to a minimum.

**Case Study**

Broadmoor High Security Hospital has a dedicated waiting list support CPN, whose role is not only to manage the Hospital's waiting list but also to provide active support and advice to the facilities currently managing the care of patients waiting for admission.

## Throughcare

- 3.21 Each individual coming into custody will join the mental health needs ladder at a different point. Some will need no more than the sensitive and positive mental health promotion described earlier. Others will come in at the top end of the scale. For many, however, their needs will probably fluctuate, and the aim must be to provide effective throughcare that responds quickly and seamlessly to their changing needs. Sentence planning should include mental health needs, and both should include a drug treatment programme where this is needed. As paragraph 3.9 makes clear, someone who is known to have been on CPA in the community should have that continued while in prison. Also, no one who has been in receipt of medication for a mental disorder should have

it automatically withdrawn on entry into prison unless and until a proper psychiatric assessment has indicated that this is appropriate. In some cases, if the dose is considered to be excessive, ie benzodiazepines, a reducing dose may be commenced whilst more information is obtained.

- 3.22 It is also important for prison staff to make every effort to ensure that there will be continuity of care for those patients with mental health problems when they are released. Where possible (and generally with the patient's consent) relevant information should be passed to the patient's GP, their care co-ordinator where they were in contact with community mental health services, or to whichever services will be involved in their care. A multi-disciplinary team comprising those who have been caring for the individual within the prison and those who will be responsible for his or her care on release should develop individualised care plans. These should involve the patient and where possible his or her family, and with a care co-ordinator identified to help ensure that the plan is followed.

**Case Study**

HMP Leeds is piloting the Custody Plan, which profiles prisoners' needs and brings together Probation, NACRO, Careers Officers and other key service providers. The aim is to identify any areas of concern on reception, eg housing or social welfare concerns, and then provide support to reduce anxiety throughout custody as well as developing a plan for when leaving prison. Ongoing mental health care needs can also be identified and met through this mechanism.

**Access to effective treatments**

- 3.23 Alongside the reconfiguration of services that will be needed to deliver improvements to mental health provision for prisoners, it will also be important to grasp the opportunities offered by future developments in the mental health field. For example, the National Institute for Clinical Excellence is currently conducting a technical appraisal of the new anti-psychotic medications that have become available, and is expected to report in the near future. Services for prisoners will need to take account of the outcome of that work. While some may put greater pressure on already stretched budgets, it may be that the effective clinical use of these medicines can reduce the need for other clinical support and can be equally, or more, cost effective. There are other, non-medication based, treatments becoming more wide-spread in the community as well, for example psychological treatment approaches, and services must have enough flexibility to respond to these so that prisoners can have access to the most effective treatments.

**Suicide Prevention**

- 3.24 Nine per cent of all suicides in prison occur during the first 24 hours in custody, 27% during the first week, and 43% during the first month. The

Director General of the Prison Service has made it clear that he considers suicide prevention to be one of the key objectives of the Prison Service. The mental health NSF gives it the same emphasis by including it as one of the 7 standards and by identifying prisoners as one of the key vulnerable groups within the standard which the NHS should be specifically targeting. Thus both the Prison Service and the NHS have been given a clear responsibility to work together in this field. The Prison Service has recently launched a new strategy for suicide prevention, and piloting has begun in 5 prisons. On the NHS side, the first wave sites for mental health in-reach deliberately include those 5 establishments, in acknowledgement of the vital links between mental ill health and suicide. However, providing effective care and treatment for suicidal prisoners will be a key task for all prisons, not just those involved in these initiatives.

### **Groups who have special needs**

- 3.25 It has already been acknowledged that different prisons will have different levels of mental health need within their populations. Some will need to have in place the full range of services discussed, whilst others may need little more than fully effective primary care services. However, it must be remembered that certain groups within the prison population will have specific needs, which need to be identified and addressed. For example, women are likely to need some services that might not be necessary in a male prison, and staff will need specific training and skills to meet the differing day-to-day needs of women prisoners. The Department of Health is developing a strategy for improving mental health services for women generally, which will inevitably have an impact on services for women prisoners.
- 3.26 Similarly, prisoners with learning disabilities will need services geared specifically to their needs, as will those with problems relating to their sexual orientation. The needs of those with sensory deficit such as hearing loss or deafness should also not be overlooked. Each prison's requirements will be different and they will need to work with their local NHS and regional partners to develop local solutions, though it is expected that the outline of service provision within this document be taken as a model of best practice.

### **Juveniles and Young Offenders**

- 3.27 The need among prisoners under 21 years of age is even greater than that of the overall prison population: 95% of under-21s have a diagnosable mental illness, or substance abuse problem, or both, and many also have personality disorders. At the same time, the arguments about effective treatment helping to reduce re-offending rates are doubly important. There are opportunities to divert teenagers and young adults from a lifestyle that might otherwise result in them becoming habitual criminals because the systems which should have helped them, both inside and outside prison, have failed to pick them up. The

Government is very clear that the needs of juveniles and young offenders have to be a priority. It is therefore important to ensure that services for young offenders take account of the special and often very complex needs of this group. It is recognised that child and adolescent mental health services in general are under development and that there is still some way to go to achieve a fully comprehensive service. Nevertheless, Young Offender Institutions, and prisons with Young Offender units, need to work closely with their local NHS services to provide the most effective service they can.

### **Responding to ethnic minority needs**

3.28 The prison population is as culturally diverse as society in general. Identifying the needs of black and ethnic minority prisoners, and ensuring that services are provided which are sensitive to them, will be essential. Provision of information in languages other than English and having ready access to interpreters is part of that. But it is equally important to ensure that those who are planning and providing services for these groups of prisoners have the competence to understand the cultural or religious obligations which may make it difficult or impossible for them to engage with traditional services. Mechanisms for overcoming such issues must also be established, including the recruitment of staff from ethnically and culturally diverse backgrounds where appropriate.

### **Dual Diagnosis issues**

3.29 When considering mental health needs, it is common for people to focus on those whom we think of as having a “traditional” mental illness, for example, clinical depression or psychosis. In the prison setting, however, many patients will also be drug or alcohol dependent, and may also have some degree of personality disorder. Service development must take account of, and link in with where appropriate, the detoxification and drug treatment or other rehabilitation programmes already well established in many prisons (Prison Service Order 3550 on Clinical Services for Substance Misusers is relevant in this context). The Department of Health will be issuing a strategy for the treatment of patients with dual diagnosis.

## 4

# Implementing Change

- 4.1 Making a reality of the vision set out in section 3 will mean change for virtually every prison and for the NHS. Existing services will need to be re-profiled so that they better reflect both the complex needs of prisoners and the changing face of mental health services generally by applying the mental health NSF standards and approach.
- 4.2 Around half the £90m or so spent each year on health care by the Prison Service is expected to be taken up in providing mental health services. The benefit of this investment clearly needs to be maximised. In some establishments health care staff are already working with their NHS partners to offer innovative and effective programmes of care. We need to identify ways to disseminate those examples of good practice more effectively. Local learning co-operatives or information sharing networks will be useful ways of sharing ideas and experiences, and those who are currently leading the field should be encouraged to share their achievements in this way.
- 4.3 In many prisons there is still considerable reliance on a medical model of health care, with psychiatrists primarily doing diagnostic and report work, leaving prisoners with very limited specialist support. There is little to offer those needing more than primary care other than transfer to the HCC, even though with appropriate medication and properly targeted therapeutic support, they could be managed on normal location or in day care facilities. Once in the health care centre, staffing difficulties, a relatively narrow skill-mix and inadequate facilities mean that there is usually very little purposeful activity available for prisoners, and only very limited therapeutic intervention, risking further deterioration in their mental health. Both prisoners and staff become frustrated and disillusioned.
- 4.4 Every prison, working with its local NHS partners, should have completed a health needs assessment by the end of March 2001. These assessments should have, as a minimum, identified the basic mental health needs within each establishment, and should act as a starting point for developing a more detailed assessment focused specifically on mental health needs leading to an action plan to meet those needs in a way that takes account of the requirements of the NSF for Mental Health. There are real opportunities for innovative thinking here to provide, for example, better wing-based support, occupational and creative therapy and greater use of clinical psychologists.



- 4.5 **By 30 September 2002 prisons and their local NHS partners will be expected to have completed a detailed review of mental health needs, based on their existing health needs assessment work, to identify gaps in provision between what is currently available and what has been set out in section 3 of this document, and have developed action plans to implement the changes needed to fill those gaps. This work should include a training needs analysis for prison staff and NHS in-reach teams.** Prisons and their local NHS partners should work together to achieve this.
- 4.6 It is recognised that in some prisons, this is going to be a demanding task, with implications for training (for prison staff, and the in-reach teams), for accommodation (eg finding a suitable location for a day care centre), and for the day to day running of the prison (ensuring that visiting psychiatric staff can enter and leave the prison as quickly and easily as is possible in a custodial environment). Action plans may need to be implemented through a phased programme of developmental work over two or three years. In other prisons, however, where less change is required, or where the level of need is less, the necessary actions could be completed in as little as a year.

### **Mental Health In-reach**

- 4.7 Mental health in-reach will provide the means to improve mental health services for prisoners and achieve the objectives of the NHS Plan (see para 2.6 above). As for all prison health care, this approach is underpinned by the basic principle that, allowing for the prison context, services should be provided as far as possible in the same way as they are in the wider community. For those prisons judged to have the greatest need, the NHS will fund the establishment of multi-disciplinary teams, similar to CMHTs, offering to prisoners the same sort of specialised care as they would have if they were in the community. It is likely that all prisoners with mental health needs will benefit to some degree from the introduction of in-reach services, but the early focus is likely to be on those with severe and enduring mental illness, in line with the NHS Plan commitments
- 4.8 The first phase of in-reach schemes started in 2001-02 in 12 prisons in England and the four Welsh prisons. A further 6 prisons came on stream in November 2001. The English sites, with their health authorities, are listed at Annex B. The Welsh prisons are HMP Cardiff, HMP Swansea, HMP Parc and HMP Prescoed/Usk. The programme will then be rolled out to around 40 prisons in 2002-03 and ultimately to the 60-70 prisons considered to have the greatest mental health need during 2003-4. In this way it will be possible to implement gradually the staffing increases required by the NHS Plan in a properly managed way.

- 4.9 Mental health in-reach will form an integral part of modernised mental health services in prisons. It is not a bolt on extra, nor can those prisons in which it is established assume that in-reach by itself will solve all the mental health problems of their population. It will be important to make plans for the service as early as possible. Those in the year 3 wave will have more time to plan and will benefit from the learning from the earlier waves. However, every prison, regardless of whether it has, or expects to have, a dedicated in-reach team must complete the actions set out in paragraph 4.5 above.
- 4.10 Funding is being given to the Health Authorities (or Primary Care Trusts as these become more established and replace health authorities in their local commissioning role) in whose catchment areas qualifying establishments are located. The prisons will need to work in partnership with their local NHS colleagues to develop an appropriate range of community style services to be delivered within prisons, using multi-disciplinary teams. Again, there will be opportunities for innovative approaches to service development. For the purposes of the in-reach project, the funding is intended to cover all inmates of the prison, not just those who come from the Health Authority/PCT in which the prison is located. Similarly, no funding goes with a prisoner who may have been receiving in-reach services in one of the sites but is subsequently moved to another establishment.

## **Monitoring and Evaluation**

- 4.11 The Prison Health Policy Unit and Task Force will be overseeing the modernisation work at a national level. The Mental Health Assessments and Action Plans will need to be approved by the Regional Task Forces currently being established, who will also monitor progress against agreed action plans and will be very willing to offer help and advice wherever needed.
- 4.12 The in-reach project in particular will be supported through the “collaborative” approach where the learning and experience can be shared among those involved. Each site will be asked to bring together a small team comprising both Prison Service and NHS representatives. These teams will come together at regular intervals to consider their work and implementation options, identifying what works well and what has perhaps been less successful. The collaborative will be supported by a central co-ordinator.
- 4.13 In addition, there are also some key deliverables that have to be met in order to meet the NHS Plan commitments. The project will therefore be monitored to ensure that by 2004 the NHS is able to demonstrate that:
- there are at least 300 *additional* staff employed to provide services to prisoners (ie adding prison in-reach to someone’s existing caseload is unlikely to suffice);

- at any one time at least 5000 prisoners with severe and enduring mental illness are receiving more comprehensive treatment (this may include being on CPA, for example);
- every prisoner with a serious mental illness has a care plan on release and a care co-ordinator to help the prisoner/patient engage with services once back in the community.

4.14 There will also be some clear performance indicators which can be used to measure the effectiveness of the strategy as a whole. These might include:

- a reduction in the number of prisoners located in prison health care centres across the Prison Service, with resources re-deployed to provide day care and wing-based support;
- a reduction in the average length of time mentally ill prisoners spend in those prison health care beds that remain;
- a more appropriate skill mix among those providing mental health care, so that prisoners have access to the right range of services to NHS standards;
- increased numbers of day care places;
- improved wing-based services;
- better integration between Prison Service and NHS staff, to encourage skills transfer among staff and reduce professional isolation, and to facilitate exchange of information;
- quicker and more effective arrangements for transferring the most seriously ill prisoners to appropriate NHS facilities and receiving them back;
- increased collaboration by NHS staff in the management of those who are seriously mentally ill, including the suicidal and those vulnerable to self-harm whilst they are in prison;
- improved health and social functioning for patients.

4.15 The information needed for some of these is already available through the returns submitted by prisons to the Prison Health Policy Unit. In other cases, however, new information may need to be captured by both prisons and the NHS.

## 5 Other Issues

### Workforce Issues

- 5.1 It is clear that the strategy will have significant implications for staff, both in the Prison Service and the NHS. For example, if prisoners with emerging mental health problems are to be identified early, then all prison staff, including those working in health care, need mental health training so that they have sufficient competence to know what to look for and what to do if they have concerns. There may also be more sensitive issues to deal with where re-profiling work indicates an inappropriate skill-mix so that re-training, or perhaps relocation, becomes necessary.
- 5.2 On the NHS side, there will be concerns over whether there will be sufficient staff in the right range of disciplines to support policy implementation. This is clearly an issue, eased to a degree by working to a 3-5 year time frame. The mental health Workforce Action Team has been working out the workforce implications of both the National Service Framework for Mental Health and the mental health commitments in the NHS Plan, and prison mental health needs have been fed into that process. The work will be carried forward by the Mental Health Care Group Workforce Team. Workforce confederations will also have a role to play.

### Information Issues

- 5.3 The Prison Health Policy Unit and Task Force are looking at the options for improving information flows between prisons and other agencies besides the NHS, such as social services, the probation service, the police and courts.
- 5.4 However, issues relating to patient confidentiality are also a concern. Although there is provision in legislation for information to be passed on without consent in limited and specific circumstances, in general a patient's right to have their medical records kept confidential is not lost or superseded by becoming a prisoner. Good practice, which is already in place in some prisons, is routinely to obtain consent for medical records to be made available to the prison as part of reception screening. Account should also be taken of the implications of holding more information about prisoners who are being treated on the wings instead of in the health care centre. It would be good practice to establish information sharing protocols with local agencies, so that all are clear about what information can be shared and how, taking account of

NHS guidance on the confidentiality of health information. The Prison Health Policy Unit is actively pursuing these issues and will be issuing guidance.

### **Co-morbidity issues**

- 5.5 Issues around dual diagnosis were discussed in paragraph 3.29. Similarly, the programme of work currently being carried out to pilot approaches for providing useful therapeutic interventions for prisoners who are dangerous and severely personality disordered (DSPD) will have implications for other service provision, particularly in those prisons developing DSPD programmes. In addition, work is currently under way to develop a strategy for caring for people with personality disorders in community settings, which will have implications for prisoners with such a diagnosis who are coming up for release.

### **Funding issues**

- 5.6 It is estimated that around half of the Prison Service health care expenditure (about £90m in 2000) is spent on mental health services. However, it is not always easy for prisons to identify in detail what their overall health care spend amounts to, let alone the spend on mental health. The improvement or reform of prison health services is predicated on a good understanding of health care costs. All prisons will need to establish mechanisms which allow them to be clear about what they are spending on health care and what part of that is going towards mental health. It must be remembered that not all mental health need in prison relates to specialist mental health, and services which would be available in the community through primary care have to be provided by the Prison Service.
- 5.7 However, the overall expenditure represents a substantial investment available for mental health care that at present is not being used as effectively as it should be. Reconfiguring services in line with the framework set out in this document will allow resources to be targeted in ways more likely to meet the needs of prisoners.
- 5.8 As explained in paragraph 4.7, on top of what is already in the system, there is also some specific funding coming from the NHS to support the implementation of mental health in-reach into prisons in line with the commitments made in the NHS Plan. It is essential that the Prison Service and the NHS investments complement each other and are based on joint planning by prisons and their local PCTs.

## 6 Next Steps

- 6.1 This document sets out a framework and the direction of travel for the reform and modernisation of mental health services for prisoners. It is not intended to be a detailed blueprint for change, because no single answer will fit every prison and every local NHS community. Each must work together to develop solutions that meet their particular needs and capacity.
- 6.2 Further guidance on implementation and good practice will be developed as the programme of work unfolds. However, prisons and their NHS partners can, and should, begin work on the assessment and planning process now. The Regional Task Force Teams will be looking for evidence that it is under way and will always be happy to provide advice. Alternatively you can contact either of the following:

Liz Ryan  
Mental Health Policy Lead  
Prison Health Policy Unit  
Room 7E60  
Quarry House  
Quarry Hill  
Leeds  
LS2 7UE

Tel: 0113 254 6597

Sheila Foley  
Mental Health Adviser  
Prison Health Task Force  
Room G20  
Wellington House  
133-155 Waterloo Road  
London  
SE1 8UG

Tel: 020 7972 4568

# Annex A: National Service Framework for Mental Health: The Seven Standards

## Standard one

Health and social services should:

- promote mental health for all, working with individuals and communities;
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

## Standard two

Any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed;
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

## Standard three

Any individual with a common mental health problem should:

- be able to make contact round the clock with the local services necessary to meet their needs and receive adequate care;
- be able to use *NHS Direct*, as it develops, for first-level advice and referral on to specialist helplines or to local services.

## Standard four

All mental health service users on the Care Programme Approach (CPA) should:

- receive care which optimises engagement, prevents or anticipates crises, and reduces risk;
- have a copy of a written care plan which:
  - includes the action to be taken in a crisis by service users, their carers, and their care co-ordinators;

- advises the GP how they should respond if the service user needs additional help;
- is regularly reviewed by the care co-ordinator;
- be able to access services 24 hours a day, 365 days a year.

### **Standard five**

Each service user who is assessed as requiring a period of care away from their home should have:

- timely access to an appropriate hospital bed or alternative bed or place, which is:
- in the least restrictive environment consistent with the need to protect them and the public;
- as close to home as possible;
- a copy of a written after care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

### **Standard six**

All individuals who provide regular and substantial care for a person on CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
- have their own written care plan, which is given to them and implemented in discussion with them.

### **Standard seven**

Local health and care communities should prevent suicides by:

- promoting mental health for all, working with individuals and communities (Standard one);
- delivering high quality primary mental health care (Standard two);
- ensuring that anyone with a mental health problem can contact local services via the primary care team, a helpline or an A&E department (Standard three);



- ensuring that individuals with a severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (Standard four);
- providing safe hospital accommodation for those who need it (Standard five);
- enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (Standard six);

and in addition:

- supporting local prison staff in preventing suicides among prisoners;
- ensuring that staff are competent to assess the risk of suicide among individuals at greatest risk;
- developing local systems for suicide audit to learn lessons and take any necessary action

## Annex B: Mental Health In-reach: First Wave Sites

The eighteen English first wave sites are:

<b>Prison</b>	<b>Health Authority</b>
<i><b>From July 2001</b></i>	
HMP Birmingham	Birmingham
HMP Brixton	Lambeth, Southwark & Lewisham
HMP/YOI Chelmsford	North Essex
HMP/YOI Eastwood Park	Gloucestershire
HMYOI/RC Feltham	Ealing, Hammersmith & Hounslow
HMP Holloway	Camden & Islington
HMP Leeds	Leeds
HMP Leicester	Leicestershire
HMP Pentonville	Camden & Islington
HMP Wandsworth	Merton, Sutton & Wandsworth
HMP Winchester	North & Mid Hampshire
HMP Wormwood Scrubs	Ealing, Hammersmith & Hounslow
<i><b>From November 2001</b></i>	
HMP Belmarsh	Bexley, Bromley & Greenwich
HMP Bullwood Hall	South Essex
HMP Durham	County Durham & Darlington
HMP Frankland	County Durham & Darlington
HMP Whitemoor	Cambridgeshire
HMP Woodhill	Buckinghamshire

For those receiving funding from July 2001, the sites include the five establishments identified as red on the “traffic light” assessment of the state of prison health care centres, which is based on monthly returns from prisons. The five pilot sites for the Prison Service’s suicide prevention initiative are also covered (Feltham falls into both these categories). The remaining three were selected mainly because their proximity to establishments already chosen made it sensible to give their local health authority the opportunity to develop a unified implementation programme rather than being restricted to focussing on just one of the prisons in their catchment area.

Those receiving funding from November 2001 are prisons which are linked either directly or indirectly to the programme of work under way jointly between the Department of Health, the Home Office and the Prison Service to develop services for those with Dangerous and Severe Personality Disorder (DSPD)

# Annex C: Prison Health Developmental Programme Schematic

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## Better services for patients

The drive to modernise health services for prisoners requires partnership action, by the Prison Service and NHS, across three major areas:

- Developing the workforce and infrastructure to support health care delivery; professional development, information (including communications) and capital;
- Focusing on improvements to specific clinical services; including primary care, substance misuse and mental health; and
- Strengthening systems for managing and monitoring change; clinical governance, health care standards and performance monitoring mechanisms.

Further copies of this publication are available from:  
Department of Health  
PO Box 77  
London  
SE1 6XH  
Tel 08701 555455  
or online at the Prison Health Policy Unit and Task Force  
website [www.doh.gov.uk/prisonhealth](http://www.doh.gov.uk/prisonhealth)