HM CHIEF INSPECTOR OF PRISONS FOR SCOTLAND

Out of Sight

Severe and Enduring Mental Health Problems in Scotland's Prisons

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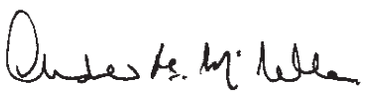
The Scottish Government, Edinburgh 2008

To the Scottish Ministers
I am pleased to forward a report on a thematic inspection of Severe and Enduring Mental Health Problems in Scotland's Prisons.



ANDREW R C McLELLAN
HM Chief Inspector of Prisons for Scotland
August 2008

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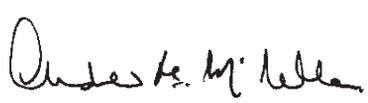
1. FOREWORD

I am pleased to publish this thematic inspection report on prisoners with severe and enduring mental health problems in Scotland's prisons. Mental health problems exist on a spectrum from mild to severe and this inspection focused on the severe end.

At least 315 prisoners, (4.5% of the prisoner population excluding HMYOI Polmont), were found to have a severe and enduring mental health problem. The number of prisoners with less severe forms of mental illness is likely to be much higher. The most common problems were schizophrenia and bi-polar affective disorder. Prison is unlikely to lead to an improvement in these conditions, and may exacerbate the problem, particularly when such prisoners are held in inappropriate locations such as segregation units. This report makes clear that prison is not the most appropriate place for many of these individuals to be living.

A wide range of conclusions is highlighted in this report. All organisations involved in the care, treatment and management of prisoners with severe and enduring mental health problems should take account of these conclusions and develop their own practice to address them.



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2. TERMS OF REFERENCE

SCOPE OF THE INSPECTION

The Focus of the Inspection

2.1 The focus of the inspection was on "severe and enduring" mental health problems of prisoners in Scotland. This includes prisoners with a formal diagnosis of a severe and enduring mental health problem, and those who have not been diagnosed, but whose behaviour indicates that they experience such problems, or who suffer substantial disability as a result of their problems.

2.2 Examples of diagnosed severe and enduring mental health problems covered by the inspection include schizophrenia; bi-polar affective disorder; Alzheimer's disease; and personality disorder.

2.3 Examples of the types of behaviour covered by the inspection include substantial confusion or depression; inability to make informed, consistent decisions, or to cope independently; inability to sustain relationships; and behaviour which poses a significant risk of injury to self or others (including self-neglect).

2.4 A basic definition of the issues covered was provided to participants and was well-recognised by many.

Aims

2.5 The aims of the inspection were to examine:

- The scale of severe and enduring mental health problems in prisons in Scotland.
- The processes involved.
- The impact on the prison.
- Issues on release.
- Prison-based and community interventions.
- Reasons for use of prison for people with severe mental health problems.

2.6 The three key approaches to inspection are relevant to the current thematic inspection.

Safety

2.7 The individual prisoner should be safe from harm by others, safe from self-harm and as far as is possible be managed in such a way that any risk that the individual poses to others is assessed and appropriate interventions put in place to respond to those risks.

Decency, Humanity and Respect for Legal Rights

2.8 The individual prisoner should be treated in such a manner as to preserve that individual's Human Rights, preserve human dignity, respect individuality and support family ties. Treatment of the prisoner should be fair and consistent and the prisoner should not be treated outwith the law and Prison Rules. The prisoner should be held in clean and hygienic conditions which promote self respect. While in prison the individual prisoner should be able to fill his or her time in a purposeful manner.

Opportunities for Self Improvement and Access to Services and Activities

2.9 The individual prisoner should have access to activities, work, education and healthcare. The prisoner should also have the opportunity to participate in cultural and religious activity and be properly prepared for release. The potential to damage a prisoner's social ties, reduce self confidence and diminish the capacity to exercise responsibility should be reduced. Interventions should be available to ensure imprisonment does not have an adverse effect on a prisoner's mental health.

BASIS OF THE INSPECTION

Preparatory Work

2.10 In preparation for this inspection, inspectors met with a number of individuals within SPS, the NHS and the voluntary sector. Following this, a small reference group was convened. This group again comprised individuals from SPS, the NHS and the voluntary sector, and focused on the development of a working definition of "severe and enduring mental health problems", provided advice on the methodology which might be adopted and commented on the questionnaires in draft.

2.11 At the end of the fieldwork, this group met again, and provided feedback on the emerging issues.

Sources of Evidence

2.12 The following sources of evidence were used to inform the inspection:

- A review of some key literature on severe and enduring mental health issues with particular reference to prisoners and the criminal justice system.
- Examination of policy documents relevant to consideration of severe and enduring mental health problems among prisoners.
- A questionnaire survey of all Scottish prisons.
- Visits to eight prisons: Aberdeen; Barlinnie; Cornton Vale; Edinburgh; Greenock; Kilmarnock; Polmont and Shotts. In each case, inspectors met with the Multi-Disciplinary Mental Health Team, with a group of staff and with prisoners (either as a group, or individually). Where further clarification was required, individual meetings were held with relevant managers.
- Visits to eight low and medium secure mental health units, and to the State Hospital, as well as the submission of a postal response from one other unit. In each visit, inspectors met with a group of staff usually involving psychiatrists, psychologists, mental health nurses, unit managers and administrators. A meeting held at the Rowanbank Clinic in Glasgow was attended by representatives of all units in the Greater Glasgow and Argyll and Clyde Board areas.
- A group discussion involving 10 voluntary organisations each with direct experience of working with offenders and ex-offenders. Following this meeting, two additional written submissions were provided, in one case from an organisation which had been unable to attend the group discussion.
- A joint meeting with representatives of the Glasgow and Strathclyde North Community Justice Authorities.
- Separate meetings with the SPS Director of Health and Care and the Mental Health & Suicide Risk Management Co-ordinator.
- A meeting with the SPS trade union side including Royal College of Nursing.
- A meeting with one Sheriff and participation in Judicial Studies Mental Health Training event.
- Meetings with the Mental Welfare Commission.

3. OVERVIEW OF SEVERE AND ENDURING MENTAL HEALTH PROBLEMS IN PRISONS IN SCOTLAND

THE POLICY CONTEXT

3.1 It is likely that people with severe and enduring mental health problems will come into contact with the criminal justice system at some time. There is a range of policy and legislative safeguards in place to ensure that their welfare is considered.

Legislation

3.2 The most relevant piece of legislation relating to this inspection is the Mental Health (Care and Treatment) (Scotland) Act 2003 [the Act]. The Act provides a number of means for the identification and treatment of people with mental health problems involved in criminal proceedings. Where there is a concern about an individual's mental health (e.g. from the police, Procurator Fiscal, court, defence solicitor, etc.), a mental health assessment can be requested to help identify whether or not there is a need for treatment, and how to deal with the case.

3.3 A court has the option to impose a prison sentence without examination of mental health issues, and may not identify a concern with this. There are, however, a number of options available under the Act for the imposition of orders relating to care and treatment which do not involve imprisonment. These provide for a range of options before and after trial which require that the individual undergoes an assessment or some form of treatment in a hospital, rather than a prison setting. In some cases, where such an order has been imposed, the order must be kept under review, and the result of this may be that an offender is returned to prison to complete his or her sentence.

3.4 Where an offender is remanded in custody, or receives a custodial sentence, and there are concerns about his or her mental health, there is a clear expectation in the Act (and in national policy set out below) that their mental health will be kept under review. Where an offender requires this, he/she can be transferred to a specified hospital for assessment or treatment. The procedure governing this is set out in the Act, and is the basis for all transfers between prison and hospital regardless of the location of the prison or the hospital. Remand prisoners may be transferred on either an Assessment Order (Section 52D) or a Treatment Order (Section 52M). The arrangements for convicted prisoners are set out in Section 136 of the Act. This is described as a Transfer for Treatment Direction, and specifies issues such as eligibility of prisoners for transfer to hospital, the way in which the decision on the need for transfer should be reached and the approval processes required. It also sets out the specific criteria which apply to admission to the State Hospital. A protocol governing the detailed liaison arrangements to apply between SPS and the NHS was agreed in 2006.[1]

3.5 While in hospital, the mental health of the patient must continue to be reviewed and, if the circumstances which required transfer to hospital no longer apply, the individual may be returned to prison to complete his sentence. A parallel protocol was also agreed in 2006, covering these transfers.

1 Scottish Executive 2006 *Forensic Mental Health Services [HDL (2006) 48]*. Edinburgh: The Scottish Executive.

The Use of Prison as a "Place of Safety"

3.6 Although the Act allows an individual to be taken to a "place of safety" for up to 24 hours when a police officer has significant concerns for their welfare, it appears that prisons are not being used to provide this. However, Sheriffs have the power to require that an accused person be detained for a period of seven days to allow an assessment to be made of his mental health. While the accused person would normally be detained in hospital, it is clear that some people are being detained in prison (e.g. where a hospital bed is not available). Although this is commonly referred to within prisons as a "place of safety order", it is in fact an "assessment order" (although it specifies detention in a "place of safety"). In this context, the Act states that:

"An assessment order may include such directions as the court thinks fit for the removal of the person subject to the order to, and detention of the person in, a place of safety pending the person's admission to the specified hospital." [Section 52D(9)]

National Policy in Relation to Severe and Enduring Mental Health Problems

3.7 Overall policy for forensic mental health in Scotland is guided by "Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland".[2] The policy sets out the basis for a multi-agency, multi-disciplinary approach to work with mentally disordered offenders, and encompasses all stages from investigation, through court processes, imprisonment and care in the community.

3.8 The overall aim of the policy is:

"... to co-ordinate care and support for the benefit of the individual and to ensure public safety."

3.9 The overall approach of the policy is that:

... Mentally disordered offenders should be cared for:

- With regard to quality of care and proper attention to the needs of individuals.
- As far as possible in the community rather than in institutional settings.
- Under conditions of no greater security than is justified by the degree of danger they present to themselves or to others.
- In such a way as to maximise rehabilitation and their chances of sustaining an independent life.
- As near as possible to their own homes or families if they have them.

2 The Scottish Office (1999) *Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland.* Edinburgh: HMSO.

3.10 Overall, the policy sets out the range of services which should be available to mentally disordered offenders through relevant providers within the NHS and local authorities. It also sets out clearly the roles of the partners, and the ways in which they should work together. The policy also sets out a clear direction for SPS in terms of the identification of mental health problems, and the responses which it should make. Key to this is the direction that prisoners who do not meet the criteria for hospital admission need to be treated in prison. It suggests the development of service level agreements with health and social work services and notes that:

"So far as possible within the constraints of resources and of imprisonment, the Scottish Prison Service aims to provide or commission services for prisoners with mental health problems in line with best practice in the wider community."

3.11 In 2003, the Forensic Network was established as a means of bringing together all agencies with a relevant interest in mentally disordered offenders (including the Scottish Executive, the NHS, local authorities and SPS).

3.12 In July 2006, the Scottish Executive issued a new policy on Forensic Mental Health Services, which set out a new structure for the delivery of in-patient services, and established a set of standards for various aspects of this care (referred to as HDL (2006) 48).[3]

3.13 The structure of in-patient services is relevant to this inspection as this sets out where, and under what conditions, prisoners will be held if they are transferred to hospital. Essentially, there are three levels of facility: national, regional and local. Within this, there are three basic levels of security: high, medium and low. HDL48 sets out clear guidance on the component parts of these three levels of security, designed to protect the patient and the public, but to do so in a way which subjects the patient to the minimum level of security required.

3.14 HDL48 also sets out the pattern of services for women, and for adults with learning disabilities. In relation to women, there were to be no beds in high secure conditions, and a limited number in medium and low secure units. In relation to learning disabilities, some beds were to be retained in high secure conditions, with additional provision in medium and low secure units.

3.15 The implementation of this policy was underway at the time of the inspection. This requires a new hospital to be built on the site of the State Hospital at Carstairs, the commissioning of new medium secure beds in Perth and Glasgow, and the redevelopment of low secure beds in a number of locations. In addition, a number of new beds for adults with learning disabilities are being created. This is, therefore, a transitional period for forensic mental health services.

3 Scottish Executive 2006 *Forensic Mental Health Services [HDL (2006) 48]*. Edinburgh: The Scottish Executive.

3.16 At an individual patient level, the Care Programme Approach, first introduced in 1991, is used across the NHS to provide a co-ordinated approach to the assessment, planning and review of care for people with a range of mental health problems, including all of those who would be covered by a diagnosis of severe and enduring mental health problems. This is not currently mandatory in Scotland.

3.17 In April 2007, eight Community Justice Authorities (CJAs) were established across Scotland. They have been established as a means of taking a co-ordinated approach to the planning and delivery of services to offenders. Their overall aim is to contribute to the reduction in re-offending. The CJAs are at an early stage in their development, but it is expected that they will consider policy and practice relating to mentally disordered offenders in due course.

Policy in SPS

3.18 The key aims of SPS are:

- To keep in custody those committed by the courts.
- To maintain good order in each prison.
- To care for prisoners with humanity.
- To provide prisoners with a range of opportunities to exercise personal responsibility and to prepare for release.
- To play a full role in the integration of offender management services.

3.19 Overall, all healthcare within SPS prisons is governed by the agency agreement between Scottish Ministers and SPS. Healthcare in HMP Kilmarnock is governed by the contract between SPS and SERCO.

3.20 There is a recently established Mental Health Steering Group within SPS, which is intended to provide a strategic direction for mental health and to consider practical policy issues.

3.21 In terms of policy direction, there is a number of policies which impact on the identification, treatment and management of prisoners with severe and enduring mental health problems.

3.22 Mental health well-being is an important part of the SPS policy on the "Health Promoting Prison".[4] The policy is based on four main principles: empowerment; partnership; equity and sustainability. In relation to mental health well-being specifically, the policy sets out five broad areas of work:

- Creating a supportive environment.
- Involving prisoners, communities and partners.
- Developing personal skills.
- Integrating healthcare services.
- Monitoring and reviewing progress.

4 SPS 2001. The Health Promoting Prison. Edinburgh: SPS.

3.23 Following this, SPS published a policy statement "Positive Mental Health"[5] which remains current. It aims:

> *"... to provide a setting which encourages positive mental health in all aspects of prisoner management and care, which responds to the mental health and care needs of prisoners, and arranges specialist healthcare provision for those with mental illness within the prison population as appropriate."*

3.24 To achieve this, the policy recognises that a range of factors should be emphasised within the regime relating to: a secure and well ordered environment; supportive relationships and modelling of good interpersonal skills by well-trained staff and management; purposeful activities to promote self esteem; drug and alcohol detoxification, rehabilitation and relapse prevention programmes; healthcare services responsive to prisoner needs and liaison with community agencies.

3.25 The policy recognises that a range of outcomes would be required relating to staff understanding and responses, the interventions provided, continuity of care, management information systems and the adoption of multi-disciplinary team working, evidence-based approach.

3.26 Within SPS, the delivery of mental health policy is overseen by the Mental Health Steering Group and is taken forward locally by multi-disciplinary mental health teams (MDMHTs).

3.27 At a broader level, in 2006, the Scottish Executive set out a series of outcomes for offenders. Although these relate to reoffending, and to all services working with offenders, these have been adopted by SPS, and overall healthcare policy takes account of these. Of the outcomes, a number are directly relevant to prisoners with severe and enduring mental health problems, including:

- Sustained or improved physical and mental well-being.
- The ability to access and sustain suitable accommodation.
- Reduced or stabilised substance misuse.
- Maintained or improved relationships with families, peers and community.
- The ability to access and sustain community support, including financial advice and education.
- The ability to live independently if they choose.

3.28 The national Choose Life strategy also has relevance to work with prisoners with severe and enduring mental health problems. It is worth noting that, as a result of SPS participation in Choose Life, an approved national training programme, Mental Health First Aid, has been introduced in a number of prisons. This provides basic awareness of mental health issues particularly related to the risk of suicide and self-harm, and provides participants with information about how best to address these issues in a prison setting. The SPS anti-suicide strategy Act2Care is clearly also relevant, as it sets out procedures which staff must follow in the event of concerns being raised. These procedures should lead to the identification of, or at least a suspicion of, severe and enduring mental health problems where these exist.

5 SPS 2002. *Positive Mental Health*. Edinburgh: SPS.

3.29 At the time of inspection, the SPS was conducting a scoping exercise to look at the feasibility of transferring the provision of prison healthcare to a contracted out arrangement by the NHS. Prisoners with mental health problems should have the same quality of healthcare, and access to it, as anyone else.

3.30 At a broader level, the liberation of prisoners with severe and enduring mental health problems is generally covered by the same policies as other prisoners. For all prisoners, throughcare arrangements apply, and for longer-term prisoners, parole and license conditions may also be relevant. Integrated Case Management (ICM) arrangements would also apply to designated prisoners with severe and enduring mental health problems (as with any other prisoner falling within its scope). For sexual offenders, MAPPA (multi-agency public protection arrangements) would apply, as a result of the potential risk to the public.[6]

THE NATURE OF MENTAL HEALTH PROBLEMS

3.31 The Mental Health Foundation notes that the term "mental health problem" is used to encompass a wide range of problems and it is important to identify the types of behaviour covered by this. There are a number of diagnostic and classification frameworks and, amongst these, the most common is the World Health Organisation's "International Statistical Classification of Diseases and Related Health Problems" (the ICD-10) which classifies mental health problems in a number of categories.

3.32 Mental health "disorders" are subdivided into "organic" or "functional", within which there is a range of individual disorders. Organic disorders involve identifiable brain malfunction and include issues such as acute confusion or delirium; dementia (including Alzheimer's disease); and learning disability. Functional disorders are those which are not due to simple structural abnormalities of the brain and include disorders such as: schizophrenia; mood disorders (including bi-polar affective disorder); mania and depression. There are also "neurotic mental disorders" (including obsessive compulsive disorder and post traumatic stress disorder); eating disorders; substance misuse disorders (such as drug-induced psychosis); personality disorders and conduct disorders.

3.33 The Mental Health (Care and Treatment) (Scotland) Act 2003 defines mental disorder as:

> *"... any mental illness, personality disorder or learning disability, however caused or manifested."*

3.34 As such, the Act includes both organic and functional disorders.

6 Management of Offenders etc. (Scotland) Act 2005.

Severe and Enduring Mental Health Problems

3.35 Mental health problems exist on a spectrum from mild to severe, and from common to less common. In terms of the identification of "severe and enduring mental health problems", "common" mental health problems include anxiety, depression, phobias, obsessive compulsive and panic disorders, while "severe and enduring" mental health problems include those such as psychotic disorders (including schizophrenia) and bi-polar affective disorder (manic depression).[7] "Personality disorder" is also identified as a mental disorder under the Mental Health (Care and Treatment) (Scotland) Act 2003. This has been defined as "an enduring pattern of inner experience and behaviours that deviates markedly from the expectation of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment".[8]

THE PREVALENCE OF MENTAL HEALTH PROBLEMS

3.36 It is worth considering the general prevalence of mental health problems in the wider population as a whole, before considering the findings of this review in relation to the prison population in Scotland.

Prevalence of Mental Health Problems

3.37 NHS Quality Improvement Scotland (2005) has identified the high prevalence of mental health problems in Scotland and the impact of this on the quality of life of those affected. The "Framework for Mental Health Services in Scotland" identifies that more than 20% of adults are affected by mental health problems at any one time, and that 30% of general practice consultations involve mental health problems. Amongst those experiencing mental health problems, the proportion of people experiencing *severe and enduring* mental health problems is much smaller. For example, 0.4% of people living at home have been found to have schizophrenia, and 0.5-1% have bi-polar affective disorder.[9] A recent report by SAMH[10] estimated the social and economic costs of mental health problems in Scotland at £8.6 billion (and this did not include the costs borne by the criminal justice system).

3.38 The Sainsbury Centre for Mental Health identified considerable overlap between the populations who have contact with mental health services and those who have contact with criminal justice services.[11] Tickle (2005)[12] stated that more than 60% of offenders entering prison in Scotland had a mental illness (compared to 16% of the general population). The Mental Health Foundation has suggested that nine out of 10 prisoners have a mental disorder, and the Sainsbury Centre for Mental Health (2007) identified that around 70% of sentenced prisoners in England and Wales experience two or more mental health problems, and 20% of male and 15% of female prisoners have previously had a psychiatric acute admission to hospital.[13]

7 London Health Observatory (undated). *Mental Health Overview and Definitions*. Via internet.

8 American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV). Washington DC: APA.

9 Framework for Mental Health Services in Scotland internet site.

10 SAMH (2006) What's it worth? The social and economic costs of mental health problems in Scotland. Glasgow: SAMH.

11 The Sainsbury Centre for Mental Health (2007). *Mental Health Care in Establishments. Briefing 32*. London: The Sainsbury Centre for Mental Health.

12 Tickle, L. (2005) *Is the Prison System Failing Mentally Ill People?* The Herald Society Supplement 19th July 2005.

13 Prison Reform Trust (2007) Prison Factfile Bromley Briefing May 2007.

3.39 Data from an unpublished inspection on High Risk Offenders identified that 30% of prisoners (from sample) presented with a history of mental ill health on admission, with 41% going on to receive some form of support for mental health whilst in prison.

3.40 International studies suggest that 3-7% of prisoners have severe and enduring mental health problems, and Tickle suggested that around 5% of the prison population experience such issues, a prevalence identified as four times that within the wider community. The Sainsbury Centre for Mental Health (2007)[14] identified that, while most of the mental health problems in prison are common conditions such as depression or anxiety, some have more severe problems such as psychosis. Singleton *et al* (1998)[15] suggested that, in England and Wales, 10-20% of prisoners are in the group with the most serious mental health problems.

3.41 There are many difficulties in measuring the actual prevalence of severe and enduring mental health problems in prisons, including problems in terms of identifying "severe and enduring" mental health problems as a distinct group, and in taking account of those prisoners who may have undiagnosed or less visible problems. For these reasons, the figures from this inspection cannot be seen to be definitive, but provide an estimate of the scale of the problem in Scotland.

Severe and Enduring Mental Health Problems in Prisons in Scotland

3.42 There are prisoners with mental health problems throughout the prison system in Scotland. As in the wider population, however, prisoners with *severe and enduring* mental health problems in prison make up a relatively small proportion of prisoners with mental health problems. People with severe and enduring mental health problems also constitute a relatively small proportion of the total number of prisoners receiving medication for some form of mental health problem.

3.43 Some MDMHTs commented on the high number of prisoners overall with some form of mental health problem. One, for example, noted that almost all exhibited some form of personality disorder, while another suggested that about 70% of prisoners had some form of mental health issue (similar to the figure quoted by Tickle in 2005, and representing a much higher proportion than in the population as a whole).

3.44 In terms of severe and enduring mental health problems, although there were some issues with the means of classification, at least 315 prisoners were identified as having some form of diagnosed condition. This figure excludes those in Polmont, as psychiatrists there are generally reluctant to reach a formal diagnosis on young people (an issue discussed later). A further eight prisoners were identified who were, at that time, undergoing assessment in a hospital facility.

14 The Sainsbury Centre for Mental Health (2007). *Mental Health Care in Establishments. Briefing 32*. London: The Sainsbury Centre for Mental Health.

15 Singleton, N., Meltzer, H. and Gatward, R. (1998) *Psychiatric Morbidity Among Prisoners in England and Wales*. London: Office for National Statistics.

3.45 Excluding Polmont, this represents around 4.5% of all prisoners. As with the figure for mental health problems overall, this is again similar to the figure quoted by Tickle in 2005, and represents a much larger proportion of people with severe and enduring mental health problems in prison than in the wider community. Some prisoners' behaviour suggested that they may have undiagnosed severe and enduring mental health problems, and prisoners with personality disorders may be amongst those most likely to be within this group.

3.46 Only a very small proportion of prisoners with severe and enduring mental health problems were found to be subject to the anti-suicide strategy Act2Care.

Changing Trends

3.47 Although there is a relatively low number of prisoners with severe and enduring mental health problems, prisons felt that the number has been increasing in recent years, along with the severity and complexity of the problems. Additionally, 10 prisons indicated that the number of prisoners with severe and enduring mental health problems had risen in the last three years.

3.48 Although there was seen to have been a general increase in severe and enduring mental health problems, some particular mental health problems were identified as having increased specifically, and those highlighted included: drug-related problems; learning disabilities; Post Traumatic Stress Disorder (PTSD); Attention Deficit Hyperactivity Disorder (ADHD); and autistic spectrum disorder. However, this increase may be due to a greater knowledge of these conditions resulting in increased assessment and diagnosis.

3.49 A number of hospitals, however, stated that they had not seen a particular change in the *types* of severe and enduring mental health problems which prisoners who were referred to them experienced and it was suggested that many of the problems facing prisoners would be dealt with in prison. One hospital stated explicitly that its experience was mostly of prisoners with "psychotic" disorders: the rest remaining in prison.

3.50 Five possible reasons for the perceived increase in the number of prisoners with severe and enduring mental health problems in prisons were highlighted:

- The rising number of prisoners overall.
- The closure of long-stay psychiatric hospitals and a perceived lack of sufficient support in the community.
- The increase in long-term substance misuse problems.
- An increase in the elderly population.
- A greater awareness of mental health disorders supported by increased assessment and diagnosis.

3.51 However, the increasing visibility of these problems may not necessarily reflect an actual increase. Instead, it was suggested this could be as a result of improvements in the recognition of mental health problems, and the availability of mental health assessment in prison, accessibility of support, and individuals' willingness to seek help. One of the hospitals also suggested that there had been changes to the perception of the need for transfer of prisoners to hospital, rather than an actual increase in the number experiencing severe and enduring mental health problems.

3.52 Whatever the reason for the changing patterns, there is an increasing requirement for prisons to respond to these issues.

Types of Severe and Enduring Mental Health Problems in Prisons

3.53 Amongst severe and enduring mental health problems experienced by prisoners, most of the prisoners spoken to stated that they had experienced their mental health problems for a long period of time, and most had had problems before they came into the prison.

Common Issues

3.54 The majority of participants were able to identify the severe and enduring mental health problems which they considered to be particularly prevalent amongst prisoners. The most common types of problems highlighted were those which would be classed as "functional" mental disorders, with the most prevalent seen to be schizophrenia and bi-polar affective disorder.

3.55 There were also some examples of organic mental disorder highlighted, such as prisoners with learning disabilities, and some instances of dementia. "Neurotic" mental disorders, such as anxiety, obsessive compulsive disorder (OCD) and PTSD were also identified as amongst the types of severe and enduring mental health problems experienced. Some prisoners also described specific symptoms of mental disorder, such as hallucinations, insomnia, paranoia or self-harm.

3.56 Included within the group of prisoners with severe and enduring mental health problems were a number with a personality disorder.

3.57 Some of the differences of view of whether or not the inclusion of personality disorder was appropriate became apparent during the inspection, and it was suggested that it was unusual, for example, for hospitals to accept patients with a sole diagnosis of personality disorder. It was clear, however, that there are difficulties in identifying some mental health problems such as "severe and enduring" (as distinct from less severe), and the point at which a problem becomes severe and enduring was often difficult to establish.

Co-morbidity

3.58 The term "co-morbidity" refers to the presence of more than one mental health disorder, and there is clear evidence of co-morbidity relating to substance misuse and mental health problems. Grant[16] (2004) noted that up to three in four people who use drugs have mental health problems, up to one in two patients with alcohol problems may also have mental health problems and up to two in five people with mental health problems, may have a drug and/or alcohol problem.

3.59 This issue of co-morbid substance misuse and mental health problems was also identified in this inspection. The large majority of prisoners with mental health problems also have substance misuse issues. Prisoners confirmed this. Estimates varied, but the commonest were that co-morbid substance misuse is an issue for around 80% of prisoners with severe and enduring mental health problems. Hospital and voluntary sector participants were also clear that a very high proportion of these prisoners have co-morbidity issues, with several hospitals suggesting that this was "virtually all".

3.60 Although it is recognised that there is not a simple causal relationship between substance misuse and mental health problems, substance misuse was seen to impact upon mental health problems in a number of ways, such as drug-induced psychosis. The point was also raised that substance misuse leads to considerable physical damage and cognitive impairment, which were seen to be high amongst the prison population. Similarly, mental health problems were seen to increase the likelihood of substance misuse, with some prisoners stating that they had "self-medicated" with alcohol or other non-medicinal drugs. One MDMHT also suggested that the high level of drug use in prison could mask a lot of mental health problems.

Issues for Particular Groups

3.61 Some groups of prisoners experience specific issues relating to their mental health. The majority of prisons believed that there were some groups of prisoners amongst whom severe and enduring mental health problems were particularly prevalent. Those identified included: those with substance misuse issues; those with personality disorders; "vulnerable prisoners"; prisoners in particular age groups; survivors of childhood sexual abuse; short-term prisoners; and prisoners with a blood borne virus.

3.62 As well as groups for which there was seen to be a higher *prevalence* of mental health problems, it was also suggested that some groups faced particular issues. For example, particular issues were highlighted amongst young offenders, in terms of the types of mental health problems they experienced and their general "vulnerability". Some disorders of childhood, adolescence and development affect this group particularly, such as Attention Deficit Hyperactivity Disorder (ADHD), autistic spectrum disorder, communication problems and learning disabilities.

3.63 In terms of co-morbidity, the issue of co-morbidity for young people often relates to alcohol, rather than to other drugs. An issue also arose with the diagnosis of young people, with the suggestion that many young people have symptoms of severe and enduring mental health issues, but are not yet diagnosed, as psychiatrists are unwilling to do so.

16 Grant, S. (2004). *National Mental Health Services Assessment.* Edinburgh: Scottish Executive.

3.64 A further group identified as experiencing specific mental health issues was women. One hospital had seen an increase in the number of women patients, and that women prisoners would generally have more complex needs and issues, with particular experiences of abuse, emotional damage and substance misuse issues. Family dynamics and complex social situations can also have an impact on their mental health. One MDMHT identified particular issues for women with severe and enduring mental health problems with babies, noting that there could be fears for the safety of the baby. It was also identified, however, that being separated from the baby could also have an impact on a woman's mental health.

3.65 There are also issues for women prisoners relating to experiences of rape and sexual abuse, and some women themselves identified these issues as contributing to their symptoms and experiences of mental health problems.

3.66 A small number of participants also identified that there were specific difficulties for disabled prisoners in coping both with a physical disability and mental health problems in prison. It was also suggested that there could be problems for prisoners with communication difficulties.

3.67 Specific mental health issues were also identified for older prisoners, with the suggestion that there is an ageing population of long-term prisoners and that this group has their own set of problems.

3.68 It was also suggested that ethnic minority prisoners may have specific needs relating to their health and mental health, as well as having a need for access to information in an appropriate language. Cultural issues may impact upon the identification of mental health problems.

3.69 The point was raised that there may be severe and enduring mental health issues for Transgender prisoners, although mental health issues affecting Lesbian, Gay, Bisexual and Transgender (LGBT) people were generally not highlighted frequently.

3.70 Sex offenders and prisoners who require protection from other prisoners may also have specific mental health needs, and one MDMHT noted the receipt of a significant number of referrals from protection prisoners.

3.71 There were also issues identified relating to a prisoner's length of sentence. For example, it was noted that short-term prisoners and those on remand can experience a lot of adjustment issues, stress and social issues. Amongst long-term prisoners, a lack of progression and lack of activity may impact upon mental health. One prison suggested that some long-term prisoners could have a very long history of substance misuse, which impacts upon their mental health, while another suggested that long-term prisoners could reach a stage in their sentence when their mental health becomes poor. Long-term prisoners may also experience mental health problems at the start and towards the end of a long sentence.

3.72 More generally, prisoners with severe and enduring mental health problems often have common experiences of poverty, social problems, communication problems and a lack of support and that many have come through the care system.

3.73 All of these issues have implications for the identification of needs, and the treatment of these groups, and will be addressed later in this report.

THE IMPACT OF MENTAL HEALTH PROBLEMS

3.74 Almost all prisons stated that having prisoners with severe and enduring mental health problems has an impact on the establishment as a whole, on staff and on other prisoners, and that this impacts in a range of ways.

Impact on Prisons

3.75 Prisoners with severe and enduring mental health problems have an impact on the general running of a prison in a number of ways:

- Prisoners with complex needs, or who require frequent checking, are resource-intensive. Other activities may be restricted as a result.
- Disruption by one person with a severe and enduring mental health problem can require disproportionate staff input and time.
- Where prisoners need to be located alone, this can make extra demands on staff resources.
- Where prisoners are located in the segregation unit this impacts on the other resources available.
- There may be a lack of appropriate facilities for people with severe and enduring mental health problems.

3.76 By contrast, most hospitals did not suggest that the presence of prisoners had any particular impact on their facilities.

Impact on Staff

3.77 There is also an impact on prison staff:

- Officers often have to manage difficult behaviour and respond to complex needs.
- Staff may feel that they are not appropriately skilled or resourced for the tasks required.
- Staff may be the subject of allegations by people with mental health problems.
- There can be assaults on staff.
- Working with prisoners with severe and enduring mental health problems is stressful, emotionally demanding and can be upsetting, particularly for staff in single posts: "something that's never considered is the impact on *staff* mental health and well-being".

Impact on Other Prisoners

3.78 There is a number of ways in which prisoners with severe and enduring mental health problems impact on other prisoners, particularly in terms of their actions and behaviour:

- There can be noise and disruption (including at night) and a general "lack of peace" (with one example given of a prisoner who banged his door rhythmically for hours on end).
- Tension and stress can increase the risk of unpredictable behaviour from other prisoners.
- Some behaviours may pose a threat to other prisoners.
- Other prisoners may not be able to access staff resources, with disproportionate time taken up by prisoners with severe and enduring mental health problems.
- Prisoners may not wish to share a cell with others with mental health problems, but there can be perceptions of favouritism and pressure on such accommodation if those with mental health problems are moved to a single cell.
- In one prison a recent suicide was seen to have had a particular impact on other prisoners, with everyone "on a downer".
- Sometimes the prison needs to be locked down to deal with issues for people with severe and enduring mental health problems, and this can lead to loss of recreation and interaction time for others.

The Impact of Imprisonment on Prisoners with Severe and Enduring Mental Health Problems

3.79 The fact and nature of imprisonment itself can have a negative impact on people with severe and enduring mental health problems:

- The environment is not seen as conducive to recovery.
- Factors such as separation from family and social support can have a detrimental effect.
- Other prisoners may bully or "rile" people with mental health problems, and lack understanding of these issues.
- Staff attitudes can affect mental health, and there can be stigma.
- Prisoners may be singled out and ostracised.
- Poor conditions can impact on mental health. Segregation in particular can impact on this.
- Other aspects of the living conditions, and a lack of activity, can lead to worsening of specific symptoms.
- Prisoners may well worry about family issues – particularly women.
- The nature of the regime, boredom and "time to think" can exacerbate mental health problems.
- Prisoners may experience difficulties in adjusting and sleeping.
- Prisoners with severe and enduring mental health problems can be a threat to themselves.
- There can be a lack of progress for some prisoners with severe and enduring mental health problems, and a dependency on nursing staff and officers.

Interaction with Overcrowding

3.80 Overcrowding may exacerbate the challenge of managing prisoners with severe and enduring mental health problems. Overcrowding may:

- Make extra demands on staff resources and compound the difficulties identified.
- Affect prisoners' mental health directly.
- Contribute to behaviour (such as bullying) which can impact on mental health.
- Make it more difficult to identify mental health issues and provide support.
- Make it too easy for prisoners to stay in their cells and focus on their problems.

CONCLUSIONS

3.81 In terms of the **prevalence** of severe and enduring mental health problems, the main conclusions are as follows:

3.81.1 A very large proportion of prisoners have some form of mental health problem. Of these, only a small proportion have severe and enduring mental health problems. At least 315 prisoners with severe and enduring mental health issues were identified by prisons (not counting Polmont). A further eight prisoners were identified who were at the time, undergoing assessment in a hospital facility. Excluding Polmont, this represents around 4.5% of all prisoners.

3.81.2 The number of prisoners with severe and enduring mental health problems appears to be rising, although it was not clear if the numbers themselves are increasing, or if the visibility of mental health problems is increasing. Whatever the reason for the changing patterns, there is an increasing requirement for prisons to respond to these issues.

3.81.3 The most common types of severe and enduring mental health problems in Scottish prisons are schizophrenia and bi-polar affective disorder. There is also a significant number of prisoners with a personality disorder. The majority of prisoners with mental health problems also have substance misuse issues. Smaller numbers of prisoners with other mental health problems were also reported.

3.81.4 There are some groups amongst whom severe and enduring mental health problems are seen to be particularly prevalent, as well as some groups which experience specific issues relating to their mental health, including: young people; women with babies; disabled people; older people; ethnic minority people; sex offenders and protection prisoners; and prisoners serving particularly long or short sentences.

3.82 In terms of the **impact** of severe and enduring mental health problems in prison, the main conclusions are as follows:

3.82.1 Prisoners with severe and enduring mental health problems have an impact on the general running of an establishment, with this group seen as being both resource-intensive and a cause of disruption.

3.82.2 There is also an impact on prison staff, in terms of the physical and emotional demands of being required to manage difficult behaviour and respond to complex needs. This is exacerbated by a lack of training and guidance.

3.82.3 The impact on other prisoners is general disruption; hampering access to staff and facilities; and affecting the overall atmosphere.

3.82.4 The fact and nature of imprisonment itself does real harm to people with severe and enduring mental health problems.

3.82.5 These impacts are exacerbated by overcrowding.

4. PROVISION FOR PRISONERS WITH SEVERE AND ENDURING MENTAL HEALTH PROBLEMS IN PRISON

4.1 This chapter examines the ways in which prisons address severe and enduring mental health problems, from identification to provision of treatment, interventions and other support.

IDENTIFYING NEEDS

4.2 The first stage in the process of addressing severe and enduring mental health problems is the identification of needs, and this can take place at various stages.

Reception and Induction

4.3 The processes at reception and induction are important in identifying if a prisoner has severe and enduring mental health problems, and there are a number of ways in which this takes place.

4.4 Firstly, information about mental health needs may be received upon reception, although this varies. For example, there may be written reports from court (including psychological, psychiatric or social enquiry reports), there may be information from RCS (the escort services contractor), or the prison may be notified by the court, a social worker or other individuals or organisations in the community. This is more likely to be the case where there is a long-standing mental health problem. Additionally, if a prisoner has been in prison previously, his records may contain some relevant mental health information. However, some prisoners arrive with no background information at all.

4.5 Secondly, the reception or induction process itself may highlight problems, as well as providing an opportunity to pass on information to prisoners about the mental health team. The processes most commonly used for identifying needs were the provision, at reception, of a nursing assessment and the Act2Care process. In some prisons, the nurse at reception is always, or almost always, a mental health nurse, whose expertise can assist in the process of identification of needs.

4.6 A very small number of prisons made specific reference to exploring mental health issues in more depth. For example, one noted that the World Health Organisation Assessment was completed by a mental health nurse on admission for every prisoner. Another noted that all prisoners were seen by a mental health nurse on admission, and a third that prisoners were asked a range of specific questions about previous mental health issues.

4.7 A small number of other aspects of the process were also identified as additional means of identifying problems; one establishment uses a "first night checklist", and another uses some "general questions" which could help to indicate mental health issues. The use of follow up medical assessment was also highlighted, and some participants mentioned the use of the cell sharing risk assessment, the risk management process or the Integrated Case Management process in this context.

4.8 Thirdly, the prisoner may disclose his or her mental health problems at some stage during reception or induction. Self-disclosure has become more likely in recent years. Prisoners can also be provided with information about how to access services at induction, which could assist in enabling them to disclose the issues which they face.

4.9 Some officers have received Mental Health First Aid training. Where prisoners had been in the prison before, staff may already be aware of the issues which they face.

During a Sentence

4.10 During a sentence, the main means of identifying severe and enduring mental health problems are: observation by staff; self-disclosure by prisoners; information provided by other prisoners; information provided by other organisations; and issues raised in multi-agency discussions.

4.11 The process of observation by prison staff is one of the key means of identifying severe and enduring mental health needs, and staff ability to recognise potential mental health problems has improved. Staff highlighted that they would look for behavioural changes, and there were some examples of identifiable behaviour which might be taken to indicate need such as where a prisoner does not come out of their cell at meal times, refuses to eat, refuses an order to leave their cell or attend a meeting, wants to stay in bed all day, or carries out an assault.

4.12 There may, in some cases, be direct disclosure of mental health problems by a prisoner during a sentence, or instances where they self-harm or attempt suicide. Good relationships between staff and prisoners can assist with staff identification of issues and in enabling disclosure by prisoners, as can specific awareness raising events to encourage people to identify the issues which they face.

4.13 Information may also be provided by another prisoner where there are cell sharing problems, or where a prisoner has identified someone who is "struggling", and examples of this were also given. External agencies, Listeners and visitors may also refer people to the mental health team.

4.14 In addition to these means, some prisoners will be the subject of multi-disciplinary discussion outwith the MDMHT, for example, if they are in a segregation unit for a period of time, and this can provide a means of identifying mental health problems. Every prisoner held in segregation for a month should be subject to a Mental Health Nurse Assessment, regardless of any previous referral. There should also be suitable healthcare representation at the initial case conference to pick up on the necessary referral to the Mental Health Team. However, these did not appear to be happening on every occasion. The role of the MDMHT is examined in detail later in this report.

Issues and Gaps in the Identification of Needs

4.15 The processes for the identification of needs are varied, and have improved as the understanding of mental health problems has increased. One overarching concern, however, identified particularly by the voluntary sector, was the lack of a clear, systematic and specific process for identifying mental health needs.

4.16 Additional issues and gaps in the identification of needs were identified. Although it is not suggested that these problems exist in all prisons, they serve as examples of ways in which *some* prisoners with severe and enduring mental health problems may not be identified.

4.17 There can be problems with the **passage of information** from courts and the community:

- Although some courts were seen to be generally good at sending information, one MDMHT noted that court reports could be "hit or miss".
- There are no formal procedures for receiving information from the community, and there are variations in the level of provision.
- Without written information, there is a reliance on prisoners disclosing issues at the early stages of sentence.
- Information from initial screening is not always shared with other staff.

4.18 There can be difficulties for prisoners in **disclosing issues**:

- People with communication or language support needs may find it difficult to disclose mental health problems.
- Prisoners may not feel able to tell staff about their mental health, because of the nature of the relationship, or embarrassment.
- Some prisoners hide their symptoms due to cultural and social pressures.
- Disclosure can be a problem where mental health problems are related to previous abuse.
- Prisoners may feel that disclosure will not result in action.
- Prisoners may be deterred by the belief that there is an assumption, when someone is unwell, that they are trying to get medication, or get to hospital.
- Prisoners may fear the consequences of disclosure: including the impact on their liberation date; the impact on their progression; the possibility of transfer to suicide cells for observation, or the possibility of ridicule.

4.19 There can be problems with **processes and operational issues**:

- Reception of a prisoner can involve a largely "tick box" approach unless there is a specific trigger such as medication. Prisoners in some prisons are not asked routinely about their mental health needs, and the existing processes are not linked explicitly to identifying severe and enduring mental health problems.
- Pressure on time at reception can lead to difficulties in identifying complex needs and in processing information.
- Late admissions can constrain the process of identifying mental health needs.
- The conditions at reception may exacerbate problems particularly in prisons where there are still small cubicles.
- In overcrowded prisons where prisoners are locked up for long periods it is more difficult to identify mental ill health.

4.20 There can be problems with **staff identifying issues**:

- A reliance on previous knowledge of a prisoner creates difficulties, as this can lead to short interviews and complacency in exploring mental health issues, while their needs may have changed.
- Nurses in reception who do not have mental health training and experience might not pick up some signs of less visible mental health problems.
- There are variations in staff skills, training and willingness to engage with these issues.
- There is a lack of an overall shared understanding of mental health problems. For example, sometimes mental health problems are seen as primarily behavioural and control issues.
- A lack of resources, staff time and overcrowding can lead to a focus on those people with the most visible problems, or those who cause problems for the management of the prison.
- Prisoners who do not draw attention to themselves, who are "quietly compliant" or "quietly mentally unwell", can be missed.
- People who have been in good mental health, but whose behaviour is poor, can become ill and may be missed. For that reason, segregation unit prisoners should be monitored closely.
- Substance misuse can make it difficult to identify mental health problems.
- Where prisoners are not out of their cells much, this can make interaction and observation difficult.
- Medical confidentiality can mean that officers do not know what they should be looking for, unless there is a specific issue with suicide or self-harm.

4.21 The impact of a lack of identification of needs will clearly vary in individual cases, but these difficulties can mean that some prisoners with severe and enduring mental health problems may not access the next stage in the process which is assessment and referral, as a precursor to their receipt of treatment, interventions and other support.

REFERRAL AND ASSESSMENT

4.22 Following the initial identification of needs, a referral is generally made to the mental health team in the prison, either by a staff member, or directly by the prisoner. There are generally forms available on which to do this, although many mental health teams also take verbal referrals, and some participants identified the development of strong and positive working relationships between mental health nurses and prison officers as an important element in the identification of needs.

4.23 Prison staff tend to "err on the side of caution" in making mental health referrals, and some officers stressed that they would be unwilling to take risks. This was particularly the case where mental health issues were linked to suicide or self-harm.

4.24 Following referral to the mental health team, most processes involved an initial assessment by a mental health nurse. This is sometimes, but not always, prioritised and carried out within a specific time period. Most prisons had some prisoners awaiting initial assessment by the healthcare team, and the time for this varied within prisons and between prisons, particularly in terms of the maximum waiting period, although this was generally no more than three weeks, and most prisoners whose needs were considered urgent would be seen within 24 hours. One prison had no assessment provision available at the time of the inspection, although the MDMHT was exploring ways of addressing this. It was also noted that specific forms of support, such as Cognitive Behavioural Therapy (CBT) or Speech and Language Therapy could involve a longer waiting period and in many prisons was not available.

4.25 There was also variation in the means of consideration of new cases by the MDMHT. In some prisons, *all* first referrals would be considered and their treatment and throughcare planned in this way, but this is not always the case. In one instance the nurse would make a decision about whether or not to refer the prisoner to the MDMHT for further consideration, and some nurses would input support or develop a care plan without the full team being involved. In one prison the whole MDMHT would only see a case where there was a need to make a referral to another of the team members. Another works on a shared assessment process involving social workers, healthcare centre staff, Phoenix Futures and others.

4.26 In general, the main parts of the process are the involvement of the mental health nurse in assessment, then referral to the MDMHT where the care required would be discussed and planned and, in some cases, a case manager identified from within the MDMHT.

4.27 All prisons seek additional information from organisations in the community should a prisoner experience severe and enduring mental health problems. The range of organisations identified varied between prisons, but included health contacts, social workers, addictions workers and other organisations, as well as, in some cases, families.

4.28 There may also be a process of further onward referral to a psychiatrist or other forms of support.

Issues and Gaps in Referral and Assessment

4.29 Although there was overall satisfaction with the processes of referral and assessment in prisons, a small number of issues and problems were also highlighted.

4.30 Some of the problems related to **difficulties in referral** are:

- Prison staff can find it difficult to describe a prisoner's problems when making a referral: "how do you say they're not quite right?".
- Some MDMHTs consider some staff "too quick to make a referral" or that they make inappropriate referrals.
- Some officers believe that health staff do not accept their views of a prisoner, and that they can often make a referral and no action will be taken.
- There can be a lack of feedback from mental health staff about inappropriate referrals, making it difficult to improve practice.
- Prisoners may be confused or unclear about the nature of their own mental health problems.
- Not all prisons had a functional MDMHT or nominated mental health nurse.

4.31 Some of the problems related to **difficulties in assessment/diagnosis** are:

- There can be a lack of assessment tools.
- It can be difficult to assess remand prisoners and those serving short sentences because of a lack of time and a perceived unwillingness of these prisoners to disclose mental health problems.
- The level of demand on mental health nurses and shortages of staff can lead to a gap in time between referral and assessment.
- Some mental health problems are difficult to diagnose.
- Drug taking can mask mental health problems.
- There is no routine assessment for specific issues such as alcohol-related brain damage, learning disability and personality disorder.
- Information about individual prisoners in residential areas is not always written down.
- Information "alerts" may be more focused on suicide risk.
- Information from community sources is not always received in time to contribute to the process, and there is a lack of a formal system to ensure the provision of historical records.
- There can be differences of view between the psychiatrist and others about whether or not a prisoner has a diagnosable mental health problem. Particular concerns were raised about the issue of personality disorder, as well as with a perceived unwillingness to diagnose severe and enduring mental health problems amongst young offenders.

4.32 Although it is not suggested that these problems occur in every establishment, they are likely to impact upon whether or not a prisoner receives timely and appropriate treatment, intervention and support.

TREATMENT, INTERVENTIONS AND OTHER SUPPORT

The Nature of Treatment, Interventions and Support in Prison

4.33 Once prisoners have been identified as having severe and enduring mental health problems, but do not require transfer to hospital, the treatment which they receive in prisons generally includes:

- Medication.
- Access to a psychiatrist.
- Input from a mental health nurse (where available).

4.34 There are a number of additional forms of treatment, intervention and other support which may be available, although these vary considerably between prisons. In some prisons there is some access to Cognitive Behavioural Therapy (CBT). There is also variation in other aspects of psychological support, and in access to one-to-one support and "counselling". In one prison psychologists work alongside personal officers while, in others, psychologists may be involved only in programme work.

4.35 There was a clear absence of specific regimes for prisoners with severe and enduring mental health problems. One prison had established a self-help group for mental health service users with input on issues such as communication skills, but while this was described as "practical good practice", such provision was uncommon.

4.36 A small number of prisons have specific facilities considered relevant to prisoners with severe and enduring mental health problems, such as: a Residential Care Unit (Barlinnie); a "Safer Custody Unit" for vulnerable prisoners (Kilmarnock); single cell accommodation within the healthcare department for closer observation and 24 hour care (Kilmarnock); a Personal and Social Development Unit and supportive work party (Polmont); daycare provision (Barlinnie); a multi-sensory room (Cornton Vale – although this was not being used at the time of the inspection) and input from specialist staff organisations, such as a local Stress Centre (Barlinnie); a speech and language therapist (Polmont); a Community Learning Disability Nurse (Cornton Vale); addictions staff or organisations working with survivors of abuse (e.g. work in Edinburgh, and work developing further in Cornton Vale and Greenock). There had been Occupational Therapy provision in Cornton Vale in the past, but this is no longer available. One prison, at the time of the inspection, was trying to develop a therapeutic day centre. Where these forms of provision exist (and are made available), they are seen to be beneficial, and prisoners generally expressed positive views.

4.37 There was also use made of other facilities in a flexible way. For example, some prisons identified a particular hall where prisoners with mental health problems would be located; Greenock has a two and three bed unit, which was seen to provide a "good halfway house" from the anti-ligature cells; and there are "buddy cells" in Edinburgh. There were examples of Independent Living Units identified as being helpful to prisoners with mental health problems, and the National Induction Centre in Shotts was seen to provide an opportunity for support to very long-term prisoners.

4.38 Although officers have a good deal of day-to-day contact with prisoners, they have limited involvement in providing treatment, interventions and other support following referral to the mental health team. Officers were often unaware of the treatment provisions available, or the actions taken with individual prisoners, and received little information about this, with the exception of prisoners on Act2Care.

4.39 Despite their lack of involvement, the attitudes and approach of prison staff can make a difference to people with severe and enduring mental health problems. The importance of staff commitment is clear. Some prisoners identified specific officers they could trust and talk to, and highlighted the value of staff who were willing to listen and provide support. Some officers also stated that they adopt a flexible approach to people with mental health problems: they would "make allowances" and "go that extra mile for vulnerable prisoners". A number of prisoners also said that they received support from other prisoners.

4.40 A small number of other individuals and organisations were also identified as providing treatment, interventions or other support, and some prisons also identified access to throughcare as part of the treatment, support and interventions available. Some of the other organisations highlighted included: addictions services; chaplains; counsellors; listeners, and other voluntary sector services working in the prison.

4.41 A small number of prisoners were identified as awaiting treatment at the time of the inspection, and the waiting times again varied between prisons and between types of input. Medication could generally be made available quickly, but some forms of support, such as psychologists and specialist organisations sometimes involved a longer wait.

Segregation and Restraint

4.42 Segregation units/separate cells are used at times for some people with severe and enduring mental health problems by most prisons, and most reported a small number of circumstances in which they may do this. These were: when they were violent or disruptive; displaying anti-social behaviour; posing a risk to themselves or others; or during an acute psychotic episode. Most of the prisons visited had prisoners in the segregation unit within the caseload of the MDMHT, and a small number stated that their segregation units were being used, at least in part, as quasi-care units.

4.43 Staff were aware of the difficulties in making distinctions between mental health and behavioural/management problems and recognised that the behaviour leading to the use of segregation maybe linked to mental health problems.

4.44 There were concerns expressed about the use of segregation in these circumstances, and one MDMHT did note that if they had people with a mental health problem in segregation, they would generally push for them to go to hospital. It was also suggested, however, that the nature of the staff involved, and their sometimes greater level of understanding, could provide some support to some prisoners, and there were some good examples of people having been well looked after in segregation. One prisoner also expressed a personal preference for segregation and "my own space". Constraints to this were also highlighted, however, particularly when staffing is low, and segregation was often seen to be used inappropriately because of a lack of alternatives to deal with prisoners whose problems led to disruptive behaviour. As one prisoner stated:

"You've got to think of the guys who've flipped – where are they going to put them? They don't know how to deal with you so they put you to the digger [Segregation Unit]. That makes you worse."

4.45 There is a small number of prisoners managed nationally by the ECMDP (Executive Committee for the Management of Difficult Prisoners). Such prisoners may have severe and enduring mental health problems, or may be "difficult" for other reasons. The basis of their management is that they are rotated around a number of prisons on a regular basis, and are housed in the segregation unit. During the period such prisoners are in a prison, they would generally become part of the MDMHT caseload, and would be worked with by the mental health team, although their overall management remains with the ECMDP.

4.46 Where prisoners pose a significant risk to their own welfare through their behaviour, intervention usually involves the use of control and restraint techniques by specially trained officers.

4.47 A very small number of examples was given of the use of a body belt in particular circumstances, such as to prevent self-harm/threatened suicide, but this is very uncommon and a "last resort". Some prisons have not had to do this in the period for which records were available.

4.48 There is some variation in understanding of the use of medication in crisis situations. Although there was a common belief that this was not allowed, several psychiatrists stated that emergency medication could be given in some circumstances to deal with an acute and immediate problem. They also noted, however, that it is not permissible to force a prisoner to take medication which has been prescribed for a particular mental health problem. It is clear, however, that there is some measure of uncertainty about these issues.

The Involvement of Prisoners and their Families Advocacy

4.49 There has been a growing emphasis on prisoners identifying their own needs and participating in their own care. In practice, however, this is limited, and variable, ranging from one MDMHT which stated clearly that prisoners would take part in assessments and discussions through to other cases where there was seen to be very little involvement by prisoners.

4.50 Mental health nurses discuss treatment with prisoners. Some MDMHTs involve prisoners in case conferences. The involvement of prisoners in care plans was highlighted by a group of prisoners, while one MDMHT noted that treatment and care plans involved prisoners but added that the mental health nurses did not have care plans in place at present. In one prison a specific group of prisoners have no say in their care and treatment (i.e. those subject to Rule 37 which requires a medical officer to report to the Governor and Scottish Ministers about any serious concerns they may have about the health and welfare of a prisoner). Prisoners do not appear to receive feedback about discussions which take place at the MDMHT.

4.51 A number of MDMHTs discuss the issue of consent from prisoners to sharing information about their mental health care with non-medical staff. There are some processes in place for this, although these vary. In some cases, a written consent form is completed and there were also examples of consent being given verbally. Some information *must* be shared with social work staff, such as child protection issues, whether or not there is consent.

4.52 Awareness of the need for, and the nature of, consent was mixed amongst prisoners. There was also evidence of some staff lacking recognition of the need to ensure that consent forms were signed, as well as lacking clarity about what required consent and what did not.

4.53 Practice is also varied in terms of the provision of advocacy support to prisoners with severe and enduring mental health problems. The overall view of the voluntary sector organisations consulted, some of whom were specialist advocacy providers, was that this was rarely provided to prisoners, and it was clear that five prisons had no advocacy available at all at the time of the inspection.

4.54 Some examples were given where prisoners *had* asked for advocacy support, or where support had been used at case conferences. A small number noted that local advocacy services had been advertised and publicised, or were available on request. One noted having "Advocard" in place, where an advocate would attend, if called.

4.55 It was clear that prisoners generally had little or no awareness of their right to advocacy support under the Mental Health (Care and Treatment) (Scotland) Act 2003.

4.56 There was also variation in the extent of involvement of families. In some cases, this was virtually non-existent, or limited to responding only where a family raised specific issues or concerns. One prison, however, has a strong focus on this, and some examples were identified of work taking place.

4.57 It can be difficult to organise family involvement, particularly where it is difficult to identify a "family", or where family members also have mental health problems, and a number of prisoners stated that they did not want to involve their families. One prison ensured that visits could be arranged through the mental health team and these could be held away from other prisoners.

Internal Transfers

4.58 The issue of transfers between prisons can also impact upon treatment, interventions and other support. Common reasons for transfer were: a prisoner having "a history" with other prisoners; committing offences within the prison; disrupting the regime; overcrowding; requiring care that could not be provided; requiring accommodation that could not be provided; or where transfer is otherwise seen to be in the interests of the prisoner.

4.59 Some of the most problematic prisoners may be transferred to the Residential Care Unit at Barlinnie, and other prisons were often keen to send vulnerable prisoners to the Unit, which, in the view of some had become "like a national facility".

4.60 Where prisoners were undergoing assessment or treatment (such as CBT), some MDMHTs gave examples of instances in which they had had input to, or had influenced decisions, by requesting that the prisoner should not be transferred at that stage. It was acknowledged, however, that people with undiagnosed mental health problems may move between prisons without the involvement of the MDMHT. It was also identified that, in some cases, prisoners may be moved without the MDMHT being made aware of plans to do so.

Issues and Problems with Treatment, Intervention and Support in Prisons

4.61 A number of examples of good practice were highlighted, including some of the facilities and input from staff, and links between some staff. Some prisoners, when stabilised on medication, could cope in the mainstream prison system and were "safe". The care available in prisons for people with severe and enduring mental health problems can also exceed that in the community, with, for example, faster access to treatment, and more regular input from a senior and specialist psychiatrist.

4.62 Against this background, however, there are problems and constraints with the provision of treatment, interventions and other support.

Problems with Existing Practices

4.63 A number of concerns exist with aspects of the **nature of existing provision**, including:

- The variation in practices, and the availability of different forms of treatment, interventions and other support in different prisons.
- A perceived greater reliance on medication than would be desirable, with limited provision of other forms of treatment, interventions and other support.
- Issues with the receipt of existing medication, such as delays in provision of medication; changes to medication; and perceived differences in prescribing practices.
- The use of segregation and anti-ligature cells which are generally inappropriate, understaffed for this purpose, and identified by many prisoners as making mental health problems worse. Some prisoners perceived this as being "punished" for their mental health problems.
- The lack of routine mental health assessment in segregation; the lack of routine mental health staff input to case conferences for prisoners in segregation and the poor conditions in some segregation areas.

- Inappropriate placement of some prisoners or the use of facilities for vulnerable prisoners which are not equipped to cope with prisoners with severe and enduring mental health problems.
- Difficulties in working with prisoners without a formal diagnosis, due to a lack of options available; difficulties in making provision for people with a personality disorder; and difficulties in working with prisoners exhibiting some behaviours where medication is not appropriate.
- Lack of use of existing facilities which may benefit prisoners with severe and enduring mental health problems.
- Separation of some forms of intervention which should be more closely integrated.
- Lack of availability of 24-hour nursing cover.

Gaps in Types of Treatment, Intervention and Other Support

4.64 Many of the concerns expressed relate to perceived **gaps in the types of treatment, interventions and other support available**. These include perceived gaps in the following:

- Daycare provision.
- Prison-based in-patient facilities.
- A specific regime for people with mental health problems, with appropriate work and other activities/interventions.
- Specific forms of intervention, such as diversionary and therapeutic activities, targeted programmes, and one to one support.
- Support, in some cases, from a dedicated mental health nurse.
- Clinical psychology support, "talking therapies" and CBT.
- Specialist input for both male and female survivors of childhood sexual abuse.
- Specialist input for other issues such as PTSD; co-morbidity of substance abuse and mental health; and sex offending.
- Access, in some cases, to social work services.
- Occupational therapy.
- Specialist input to meet the specific needs of particular groups, such as women; prisoners in particular age groups; ethnic minority prisoners; LGBT prisoners; prisoners with communication or language support needs; prisoners with learning disabilities; and prisoners with a personality disorder.
- Input from other specialist services based in the community, and access to other community-based support.
- Advocacy support and a lack of information for prisoners.
- Support to people who might, if in the community, require outpatient, rather than in-patient facilities.

Attitudes

4.65 Some problems were highlighted relating to **attitudes**:

- Lack of understanding and poor attitudes amongst some of those working in prisons to mental health.
- Variations in staff attitudes, with some prisoners identifying poor staff responses which exacerbated their problems.
- A perceived assumption by some prisoners that mental health problems are always drug-induced.
- Some "gatekeeping" by staff, which can lead to difficulties in access to support.
- Perceptions of unfairness amongst other prisoners when a flexible approach is taken by staff to prisoners with mental health problems.
- Issues with the flexibility of some staff in enabling visits by psychiatrists.

Operation, Security and Overcrowding

4.66 As with the identification of needs, **aspects of the operation and security of prisons, and issues relating to overcrowding** were also seen to limit the provision of treatment, interventions and other support, and concerns include that:

- Regimes restrict the work that can be done, constraining staff time.
- The number of prisoners requiring medication (particularly methadone), and the practicalities of providing this, constrain the time available for other work.
- It is difficult to provide treatment, interventions and support to prisoners serving short sentences.
- Overcrowding and the need for progression may lead to moving people on, and the new location may not be suitable to their needs.
- Movement of prisoners can make it difficult for psychiatrists to keep track of the patients they are working with.
- Transfer between prisons, when prisoners are unwell, is difficult.
- There are some problems with the provision of information between prisons on transfer, which can lead to treatment being interrupted.
- There can be problems with continuity of care for ECMDP prisoners.
- Security, operational concerns and "the needs of the prison" can supersede mental health needs and determine the intervention made, such as the use of segregation.
- Overcrowding leads to a high level of demand for support, and a lack of time for officers to work with individuals, especially where prisoners are locked up for longer periods of time. This affects particularly the opportunity to talk and to listen, which many prisoners identified as beneficial.
- There can be difficulties in locating a large number of vulnerable prisoners in one hall.

Staffing, Information and Other Resources

4.67 Staffing, information and other resource constraints arose repeatedly in relation to problems in providing treatment, interventions and other support. The broad issues raised relating to staffing, information and other resource constraints include:

- Lack of staff.
- Lack of time and other demands upon staff which constrain their opportunity for input and follow-up.
- Lack of skills and training for some staff.
- Limitations to the role and involvement of some staff, particularly uniformed officers, and ambiguity within the role in terms of the balance between care and custody.
- Gaps in provision of specialist staff.
- Gaps in joint working between relevant services/teams.
- Waiting times and availability, in some cases, of specialist staff, or insufficient frequency or length of contact. These issues may also impact upon prisoners' motivation to address issues.
- Staff stress and "burnout" where there is intense involvement with prisoners with mental health problems.
- Staff turnover and staff absence.
- Difficulties with information sharing, lack of feedback of information to hall staff, and issues with confidentiality, causing problems for staff in knowing how to provide support, and prisoners who may have to tell their story repeatedly.
- Inappropriate or limited facilities within prisons and some difficulties with booking arrangements for psychiatrists and collecting prisoners for appointments.
- Lack of tools to measure success.

CONCLUSIONS

4.68 In terms of the **identification** of severe and enduring mental health problems, the main conclusions are as follows:

4.68.1 Reception and induction processes can provide the first opportunity to identify mental health needs, and there are a number of ways in which these can be highlighted: through information provided, aspects of the reception and induction processes; self-disclosure or a member of staff being aware of such needs.

4.68.2 During a sentence, the main ways of identifying mental health problems are through observation by prison staff, other workers, prisoners, and through self-referral.

4.68.3 There is a number of gaps in the identification of mental health problems and needs. These include: problems with the transfer of information from courts and the community; difficulties for prisoners in disclosing issues; problems with processes and operational issues; and problems with staff being able to identify issues. These difficulties can mean that some prisoners with severe and enduring mental health problems may not access assessment and referral.

4.68.4 Following the initial identification of needs, a referral is generally made to the mental health team in the prison, and there are some differences in processes at this stage, particularly in waiting times and in when the MDMHT becomes involved. Most involve an initial assessment by a mental health nurse, after which there may then be a process of further onward referral.

4.68.5 A small number of issues and problems with the processes of referral and assessment in prisons were identified, including: a lack of a shared understanding of when a referral is required; some technical issues with the processes of assessment and diagnosis; and a lack of evidence and information to inform the process.

4.69 In terms of the **treatment, interventions and other support** for people with severe and enduring mental health problems in prison, the main conclusions are as follows:

4.69.1 Once prisoners have been identified as having severe and enduring mental health problems which do not require transfer to hospital, the treatment which they receive in prisons generally includes: medication; access to a psychiatrist; and input from a mental health nurse.

4.69.2 There are a number of additional forms of treatment, intervention and other support, which vary considerably between prisons. A small number of prisons have specific facilities considered relevant, as well as some resources such as books and CDs. There was, however, little evidence of input from community-based mental health and other relevant organisations focusing on mental health during sentences.

4.69.3 Segregation units/separate cells are used at times, with difficulties faced in making distinctions between mental health and behavioural/management problems. The use of segregation as a response to mental illness is wrong.

4.69.4 Mechanical restraints are used very rarely in prison but are never used in hospitals. The use of mechanical restraints to control prisoners with mental health problems is unacceptable.

4.69.5 There has been a growing emphasis generally on the involvement of prisoners in identifying their own needs and participating in their own care, but this remains limited and variable.

4.69.6 The provision of advocacy support varies. In some prisons, there was no provision, or it was virtually non-existent. Prisoners generally had no awareness of their right to advocacy support under the Mental Health (Care and Treatment) (Scotland) Act 2003.

4.69.7 The issue of transfer between prisons can impact upon treatment, intervention and support, and most MDMHTs stressed that prisoners would not be transferred to another prison solely on the basis of their difficult behaviour. MDMHTs are generally consulted about any proposed move of a prisoner within their remit.

4.69.8 A number of concerns were expressed with: aspects of the nature of existing provision (e.g. variations in practice and availability; issues with medication; issues with the use of segregation; practical difficulties; a lack of an holistic approach; gaps in types of treatment, intervention and other support (e.g. lack of daycare; lack of "talking treatments"; lack of a specific regime; the removal of in-patient facilities; lack of specific forms of intervention and specialist intervention for issues such as sexual abuse); attitudes (e.g. variation in understanding; and some inappropriate attitudes and behaviour); aspects of the operation of prisons and issues relating to overcrowding (e.g. pressure and time constraints, and operational demands); staffing, information and other resources (e.g. lack of staff, time and training).

5. PROVISION IN LOCAL AND REGIONAL SECURE MENTAL HEALTH FACILITIES AND THE STATE HOSPITAL

5.1 This chapter examines issues relating to provision for prisoners with severe and enduring mental health problems who require treatment in hospital, and highlights issues relating to the involvement of local or regional secure mental health facilities and the State Hospital. It is not an inspection of the hospitals or mental health facilities themselves.

THE FORENSIC MENTAL HEALTH ESTATE

5.2 Generally, hospital wards are categorised as being either high, medium or low secure. A secure ward can exist within a wider hospital context with a number of open wards.

5.3 The only high secure mental health facility in Scotland is the State Hospital at Carstairs. The hospital is part of the NHS, and is currently undergoing a period of transition, with a new hospital being built on the current site. The current capacity is 228, with 183 patients being held. By 2010, the site will have the capacity to hold 144 patients in four hubs of three wards, each with 12 patients. There will be a 12-bed ward for people with learning disabilities. No women will be held in the new facility. This is in line with anticipated demand as a result of changes in the assessment of the level of security required by patients.

5.4 Following a review, the NHS is in the process of creating three separate medium secure units. This is running in parallel to the reduction in capacity being undertaken at the State Hospital. The Rowanbank Clinic is located at Stobhill Hospital in Glasgow. It is currently being commissioned, and, once the full staff complement is in place, will have the capacity to hold 74 adults, both men and women, with a 10-bed admission unit. At the time of this inspection, it was operating at around 35% capacity, and was expected to be fully operational by 2009.

5.5 The Orchard Clinic is part of the Royal Edinburgh Hospital. It opened in 2001, and, at the time of the inspection, held 42 patients.

5.6 A new-build facility is being created at the Murray Royal Hospital in Perth. By 2011, it will have the capacity to hold 35 adults. At the time of the visit, there were two low secure units on the site with 27 patients with 10 in an admissions unit.

5.7 Once operating, the intention is that these three facilities should operate on a regional basis, each covering an area of Scotland. At present, however, there is a need for prisoners to be transferred to a unit where there are beds available. This may mean that a prisoner requiring medium secure accommodation may be located a considerable distance from their family and any community-based workers providing support.

5.8 Some frustration was expressed by staff in both NHS and prison settings with the rate at which new medium secure beds are becoming available.

5.9 There is also a variety of low secure facilities across Scotland, including a private sector unit in Ayrshire. Recent changes to the way in which prisoners are regarded means that some facilities previously accommodating prisoners cannot now do so as a result of being unable to offer sufficient security.

Views on the Adequacy of the Supply of Beds

5.10 Overall, there were mixed views expressed by NHS staff, prison staff and members of the Judiciary, about whether facilities are adequate to meet demand. This varies on a geographical basis, with some areas reporting it to be much more difficult to satisfy demand than in, for example, west central Scotland. The knock-on effect of this is that prisoners have to remain in prison for extended periods of time, in effect, on a waiting list for admission. The State Hospital only rarely has to operate a waiting list.

5.11 It can occasionally be difficult on a case by case basis for NHS staff to identify a suitable bed for a prisoner. The NHS generally operates units at, or near capacity, and this may lead to some delays in admissions. One unit holds two beds in reserve, when possible, for urgent admissions, but clearly, this is not possible everywhere.

5.12 There seem to be slightly greater difficulties in securing places for women than men although this varies from area to area. One unit noted that the women patients typically referred are small in number but "regular" and are therefore well known to staff, and may have been referred both while in prison and in the community. In one area, it was noted that moving women from high and medium secure facilities was a "good idea in principle", but there may not be suitable low secure bed spaces, particularly close to their home area.

5.13 There also seem to be some issues with securing places for young offenders. To some extent this may be practical, in that the suitability of the unit needs to be considered in terms of different legal requirements to those applying to adults. The mix of patients, and particularly the presence of any who could pose a threat to a young person, also limits choice. There is currently no specialist unit in Scotland for under-18s with forensic mental health needs.

5.14 Psychiatrists made it clear that decisions on admission, and the priority given to individual cases, was a matter of clinical judgement, based on the needs of the individual. Staff in a number of hospitals indicated that, if they were unable to accommodate a prisoner requiring admission, they would seek to find a bed in another area, even where this was intended to be a temporary measure.

5.15 A number of prison staff and members of the Judiciary expressed concerns about difficulties in finding beds for prisoners with severe and enduring mental health issues. The main concern was that, with the closure of in-patient beds across the SPS, staff were left with little choice but to locate prisoners in halls, and in some cases, in segregation units. Members of the Judiciary raised concerns specifically about the closure of psychiatric hospital beds in the community.

5.16 The physical condition of units vary, and in some locations, development is underway which will lead to outdated accommodation being replaced.

REFERRAL, ASSESSMENT AND TRANSFER OF PRISONERS

5.17 In terms of the arrangements for transfer, where there is seen to be a need for transfer of a prisoner to local or regional secure mental health facilities or the State Hospital, the first stage in the process will be referral and assessment.

The Processes of Referral and Assessment

5.18 Sentenced prisoners who are thought to require a transfer to local or regional secure mental health facilities are generally identified in discussion at the MDMHT, and by the prison psychiatrist. A referral is made to a hospital with the appropriate level of security required, with an application under the Mental Health (Care and Treatment) (Scotland) Act 2003.

5.19 The circumstances in which a prisoner would be considered for transfer to a hospital included: where he was seen to require further assessment, intensive nursing care, or care and treatment not available within a prison. Other circumstances include: where there is a "rapid deterioration of mental health symptoms"; where a prisoner is causing risk to him/herself or others; or where the prisoner is causing extreme distress to others because of his or her mental health. In the case of the State Hospital, there is a particular focus on situations where a prisoner not only require hospital in-patient treatment or assessment but also presents a high level of risk.

5.20 Prisoners are assessed by a psychiatrist to determine if they require to be held under the Act in a secure environment. The Act requires direct consultation by a psychiatrist preferably from the admitting hospital, including the State Hospital. In some cases this is straightforward where the prison psychiatrist is also the admitting hospital psychiatrist, whilst in other cases assessment by the prison psychiatrist has to be followed up by the admitting hospital psychiatrist.

5.21 Different arrangements apply to remanded prisoners where transfer is arranged through the courts for either Assessment or Treatment Orders under the terms of the Criminal Procedures (Scotland) Act 1995 – Sections 52d (Assessment) or Section 52m (Treatment).

5.22 In most prisons, there had been some prisoners in the last year, who had first been admitted to the prison and subsequently transferred to local or regional secure mental health facilities or the State Hospital. A total of 42 prisoners had been transferred to local or regional secure mental health facilities in this period, with a further five awaiting transfer. In just over half of the prisons there had been prisoners who had been admitted to the prison and later transferred to the State Hospital in the same period. There were a total of 25 such transfers in this period, with a further three prisoners awaiting transfer. Both remand and convicted prisoners were transferred.

5.23 Some prisoners may also be transferred to secure local or regional mental health facilities or the State Hospital, either directly from court, or from prison, via court, where the court has determined that this is required. These patients will tend to go to IPCU admissions, and will be admitted for four weeks as restricted patients. Following this, these prisoners either progress to a treatment order, or will return to court or prison.

5.24 The psychiatrist will also consider the level of security required. It can be difficult to make distinctions between different levels of security required with one hospital suggesting that the use of weapons, the offence, and the mental health condition of the prisoner all contribute to the decision. There is, however, no formal checklist, and the decision rests with the assessing psychiatrist. There is guidance available on the levels of security at various facilities, and psychiatrists will be aware of this in reaching their decisions.

5.25 Most prisoners are transported to hospital by RCS although a small number are transferred by SPS, usually when the requirement is at short notice. If a nurse is required there is confusion around who should provide this resource. RCS are not contractually obliged to provide a nurse, but most SPS healthcare managers believe they are. The situation regarding the provision of nursing support on prisoner escorts needs to be clarified.

5.26 Most prisoners are transported to hospital by RCS, although a small number are transferred using SPS transport when this has to be done within 72 hours.

5.27 Some information is generally provided to the hospital at this stage, although there are gaps in this and also variations in satisfaction.

Referral, Assessment and Transfer Issues

5.28 Although the referral, assessment and transfer processes are generally appropriate, a small number of issues was identified. Some related to **referral**, are:

- There is disagreement about the need for hospital treatment for prisoners with personality disorder, particularly between prison staff and hospital psychiatrists, with some prisons considered by the latter to be making inappropriate referrals and not taking account of the policies of the hospitals concerned.
- There is little provision for people with personality disorder. There is also little constructive discussion between prisons and hospitals on this problem. A senior hospital specialist said "current practice in Scotland is that we will not take people with a personality disorder into a forensic unit".
- In addition to personality disorder, hospital staff stated that, on some occasions, SPS may suggest that other situations required hospitalisation, when hospital staff considered that they did not.
- Some of the prisoners who are referred as potentially requiring hospital treatment would be more likely to be treated as outpatients if they were in the community.
- Some prisoners who should be transferred to hospital may not be identified as such, because they do not "make a noise".

5.29 Some issues related to the **assessment, diagnosis or admittance** of prisoners are:

- Conditions for assessment vary widely between prisons.
- There can be difficulties with the attitudes of some prisons to psychiatrists coming to assess prisoners.
- Psychiatrists who assess infrequently may be unaware of changes to arrangements, systems and procedures in SPS.
- The previous behaviour of a prisoner in hospital may lead to a refusal of a transfer (although this prison view was not supported by hospital staff).
- Some prison staff believe that assumptions and stereotypes about prisoners can lead to reluctance, in some cases, to admit them.
- Some prisoners who are stable, safe, supported and have the right medication may be left in prison, as may some prisoners who show no change in their presentation, when the hospital considers that there is nothing they can do for them.
- The provision of a secure and safe environment in prison may delay transfer to hospital for care.
- Some issues are difficult to diagnose.
- Drug use can make diagnosis difficult.
- Some secure mental health facilities receive referrals relating to prisoners who require higher security than they can provide.
- There is a lack of clarity about the ways in which an assessment is made about the level of security which a prisoner requires.
- There can be some tension and variation in views of the appropriate level of security for some patients, and whether individual facilities can provide this.
- Where a prisoner requires an assessment by the State Hospital, because of perceived security issues there can be a waiting period for this. There can also be a wait for assessment for private facilities, and, on some occasions, for other facilities.
- Where an assessment is required for a prisoner in one of the national facilities (Peterhead, Dumfries, Shotts, Glenochil, Polmont or Cornton Vale), this can involve substantial travelling for some psychiatrists.
- The process of form filling is perceived to be difficult, and small mistakes, particularly in relation to papers presented to court, can lead to delay.
- There is no mechanism for prisons to disagree with, or appeal against, a decision about whether a patient requires admission.

5.30 Some issues related to the **transfer process**, including that:

- There is, for some hospitals, a lack of information from the prison on transfer of a prisoner, such as mental health notes; nursing reports, risk assessment and security information.
- Where information is provided on transfer, it is not always felt to be reliable.
- Hospitals may have to admit transferred prisoners out of hours, and this can cause difficulties in relation to the regime and medication.
- If a nurse is required on prisoner escorts there is confusion about who should provide this resource. RCS staff are not contractually required to provide a nurse, but most SPS healthcare managers believe they are.

TREATMENT, INTERVENTION AND OTHER SUPPORT IN HOSPITALS

The Nature of Treatment, Interventions and Other Support in Hospitals

5.31 In most of the hospitals visited, the number of prisoners formed a very small proportion of the total patients, although this was slightly higher in the medium and high security facilities.

5.32 These patients have access to a range of treatment, interventions and other support which is usually the same as that available to any other patient, and includes:

- Assessment, followed by structured intervention.
- Medical treatment and input from psychiatrists.
- Psychological therapies, including CBT.
- Support from psychologists, social workers and occupational therapists.
- Support with substance misuse problems.
- Activities and recreation.
- Access to rehabilitation.

Separation and Restraint

5.33 Most of the hospitals make no distinction between prisoners and other patients, with one exception where it was suggested that prisoners require a different approach because of drug and security issues. In most cases prisoners are not systematically separated from other patients, with only one hospital saying that it would try to keep prisoners separate where possible. A number of hospitals are able to remove a prisoner to another room for "time out" and a small number use "locked seclusion" when required.

5.34 Physical restraints are used when necessary. Where these are in use, there is a focus on de-escalation, and the use of restraint is subject to strict rules. It was stressed that mechanical restraints, handcuffs or loose canvas restraint jackets would not be used. One hospital noted that a nursing assessment was required any time that thumb and wrist locks were used. The use of rapid tranquillisation was also noted.

The Involvement of Patients and their Families/Advocacy

5.35 Patients are usually involved in identifying their needs and planning their care. The means of carrying this out vary, but is sometimes part of the overall Care Programme Approach. The level of patient involvement overall is developing, with a policy emphasis on a patient-focused approach. One hospital noted meeting with prisoners once a week in the IPCU and others suggested that prisoners can attend some meetings relating to their care. One suggested that the level of involvement tends to vary depending on the stage which patients are at, with admissions patients asked to participate only at the end of a meeting, whereas settled patients can attend whole meetings in some continuing care wards.

5.36 Unlike prison, advocacy was available in all of the hospitals visited, and some hospitals have an advocacy service on-site. One hospital also identified that advocacy was available via a Freephone number that patients could dial at any time. Patients are usually asked whether they wish advocacy, and this is well-used. One identified regular group meetings between advocacy workers and patients, which was considered successful and positive.

5.37 There is also a clear emphasis in most of the hospitals on family involvement, with families and carers often invited to become involved in treatment and care, although take-up varied. One hospital, which has an ethos of family involvement, has a home liaison nurse working with families. One of the hospitals also contrasted the visiting arrangements with those in prison, with more visits being permitted in the hospital setting. One voluntary sector organisation, however, noted that there can be practical problems with visits in the State Hospital, and one hospital suggested that their policy on child visiting is stricter than in prison.

Issues and Problems with Treatment, Interventions and Other Support in Hospitals

5.38 There was general satisfaction with the treatment, interventions and other support available in hospitals, and a number of prisons reported positive relationships with particular facilities. Similarly, some prisoners reported very positive experiences of specific hospitals. Some of the reasons given include: better access to work, groups and therapeutic activities; more knowledgeable and qualified staff; less reliance on medication; less stigma and a more positive approach to mental health problems. The staff to patient ratio was also much better in hospitals than in prisons.

Gaps in Provision

5.39 Although there was a range of forms of treatment, interventions and other support offered in hospital, there were also some **gaps**. These gaps include:

- A lack of provision for prisoners with learning disabilities.
- A lack of provision for prisoners with personality disorder or severe behavioural difficulties with a variation in views about whether hospital treatment should be available to people with a personality disorder as their sole diagnosis. Although they can be detained in hospital under the Act, the practice in Scotland is not to do this. Prison-based staff consider however, that some prisoners in this group should be in hospital.[17]
- A lack of provision for women, particularly women who are pregnant.
- A lack of age-appropriate provision in some hospitals for young people.
- Difficulties in securing places for prisoners in some catchment areas.
- A lack of provision for people who have physical health problems as well as severe and enduring mental health problems.
- General difficulties, in some instances, of finding hospital beds available at the appropriate level of security; difficulties about where people go when hospitals will not take them; and difficulties in moving people on.

17 This issue is well-recognised. An SPS pilot is planned, to look at throughcare and interventions for prisoners with borderline personality disorder, and complementary work by the forensic network is hoping to look at prison-based personality disorder. This work has not yet been confirmed.

The Nature of Current Provision

5.40 There were very few issues raised in relation to the **nature of current provision**, but these are:

- There is a potential tension between the need for advocacy to be independent and the hospital's responsibility to provide it.
- Prisoners and other patients can get different amounts of money, with one hospital identifying that prisoners get "pocket money" of £12-15 per week, whereas other patients get benefits of around £90 per week. This can lead to difficulties, with prisoners aware of the differentiation.
- Provision of treatment in a hospital far from a prisoner's home area can lead to loss of local links.
- Financial issues can impact on the placement of a prisoner, with an example given of a disagreement about the distinction between learning disabilities and mental health problems. This centred on who was responsible for providing a place and meeting costs.

The Nature of Hospital Experiences

5.41 Prisoners' experiences of hospital vary, with a number clearly believing that hospitals are more appropriate to their needs than prison, and preferable, for a number of reasons. Some, however, prefer to be in prison. A small number of issues and problems were raised with the **nature of prisoners' hospital experiences**, including that:

- Some hospitals' attitudes to prisoners are seen as "wary", with the suggestion that they may "... forget that prisoners are people and that there is more to prisoners than just offending".
- The length of what is perceived as "custody" could increase as a result of transfer to hospital. Some prisoners expressed concern about the impact on their liberation and preferred a time-limited period.

Staffing, Information and Other Resources

5.42 As with prison provision, some issues were raised relating to **staffing, information and other resources** in local or regional secure mental health facilities and the State Hospital. The main issues identified relate to:

- The availability of beds.
- One prison noted that the lack of hospital beds and the "undesirable" nature of the individuals led to a high proportion being treated with anti-psychotic medication and provided with support in prison until they could function again.
- A lack of specialist forensic intervention in one hospital.
- A lack of sufficient sessions available for the provision of support to prisons by the visiting psychiatrists.
- Difficulties with some aspects of hospital accommodation, which could constrain provision (e.g. recreation).
- A lack of information at some stages in the transfer process and a lack of ongoing dialogue with prisons.

RETURN TO PRISON

5.43 Although many prisoners are released directly from hospital, some are returned to prison prior to their release. Some hospitals feel it could lead to a deterioration in an individual's mental health. However, there are circumstances when it might be necessary including: where a prisoner goes to hospital for an assessment and returns to prison; where a facility cannot contain a prisoner; where a prisoner has been on remand in a hospital and is then sentenced to prison; and where an illness is time-limited and the hospital is certain that a person will be well. Return to prison has to be agreed by the Scottish Ministers and prisoners should be returned to the prison they came from, unless there is a strong reason for not doing so.

The Process of Return

5.44 When prisoners are returned to prison, there is generally a process of discussion and information sharing between the prison and the hospital. This is largely satisfactory, and in some cases is very good. The processes did appear to vary between prisons and hospitals, however, with differences in local practice.

5.45 In some cases, staff from the prison are invited to a case conference prior to a prisoner's return, with relationships in these cases being very positive. One hospital identified undertaking a process of developing management plans prior to prisoners' return to prison, which proved successful with some people, and stated that returns would be part of the overall Care Programme Approach. This type of face-to-face contact does not happen in every case, however, and there are instances of information sharing being undertaken in other ways, such as by letter or telephone. A number of prisons also receive medical information from the hospital about work undertaken and a written clinical assessment or discharge summary.

5.46 Once back in prison, the prisoner may have some contact with a visiting psychiatrist, and one hospital provides some outreach work where someone has not completed their treatment.

Issues Raised with Return to Prison

5.47 A small number of issues were raised with the **process of return to prison**, including that:

- Where a remand prisoner has been in hospital there are some concerns that disposals can be made by a court which are against the recommendations of the psychiatrist.
- One hospital noted that RCS would handcuff people in the ward in front of everyone when taking them back to prison or court, a practice seen to be inappropriate and upsetting both for the prisoner, and other patients.
- There is variation in views between some NHS staff and RCS, in terms of the RCS risk assessment. Some NHS staff suggest that this provides a much higher level of security than is necessary.
- Although prisoners should return to the establishment from which they came, one prisoner was transferred to a different prison within four days.
- There can be a lack of nurse escorts, and a lost opportunity for verbal handover.
- It can be difficult for an organisation working with a patient in hospital to follow through with support in prison.

- There can sometimes be a delay in the provision of written information to the prison or, in the case of a small number of prisons, a perceived lack of information.

CONCLUSIONS

5.48 In terms of the **processes of referral, assessment and transfer to hospital**, the main conclusions are as follows:

5.48.1 Prisoners diagnosed with severe and enduring mental illness and requiring transfer to hospital may wait longer than similar people in the community. The problem may be more acute for young offenders.

5.48.2 Although the referral, assessment and transfer processes are generally appropriate, a small number of issues were identified relating to referral; some to the assessment, diagnosis or admittance of prisoners for assessment in prison; difficulties in diagnosis; some tension and variation in views of the appropriate level of security for some patients; and some to the transfer process such as a lack of information and practical difficulties such as the provision of nurse escorts and timing of delivery of prisoners to hospitals.

5.48.3 In most hospitals, the numbers of prisoners form a very small proportion of the total patients, although this is larger in the medium and high secure facilities. These patients have access to a range of treatment, interventions and support, which are generally the same as that available to any other patient.

5.48.4 Hospitals generally are clear that patients would be involved in identifying their needs and planning their care. Unlike prison, advocacy is available in all of the hospitals visited, and some hospitals have an advocacy service on-site.

5.48.5 There is general satisfaction with the treatment, intervention and other support available in hospitals, and a number of prisons report positive relationships with particular facilities. A small number of issues were raised in relation to hospitals' involvement with prisoners.

5.48.6 There are some perceived gaps in provision: a lack of provision for prisoners with learning disabilities; people with personality disorder and women; a lack of age-appropriate provision; and some geographical and general gaps. There is a small number of issues with current provision and some issues with the nature of prisoners' experiences in hospital. As with prison provision, some issues were also raised relating to staffing, information and other resources in local or regional secure mental health facilities and the State Hospital.

5.48.7 Although some prisoners are released directly from hospital, some are returned to prison prior to their release, although this is very rare. Where prisoners are returned to prison, there is generally a process of discussion and information sharing between the prison and the hospital, and this is largely satisfactory. A small number of issues were raised with this, such as the nature of RCS's approach to risk management, the timing of the return to prison and, in a few cases, information issues.

5.48.8 A number of concerns was raised about the specific situation of prisoners held in hospital who are liberated following a court appearance, in circumstances where a psychiatrist would recommend that further assessment or treatment is required.

6. RETURN TO THE COMMUNITY

6.1 Prisoners with severe and enduring mental health problems are likely to require to continue to receive treatment, interventions and other support when they return to the community, either from prison or hospital. The nature of this provision, and the continuity of care will have an impact upon their future experiences, and this chapter examines the nature of the treatment, interventions and other support which are provided to them at that stage, and any issues arising with this.

PRE-RELEASE

6.2 Prisoners face a range of issues as they approach their return to the community. Some described the general stress and worry of being released, and also felt that their mental health problems could increase. The importance of accessing support, where this was the case, was noted:

"Some mental health problems are quite scary and you worry about when you do get out if it [the mental health problem] does come back what to do."

6.3 There is a need for support of different types, particularly access to hospital treatment. Accommodation is also a key issue, with a lack of housing linked to increased stress. Other forms of support which are required include social work support, family support, benefits help and access to the services required. More generally, one prisoner stated that:

"If I was given a bit of help then I could get on with my life, I could manage."

Preparation for Release from Prison

6.4 Work is being carried out in all prisons to assist prisoners in preparing for their release and in accessing support for mental health issues. Most have a Links Centre, within which connections are made to a range of services as prisoners approach liberation. The nature of this varies between prisons, and the work highlighted below comprises *examples* of the types of preparation which can take place.

6.5 One of the areas of variation is in the level of formalised planning undertaken with prisoners with severe and enduring mental health problems. Some prisons conduct relatively formal processes of assessment prior to release. These include the use of case conferences or pre-release meetings, sometimes involving the mental health team, and sometimes involving services from the community. However, this does not generally take place for *all* prisoners.

6.6 In some cases, addressing mental health needs may take place as part of the Integrated Case Management process, or as a specific component of throughcare and the general liberation planning process. While most prisons have some ICM practice in place, it is varied in the nature and extent to which mental health needs are taken into account of, and whether ICM Co-ordinators sit on MDMHTs, the use of case conferences, and approaches to information.

6.7 One prison stated that everyone gets a Community Integration Plan "of sorts", and that all of the prisoners known to have mental health problems get help with planning for their release. A small number of prisons mentioned the use of the MAPPA process, or the Care Programme Approach as part of planning for release. The voluntary sector organisations also recognised that there was some relevant work being done through Community Integration Plans (CIP) and Integrated Case Management, but it was also noted that there is variation between services and areas in terms of whether or not they are willing to engage with prisoners prior to release. The value of more formalised arrangements was highlighted.

6.8 In terms of making contact with specific services, one of the key sources of support for people with mental health needs is the continuation of healthcare support, and almost all prisons provide assistance with accessing GP provision. Some prisons also alert a prisoner's GP on their release, and a number provide a discharge letter to the GP. One prison highlighted the fact that no one with mental health needs leaves the prison without a doctor being available. Others noted that they would try to link to doctors in the community in relation to medication, or notify the local health centre.

6.9 Assistance is also provided, through the MDMHT, the prison psychiatrist or the health centre, with arranging mental healthcare on release. Appointments for prisoners are arranged at the time of release. For some prisoners, a link may be made with a CPN in the community or a community mental health team, and the CPN may also assist in arranging appointments.

6.10 Some prisons have good links with social work services, and social work teams may take responsibility for organising a care package. Community social work staff may also come into prison to help some prisoners prepare for release and assist in making relevant arrangements, although not all prisoners have an allocated supervising social worker in the community before they are released.

6.11 Some housing services also come into prisons to assist with housing issues in preparation for release, and all but one prison noted that assistance is provided with this. If specialist housing is required, prisons may be able to assist in accessing this.

6.12 Some other aspects of general preparation for release were also felt to be particularly relevant to mental health needs, particularly "life skills". In one case, a support group was involved from the start of the sentence in planning how prisoners would cope on release.

6.13 There has been a general improvement in contacts with outside agencies in recent years, and prisons are trying to build upon existing work and develop this further.

6.14 Some voluntary organisations also suggested that throughcare has been much improved, with developments to their role in the process. Again, however, there is variation within and between prisons with one providing the example of a prisoner with mental health problems being liberated with a range of multi-agency support in place, while another from the same establishment had been liberated with no support.

6.15 Home leave prior to release provides an opportunity for prisoners to make contact with services.

6.16 A number of prisoners with severe and enduring mental health problems are released from prison into homeless accommodation or may not have a GP. In these instances throughcare is very difficult to organise.

Preparation for Return to the Community from Hospital

6.17 Return to the community directly from hospital for people who have been transferred from prison is relatively common. In these cases, there is a more systematic and consistent formal process for making arrangements to ensure that mental healthcare continues.

6.18 Preparation for return to the community from hospital involves a relatively formal discharge planning process, which includes relevant staff identifying all of a patient's needs. The Care Programme Approach requires co-ordination of care and implies input from a number of services.

6.19 Hospitals also identified the MAPPA process being in place for some individuals where there is a significant risk to the public. In these cases there would also be likely to be specific links to the police and criminal justice social workers.

6.20 Through these mechanisms, hospitals generally make contact with all of the relevant service providers and try to enable smooth transition to community support, linking individual patients to appropriate services, and inviting service providers to the hospital as appropriate. One hospital identifies service providers, develops confidence in the service providers, as well as providing some follow up support themselves. The whole process of treatment and care involves a progression from illness through treatment, management, rehabilitation and discharge.

RETURN TO THE COMMUNITY

Release from Prison

6.21 Although some preparatory work is carried out prior to liberation both in prisons and in hospitals, and there appears to have been developments in this work, the actions taken at the point of release can have a key impact upon the subsequent experiences of an ex-prisoner. The actual point of release, and the period following this, are crucial stages in the continuity of care, and there are a number of problems which can affect ex-prisoners at this time.

6.22 Prisoners being released from prison with severe and enduring mental health problems need to get from the prison to the area in which they will live, secure their accommodation, settle in, and take all of the actions necessary relating to their health, housing and finance. The services which they will access also need to know about them. In many cases, ex-prisoners have to approach these organisations at their own instigation, or, where appointments have been made previously, to approach the organisations and attend these appointments with little or no support.

6.23 In terms of continuity of health care, some prisons give ex-prisoners a short-term supply of medication upon release. Thereafter they will need to gain access to this in the community. Similarly, where appointments have been made, prisoners will be informed of these and will need to attend.

6.24 The types of services available upon release, vary between areas, but include statutory services (health and mental health; housing; and social work) and voluntary sector provision (in these areas, and in relation to other forms of specialist support, such as organisations working with ex-offenders; abuse issues; addictions; befriending; and other forms of issue-based work).

6.25 A small number of initiatives to provide support with making or attending appointments was identified. One involves a "Routes Out of Prison" initiative, with "life coaches" providing assistance to released prisoners from the earliest stage, who can help them to access services and accompany them to appointments. The initiative is only available in certain areas.

6.26 One prison ensures that people who are high risk and on Act2Care receive specific support on release, such as having someone to collect them or take them to their local GP. Similar provision is made in another case where "health information advocates" accompany prisoners to register with doctors, and to hospital appointments. Social workers might sometimes accompany ex-prisoners to appointments.

6.27 One prison set up a multi-disciplinary approach for someone who was struggling without support, in which the individual was placed on a three-month supervision order to try to ensure support. Prisoners who had experience of support in the past were very appreciative of it.

6.28 The prison can also contact family members, if they can be identified, where a person is unwell, and ask the family to meet the ex-prisoner at the gate.

6.29 For many, however, there is no such support in place:

"They're just giving me a grant and showing me the gate."

Return to the Community from Hospital

6.30 In terms of the provision made for patients leaving hospital, those who have not committed violent or sexual offences are generally transferred to the care of community medical services. One hospital noted that people were unlikely to be released without any form of referral from the hospital, and some identified that they had a community service which works with ex-patients, or that they would continue to respond to emergencies. Social work services can also fund packages of care for particular patients.

6.31 The provision of assistance with housing and other support was also highlighted. For example, some have access to facilities provided by support organisations (such as SACRO, Barony, and the Richmond Fellowship), which can provide accommodation and care.

6.32 Patients returning to the community from a high security facility within the mental health system generally do so via a rehabilitation unit, which ensures their ongoing support in the community.

The Risk of Re-offending

6.33 Although people with severe and enduring mental health problems who are otherwise fairly well, and have support outside prison can, and often do, survive for long periods of time in the community, some have difficulties in securing continuity of care and access to appropriate support – which increases the risk of their re-offending. Prison staff made the following point:

"Before release they'll tell you they'll be back because there's nothing for them out there."

The voluntary sector also made the point that:

"People fall through the gaps, and that's why they go to prison and then they come out and it's the same gaps."

Prisoners agreed with this:

"You're put out and left to fend for yourself ... if you get no support and you've nowhere to go, you're back in here and that's a vicious circle."

6.34 Prisoners also suggested that re-offending can be the result of "masked" mental health problems, and examples were given of them taking alcohol and drugs to help them cope. One prisoner pointed out that he had had to commit another offence before he got help, and others suggested that some would stop taking their medication after release, as a way of ensuring that they returned to prison.

Issues and Problems with Continuity of Care and Return to the Community

Gaps in Preparation for Release

6.35 As well as the issues raised in relation to the variation in the level of preparation for release within and between prisons, some additional **gaps in preparation for release** were highlighted, including that:

- It is difficult to make arrangements for release for short-term prisoners.
- There is a lack of formalised throughcare focusing specifically on mental health issues. Although some of the processes, such as ICM offer a move to an holistic approach, the extent to which these address mental health is unclear, and there is still a focus on statutory services. The processes also depend on mental health needs being identified.
- There can be a lack of provision of information to prisoners about how to access mental health services when they leave prison.
- Prisoners do not always engage with the process of pre-release planning.
- The prison Links Centre will not necessarily receive the information required in relation to a prisoner's mental health needs.
- Organisations working with prisoners to address related needs such as housing and employment will not always know that prisoners have mental health problems, and this can make it difficult to work with them.
- There can be a reluctance for some services in the community to assess prisoners while they are still in custody.
- It can be difficult for some prisons which act as a national facility to link to local services in a prisoner's home area.
- It can be difficult for local prisons to arrange healthcare where a prisoner lives outwith the local NHS area.
- Prisoners may not have a release address sufficiently in advance to make local arrangements.
- There can be a lack of communication between community mental health services and prison.
- When services such as CPNs and social work do assist with preparation for release, time spent with a prisoner can be very limited.
- Prisoners are not always seen by a doctor prior to release.
- The perceived impact of mental health problems on a prisoner's liberation date can lead to the prisoner hiding his or her other issues, which makes it more difficult to ask for support.
- It can be more difficult to make provision for women because of complexity of their needs.
- There is a lack of an holistic approach to addressing needs approaching release, and there can be a lack of partnership working and co-ordination.

Access to Services

6.36 Some issues were raised related to perceived difficulties in securing **access to services** following release:

- Some prisoners are not registered with a GP.
- There can be difficulties in accessing a hospital bed for some ex-prisoners, including where someone has been stabilised but is seen by prison-based staff to present a high risk.
- There can be problems securing appropriate housing, with homelessness having a negative impact upon mental health, and hostels seen to be inappropriate for "vulnerable" people.
- It can be difficult for ex-prisoners to access treatment programmes.
- There is variation in the availability of different kinds of services in the community in different geographical areas, and some support may not be available.
- There can be specific gaps in services in the community such as a lack of suitable accommodation and effective treatment for pregnant women.
- Particular groups of ex-prisoners may have specific difficulties in coping or accessing support in the community, including people with addiction problems; homeless people; people with learning disabilities; sex offenders; and foreign national prisoners.
- Mental health and addictions services in the community are not always linked.
- Services in the community, including NHS primary care services for people with chronic mental health conditions, are stretched and may be unable to meet ex-prisoners' needs, or there may be a lengthy waiting period.
- Some services will not work with people on release who are from outwith their designated geographical area, but some ex-prisoners do not want to return to their previous address.
- Some services may be unwilling to work with ex-prisoners: "you get doors shut in your face with mental health problems".
- There is a lack of a "joined-up" and holistic approach to meeting an individual's needs. Some people's needs may fall between services.
- There is a lack of focus on preventive work in the community and some ex-prisoners become involved with services only at the point of crisis.
- Some ex-prisoners will present a risk in the community if their mental illness is not treated.

Circumstances of Release/Timing Issues

6.37 A small number of issues related to the **circumstances of release, or timing issues** which may exacerbate the difficulties in accessing support was highlighted:

- Sometimes prisoners are liberated from court, against the recommendation of psychiatrists. One hospital noted that sometimes nurses will be despatched to court with prisoners to ensure that they can be detained in the event that they are no longer detained as prisoners.
- When prisoners are liberated at short notice or unexpectedly it can cause problems in arranging support.
- When people go to court from hospital and are liberated, they must return to collect their personal items, as RCS will not have transferred these.
- Even when community appointments have been made for individuals on release, prisoners may worry about how they will cope between their release and the appointment: *"it's making me ill and it's getting harder every sentence I do"*. Ex-prisoners may struggle even with the journey to their home area. One ex-prisoner sat at a bus stop all day following release.
- Prisoners may have to *"start all over again"* with their treatment on release, and may have to go back on a waiting list.

Lifestyle and Community Issues

6.38 Some of the problems were highlighted as affecting continuity of care on release related to **aspects of prisoners' lives in the community**:

- Ex-prisoners' lives outside prison are sometimes chaotic, and although they may have been stabilised in prison, they may return to such a lifestyle on release.
- Some will not attend appointments.
- Many ex-prisoners do not have personal support in the community.
- Some ex-prisoners are banned from services because of their previous behaviour.
- Ex-prisoners who are homeless face specific issues in hostel provision: *"what do you do with someone who is getting released and who doesn't have an address – they go to a hostel. That condemns them to link to friends who will take them down a different road."*
- Prisoners face a range of other problems in the community relating to issues such as education, employment and benefits. Although these are issues for most prisoners, they are exacerbated by mental health problems.
- Some prisoners identified continuing stigma and inappropriate attitudes from other people in the community as having an impact on their overall mental health.

CONCLUSIONS

6.39 In terms of **preparation for release and release** of people with severe and enduring mental health problems, the main conclusions are as follows:

6.39.1 Prisoners face a range of issues prior to liberation, and accessing support is very important.

6.39.2 Some work is being carried out in prisons to assist prisoners in preparing for their release and in accessing support, but the nature of this varies between prisons, particularly in relation to the level of formalised planning undertaken.

6.39.3 Mental health is not regularly considered as part of the ICM process.

6.39.4 A more systematic, formal, process for making arrangements to prepare people for return to the community and to ensure that their care continues is in place in hospitals. This generally involves a relatively formal discharge planning process, which includes relevant staff in identifying all of a patient's needs.

6.39.5 In many cases, prisoners being released from prison have to approach organisations in the community at their own instigation, with limited external support available, although a small number of initiatives were identified.

6.39.6 In terms of the provision made for patients leaving hospital, those who had not committed violent or sexual offences would generally be transferred to the care of community medical services.

6.39.7 The point of return to the community, particularly from prison, is a key area of concern in terms of securing continuity of care. One hospital stated that, when prisoners have been transferred to the mental health system, the problems are no greater than those faced in planning the discharge of any other patients. A number of problems can arise, however, when individuals with a mental disorder are in prison, and are being released directly into the community.

6.39.8 Some prisoners with severe and enduring mental health problems are, incredibly, liberated from prison with few if any links to continuing support in the community, and without any arrangements for the continuation of any work which had started in prison.

6.39.9 There are some specific gaps in preparation for release such as a lack of focus on throughcare specifically for prisoners with severe and enduring mental health problems and the lack of an holistic approach.

6.39.10 Some prisoners do not engage with pre and post-release planning, in some cases arising from a fear that disclosure of needs may delay their liberation date.

6.39.11 There is a number of perceived difficulties in securing access to services upon release (e.g. GP services, hospital services and housing) and issues for some specific groups. There are also difficulties in gaining access to an in-patient bed when this is required.

6.39.12 There are issues relating to geographical variations and capacity of services, as well as a lack of communication between agencies.

6.39.13 Women may find it more difficult to access services due, in some cases, to the relative complexity of their needs.

6.39.14 Other groups who may also face problems include drug and alcohol users; homeless people; people with learning disabilities; sex offenders and foreign nationals.

6.39.15 There is a small number of issues relating to the circumstances of release, or timing issues which may exacerbate the difficulties in accessing support.

6.39.16 Some of the problems experienced on release relate to aspects of prisoners' lives in the community: chaotic lifestyles; behaviour; drug and alcohol use; lack of support and access to economic and social participation; and stigma. These may also impact on their likelihood of being able to access support services.

6.39.17 In some cases, the problems faced by ex-prisoners in these circumstances increase the likelihood of their re-offending.

7. RESOURCES AND STRUCTURAL ISSUES

7.1 Resources and structural issues impact upon work with prisoners with severe and enduring mental health problems in prisons, in hospitals and in the community. This chapter examines the resources available to prisons and hospitals. It will also examine joint working between prisons and with the NHS and voluntary sector.

STAFFING AND ROLES

7.2 Prisons were asked to provide a summary of the resources available to them for mental health work. This is summarised below. It represents the position at mid-December 2007.

7.3 **Aberdeen:** Aberdeen has no dedicated mental health staff, other than a psychiatrist for two hours per week. A full-time RMN had been recruited, and was expected to be able to dedicate 15 hours each week to prisoners with severe and enduring mental health problems. The balance of time was expected to be made available for general nursing duties.

7.4 **Barlinnie:** Barlinnie has an allocation of 111 hours from RMNs, of which 60 hours were available to prisoners with severe and enduring mental health problems. A further eight hours were available from a psychiatrist. A total of seven hours was available from an addictions nurse working on "dual diagnosis", but it is difficult to quantify the time that might be spent with prisoners with severe and enduring mental health issues. Although Barlinnie has access to a psychologist, none of his or her time is specifically dedicated to prisoners with severe and enduring mental health problems, although such prisoners may take part in programmes run by a psychologist. In addition, prisoners with severe and enduring mental health problems are eligible to receive support from voluntary organisations working in the prison, although this was unusual, as these groups tend to work with prisoners with less severe problems.

7.5 **Cornton Vale:** Cornton Vale has access to 12 hours each week from a psychiatrist, of which 10 hours were dedicated to prisoners with severe and enduring mental health problems. A total of two hours (out of 7.5 hours) of psychologist time were also available. Cornton Vale also has a variety of nurse resources available, including a nurse dedicated to Ross House for remand prisoners (with 25 dedicated hours), an addictions nurse (with 30 dedicated hours) and a further 20 hours available from other mental health nurses. In addition, it is estimated that around 18 hours per week of their time, and a further two hours of the medical officer's time were dedicated to prisoners with severe and enduring mental health problems.

7.6 **Dumfries:** The total number of hours available from staff at Dumfries consists of three hours from a consultant psychiatrist, six from a psychological counsellor, two from an addictions nurse, and five from an addictions counsellor.

7.7 **Glenochil:** Glenochil is unusual in having a time commitment from two psychiatrists, one a forensic, the other a general psychiatrist. A total of 11 hours is available. A total of 56 hours is dedicated from mental health nurses, and a further four from the clinical manager, who was also a registered mental health nurse. At the time of inspection, the psychologist's post was vacant. A total of five hours is available from the GP.

7.8 **Edinburgh:** Staff in Edinburgh found it difficult to assess the time available from the two RMNs which varies depending on staff availability and other tasks. Both staff were full time. Similarly, it was difficult to assess the time commitment of both the psychiatrist (with seven hours in total available) and the psychologist (with 37 hours available).

7.9 **Greenock:** Greenock has a full time mental health nurse, with 37 hours dedicated to prisoners with severe and enduring mental health problems. Beyond this, two to four hours are dedicated by a psychiatrist and one to two hours from an addictions nurse.

7.10 **Inverness:** Inverness has no dedicated mental health nurses, and three hours were available from a forensic psychiatrist and three from a forensic liaison nurse.

7.11 **Kilmarnock:** Kilmarnock has a full-time mental health coordinator, with 37 hours dedicated to prisoners with severe and enduring mental health problems. The prison also has three part-time mental health nurses, each with 7.5 hours per week dedicated to this group. The psychologists are part of the MDMHT. Four hours psychiatric input are available each week.

7.12 **Open Estate:** The Open Estate has one mental health nurse (30 hours) fully dedicated to prisoners with severe and enduring mental health problems, supported by two to three hours each from a primary care nurse, addictions nurse an Enhanced Addictions Casework Service (EACS) worker, and a further one to two hours from a psychologist.

7.13 **Perth:** Staff in Perth were unable to determine accurately the time dedicated to prisoners with severe and enduring mental health problems. The prison had two mental health nurses, a learning disability nurse, a primary care nurse and an addictions nurse, all of whom work with prisoners with severe and enduring mental health problems for varying amounts of time. The prison has access to two psychiatrists for six and three hours each week respectively, and a psychologist for two hours each week. It was not possible to estimate what proportion of this time was dedicated to prisoners with severe and enduring mental health problems.

7.14 **Peterhead:** Although Peterhead has a mental health practitioner nurse, the time dedicated to prisoners with severe and enduring mental health problems could vary from 0 to 15 hours, depending on other commitments. Beyond this, the prison has three full time practitioner nurses, a medical officer and a psychologist, all of whom work with prisoners with severe and enduring mental health problems "as required". The prison also has access to a psychiatrist for three hours every two weeks.

7.15 **Polmont:** Polmont has four mental health nurses, with around 140 hours in total dedicated to prisoners with severe and enduring mental health problems. There are 10.5 hours psychiatric input available each week. Polmont also has both a senior psychologist (three hours) and trainee psychologists (four hours), as well as an activities officer (30 hours) almost entirely dedicated to organising and supervising supported work parties and other activities for prisoners in this group. Polmont also has access to 10 hours from a speech and language therapist.

7.16 **Shotts:** Shotts has two mental health nurses, with variable amounts of time. The prison also has access to six hours from a psychiatrist, and time from a psychologist, although it was not possible to identify how much of this time was dedicated to prisoners with severe and enduring mental health problems.

Overview of Healthcare Staff and Other Specialists

7.17 The provision of healthcare staff, and particularly mental health specialist staff varies widely across prisons. While some have a full time mental health nursing team, some have no specialist nurses. In some prisons, staff are fully dedicated to mental health, in others mental health nurses are expected to distribute methadone and carry out general nursing duties.

7.18 In prisons with a dedicated mental health nurse or nurses, staff and prisoners have an obvious first point of contact; it helps clarify contacts with external organisations, and provides a focus for contact with hospital-based, and community-based forensic teams; and it allows expertise to be built up in this area.

7.19 The general pressure on healthcare staff has increased, and more prisoners are requiring to be seen. This has meant there has been a knock-on impact on mental health, with fewer resources, and staff more likely to be required to undertake general health duties. At a basic level high numbers of prisoners was also creating difficulties of physical overcrowding in health centre facilities themselves.

7.20 Generally, nursing teams are available on a Monday to Sunday basis, although there is little or no mental health nursing cover on-site overnight or at weekends. Concerns were also expressed about the impact of absences caused by illness, holidays and staff shortages.

Other Specialist Staff

7.21 Some prisons have other specialist staff working with prisoners with severe and enduring mental health problems. In one, a speech and language therapist is available. In some an occupational therapist is a useful addition to the team.

7.22 In all prisons, the social work team works with prisoners with severe and enduring mental health problems. The proportion of the caseload represented by these prisoners varies, although this may be very small.

Staff Trained in Specific Interventions

7.23 There were very few examples of staff trained in, or delivering, CBT. In one case, even where a staff member had had training, other pressures meant that this could not be offered. Where psychologists were employed, their time tended to be deployed on either programmes or addictions work. There were few examples of psychologists delivering one-to-one sessions with prisoners.

Other Commitments

7.24 Mental heath staff have a range of other responsibilities including distributing methadone, general administration and report writing, programme delivery and general healthcare duties. The net effect of these other duties is to reduce the time available to work directly with prisoners with severe and enduring mental health problems.

Residential and Operational Staff

7.25 Residential and operational staff are expected to play a greater role in the management of prisoners with severe and enduring mental health issues than in the past. This increased management role is in part due to the increasing number of such prisoners. The removal of healthcare beds also means that prisoners with severe and enduring mental health issues are being located in the halls.

Training and Awareness Raising

7.26 As a result of participation in the national *Choose Life* initiative, Mental Health First Aid training has been introduced to prisons. To date, relatively few staff have been provided with MHFA training, but where this has been possible, it has been beneficial, with staff feeling more confident in dealing with prisoners.

7.27 Also largely as a result of *Choose Life*, staff in some prisons have received ASIST (Applied Suicide Intervention Skills Training). This provides higher level training in relation to addressing the risk of suicide. Again, while not directly related to severe and enduring mental health problems, it gives staff a wider insight into these issues.

7.28 A training pack "New to Forensics" has been developed. This was originally for use in the NHS but is being adapted for use in prisons, and will extend the available mental health training into more specialist areas, particularly relating to severe and enduring mental health problems. This has been very well received.

Issues and Problems with Staffing and Roles

7.29 A range of issues was identified in relation to **staffing and roles**. Firstly, in relation to healthcare staff:

- In some prisons the level of staffing, particularly staff with mental health qualifications, is inadequate to address the needs of prisoners fully.
- Some prisons do not have a dedicated mental health nurse, although there may be staff in other roles who are mental health trained.
- Some prisons either do not have a psychologist in post, or do not have any psychologist time dedicated to mental health.
- The time allocated by psychiatrists to individual prisons varies and concerns were raised about whether demand was always met.
- Contact with a psychiatrist should be within 24 hours if necessary. When someone is distressed, and there is no nursing observation available, it is difficult to manage and medicate them during this period.

- Generally, no members of the mental health team are available overnight, or at the weekend.
- Although some prisons benefit from specialist staff, in some cases, the level of time made available through these arrangements is low.
- In some prisons, there is a relatively high turnover of staff, with long lead times for staff to be replaced. One had four vacancies in its healthcare team, with a fifth member of staff not allowed to have any prisoner contact. Another had been seven nurses below complement in the recent past.
- Qualified mental health nurses are, in some prisons, diverted to other activities, particularly the distribution of methadone.
- Staff in most prisons are not trained to provide talking therapies. Even where staff are trained, other priorities may mean that contact time with prisoners for these activities is either very limited, or impossible.
- There is a lack of clinical psychologists in prisons.
- There is no specialist provision to survivors of childhood sexual abuse.
- While there is a good deal of assessment undertaken, there is too little intervention available.
- Some staff do not feel valued or supported. The comment was made that mental health is the "Cinderella" service in SPS.
- There may be a possibility of prison-based healthcare staff losing aspects of their skills, or skills and knowledge becoming out of date, as a result of lack of access to mainstream NHS continuing professional development.
- There is a lack of clinical supervision for some of the mental health professionals working in a prison setting.

7.30 Issues relating to residential and other uniformed staff included:

- Many staff lack confidence, as well as skills and knowledge in dealing with prisoners with mental health problems.
- In some prisons, staff can lack direction and guidance, and are "just expected to get on with it".
- Staff may be reluctant to take what are perceived as risks, even though they may be reassured by managers that they should follow policy.
- Staff in some prisons find it difficult to access training, or where access to training is granted, this is delivered in a truncated form.
- There is a lack of effective mental health training for new recruits to the Scottish Prison Service.
- While staff working in some segregation units had had training in mental health issues, this was not the case in all prisons.
- Staff shortages in some prisons mean that residential staff do not have time to spend with prisoners with severe and enduring mental health problems.
- The delivery of prisoners to assessment and treatment sessions can be "ad hoc" when there are staff shortages, and was liable to be forgotten if other, apparently higher priority work intervened.
- The effect of rostering can mean that staff cannot attend two-day training programmes.

7.31 In some prisons, concerns were expressed about the attitudes of some staff, in terms of the use of inappropriate language, or through threatening the use of restraints.

JOINT WORKING

Multi Disciplinary Mental Health Teams

7.32 Multi Disciplinary Mental Health Team (MDMHT) meetings represent an opportunity for staff involved in the management of prisoners with mental health problems to discuss these cases in an open forum. Broadly, MDMHTs have two main purposes:

- To consider new cases brought to the meeting and, through multi-disciplinary discussion, determine the best course of action to be taken forward by means of a clear action plan.
- To review the ongoing treatment and management of prisoners deemed to fall within the remit of the team.

7.33 MDMHTs may also be involved as a team in planning the arrangements for a prisoner's ongoing care after liberation.

7.34 MDMHTs vary in terms of whether or not the team has any responsibility for strategic issues, including staffing and deployment, as well as reviewing the overall pattern of resources and care. In some cases, due to the number of cases within its remit, the team has to focus on case management.

7.35 The MDMHT generally has a role in considering the transfer of any prisoner within its remit. This does not always happen in practice.

7.36 Meetings are always minuted, and the minutes distributed to all of those members attending, and, in most cases, other relevant staff (for example, where one staff member represents a group of staff). In one prison, the content of the MDMHT is the subject of a briefing between the Deputy Governor and the Duty Governors over the weekend period, to ensure that they are made aware of any issues likely to arise.

The Composition of MDMHTs

7.37 All except two prisons had an operational MDMHT.

7.38 There is considerable variation in the membership of MDMHTs.

7.39 In a majority of cases (9 out of 14), the meetings are chaired by a senior member of staff, often the Governor or Deputy Governor. This was considered to be positive, with the view expressed that this gave the team more "clout", and underscored the "multi-disciplinary", rather than simply "health" view of the meetings. In those prisons where the Governor or Deputy Governor does not attend, another senior member of staff does. In other prisons, the meetings are chaired by the clinical manager or health centre manager.

7.40 In all prisons either or both the clinical manager and health centre manager attend. In all prisons with mental health nurses, one or more nurses attend. Psychiatrists attend in 11 out of 14 prisons, with psychologists in attendance at 10. GPs attend in six prisons. A representative from social work attends at all prisons except one. In all but two either an addictions nurse, or a representative of the addictions contract holder attends.

7.41 In some prisons, some additional people also attend, including representatives of some voluntary organisations, the ACT coordinator, the lifer liaison officer and, in one case, a representative of the community forensic mental health team.

7.42 There is significant variation in whether or not residential staff attend MDMHT meetings. There are strong views for and against this usually related to issues of confidentiality, and sometimes staffing levels mean that it cannot happen in any case.

7.43 Psychiatrists attend in the majority of prisons. Again there were mixed views about the attendance of psychiatrists, with some psychiatrists viewing their attendance as essential, while others viewed this as a lesser priority than their individual prisoner contact (particularly in cases where this is restricted in terms of available hours).

7.44 In most prisons, either Phoenix Futures, or a member of staff with responsibility for drugs issues attends.

7.45 A representative of the prison chaplaincy attends all but one MDMHTs. The extent to which chaplains become involved varies across prisons, with some taking a largely listening role, except where asked to raise issues on behalf of a prisoner.

7.46 Overall, attendance was high at all MDMHTs visited during the inspection.

Benefits of the MDMHT

7.47 There was a strong and consistent view that MDMHTs are a positive initiative: they are the best way of ensuring that prisoners receive the assistance they require consistently, and with no overlap. Staff also bring their own expertise, and learn from each other. The meetings also raise awareness of mental health issues across the prison. The process of ongoing review, where this takes place, also ensures that prisoners cannot be overlooked, or forgotten about.

Other Internal Joint Working

7.48 Other joint working within prisons also takes place. Although there can be tensions in relation to the transfer and sharing of information, in some prisons a "team" approach is taken. In one prison, since the removal of healthcare beds, there is now a greater reliance on residential staff carrying out observation of prisoners, and an onus is on them to report back their findings to healthcare staff. However, residential staff concerned did not always consider that they had the skills or knowledge to do this effectively.

Joint Working with External Organisations

7.49 As described elsewhere in this report, prisons work directly with staff of other organisations, either on joint basis, or where that organisation is contracted to provide a service to SPS (or SERCO in the case of Kilmarnock).

Service Level Agreements

7.50 Some prisons have service level agreements (SLAs) in place with their local NHS Board. Generally, these cover the provision of psychiatrists, but in some cases, other services such as speech and language therapy or psychological counselling.

Relationships between Hospitals and Prisons

7.51 Relationships between hospitals and prisons relate largely to the transfer of prisoners, although there are also a number of examples of joint working groups of which both prison and NHS staff are members.

7.52 In some prisons, formal liaison arrangements exist between hospitals and prisons, but in others, the relationship is ad hoc, and focused specifically on an individual prisoner. A large range of individual instances of joint working is in place and, among the staff identified as working jointly with some prisons were nurses, occupational therapists, physiotherapists, art therapists, speech and language therapists, as well as psychiatrists and psychologists.

7.53 Generally, relationships were described as good by all parties, although in some cases, it was clear that, at least in part, they could be more effective. One aspect of arrangements which is helpful is where hospital-based psychiatrists also work in the prison. In some locations, other health staff have worked both in a prison and hospital setting.

Relationships with the Voluntary Sector

7.54 The level of joint working between prisons and the voluntary sector is lower than with the NHS, and varies greatly between prisons, although a number of examples of effective joint working were identified. Amongst the voluntary organisations identified were: Samaritans; SAMH; local associations for mental health; Penumbra; a local hearing voices network; training and employment providers; and organisations supporting homeless ex-offenders.

7.55 Some voluntary organisations, however, find it difficult to work with prisons, in part because they lack information and awareness of how the SPS operates, and they may be unable to identify a suitable first point of contact.

7.56 Some voluntary organisations also find it difficult to work with the NHS, and jointly with other voluntary organisations. In part, this appears to be a funding issue.

7.57 One of the main difficulties identified both by voluntary organisations, and to an extent by prison staff, was an assumption that all work with prisoners would be funded by SPS, even where others, generally either the NHS or local authorities, were funding work in the community and in hospital. This can limit work in a number of areas such as introducing advocacy on a wider scale.

Participation by Prison Staff in Wider Forums

7.58 A wide range of examples was identified of participation by prison and NHS staff in wider joint working arrangements. These include the Forensic Network at a national level. At a local level, most prisons are members of forums specifically to discuss mentally disordered offenders and, in some cases, forensic psychiatry networks. Some prisons also take part in multi-agency groups dealing with risk assessments, for example, relating to sex offenders.

Issues and Problems with Joint Working

7.59 A number of issues with internal joint working were identified. The first group of issues relate to the **operation of the MDMHTs** and include that:

- There is clear variation in the nature and operation of MDMHTs.
- In some cases, there are practical difficulties in relation to the attendance of team members.
- There is a lack of consistency surrounding the attendance of residential staff at MDMHT meetings.
- Non-health staff in some prisons have limited awareness of the remit and composition of the MDMHT.
- Some residential staff expressed frustration at the fact that they had never been asked to contribute to MDMHT meetings, even indirectly, even though they had had direct contact with prisoners over an extended period.

7.60 In some prisons, concerns were raised about **other aspects of internal joint working**:

- In one prison, staff were described as "working in silos", and aspects of this were also identified in other prisons.
- Staff in a wide range of roles expressed frustration with the lack of information provided to them by health staff as a result of what was perceived to be medical confidentiality.
- Some concerns were also raised about the expectations placed on residential staff in relation to assuming roles they were neither comfortable in, nor considered themselves trained for.

7.61 Some issues were raised about joint working between prisons and external bodies:

- In some cases there was not a well-formed and clear understanding of the roles and responsibilities of, and, in some cases, constraints, facing prison and NHS staff.
- A small number of prisons identified problems with resources, largely time for staff to engage in networking, but also financial resources (in relation particularly to the voluntary sector).
- The sheer volume of prisoners in Barlinnie can make assessment and treatment difficult, as well as "keeping up" with prisoner receptions and liberations.

- A number of psychiatrists raised issues relating to visiting prison, including being unable to pre-book appointments, being unable to see prisoners, being expected to carry out assessments in inappropriate locations, including corridors, and being forced to cut short visits with no notice or explanation.
- Issues were also raised by psychiatrists that their allocated times may not be fully utilised due to delays in the delivery of prisoners and confusion over bookings.
- Some voluntary organisations find it difficult to make both initial and ongoing contacts with prisons, and some find it difficult to continue to work with clients who are serving a sentence.

RECORD KEEPING AND INFORMATION SHARING

7.62 Mental health information is generally kept within prisoners' medical records. Some services, however, keep their own records (psychiatrists, psychologists, social workers, chaplains etc.). In addition, some information is kept on a daily basis in halls.

7.63 MDMHT meetings provide a forum for information sharing about individual prisoners' mental health, and issues arising and the treatment provided are usually discussed. The MDMHT members, however, will not generally be provided with a prisoner's medical records, although, where consent is given, the contents may be shared. Additionally, consent can be over-ridden, and the information shared with or without consent where a prisoner is very unwell, where they themselves or someone else is considered to be "at risk" or where it is "in their best interests".

7.64 The process of holding case conferences for some prisoners is also a means of information sharing, and one group of prison mental health staff noted that Integrated Case Management records, which were seen to be relevant, would be maintained in a prisoner's PR2, although it was also noted that the mental health information provided on these records was limited.

7.65 Two prisons have access to GPASS, but the extent of this is very limited, and does not appear to extend to accessing GP records.

7.66 Little mental health information is shared with officers in the halls. Few officers attend MDMHT meetings and the lack of information is an issue for officers, some of whom suggested that the issue of medical confidentiality was being used as a reason not to provide basic details to them.

Issues and Problems with Records and Information Sharing

7.67 Some issues were raised in relation to perceived **gaps** in provision or sharing of information, including that:

- There can be some problems with the transfer of information from courts and the community, and it can be difficult to get information from GPs.
- There can be difficulties with information following prisoners on transfer and on return to the community.
- The limited information provided to prison staff about prisoners' mental health problems and treatment can constrain the knowledge they have about individual prisoners, and can also constrain their effectiveness in providing support.
- The standards of record keeping vary.
- Time constraints can make it difficult to keep records up to date.
- There may be some gaps in communication between organisations working with prisoners, particularly where organisations are not involved in the MDMHT.

7.68 There can also be some problems with the **issue of consent**:

- There can be a lack of clarity and consistency about what is confidential and what can be discussed, and a lack of shared understanding of data protection and medical confidentiality.
- There is variation in the means and rigour with which consent for information sharing is sought and recorded.
- Issues relating to confidentiality and consent, and the balance of these issues with safe management, risk and the best interests of prisoners, raise a number of ethical concerns which are not always fully recognised or addressed.

PHYSICAL RESOURCES

7.69 A large majority of prisoners with severe and enduring mental health problems are accommodated in mainstream halls. This is likely to involve sharing a cell in many cases, although a prisoner's mental health is usually taken into account in deciding whether or not to allocate a single cell. The overcrowding issues facing prisons at present are likely to have an impact on prisoners with severe and enduring mental health problems, and to serve to exacerbate their problems.

Accommodation and Facilities

Reception

7.70 The nature and quality of prisoner reception facilities varies across the SPS. Investment is being made to improve conditions, but in some prisons the conditions facing prisoners with mental health problems are not good. For example, in some prisons, individual small boxes remain in use, which effectively isolate a prisoner. As far as possible, doors are left open, and if staff are made aware of a prisoner's needs, they would try to ensure this was the case, or find another location in which to hold the prisoner. In some prisons assessments are conducted in full view of other prisoners.

Healthcare Centres

7.71 All prisons have some form of healthcare centre, designed to meet the general medical needs of prisoners, including prisoners with severe and enduring mental health problems.

7.72 Only one prison (Kilmarnock) has dedicated healthcare beds, and these are in the process of being removed. In Barlinnie previous healthcare beds have been replaced by day care facilities. The lack of day care facilities in most prisons is a source of frustration for staff.

7.73 Barlinnie has a Residential Care Unit, specifically for prisoners requiring additional support, who would struggle to cope in a mainstream hall. Not all prisoners in the Unit have diagnosed or undiagnosed severe and enduring mental health problems.

7.74 At Cornton Vale, most prisoners with severe and enduring mental health problems are located in Ross House. This area has a higher staff: prisoner ratio, and staff have been provided with additional training, including Mental Health First Aid. A mental health nurse is available to Ross House on an almost full-time basis. In addition, a day care facility is being developed within Ross House, which will provide a range of activities.

Interview Rooms

7.75 The conditions under which consultations take place vary greatly. In some prisons, these are wholly inadequate: for example, prisoners are sometimes interviewed by psychiatrists in corridors, or whenever there is space. The standard of interview rooms also varies between and within prisons.

Specialist Cells

7.76 Some prisons have a small number of specialist cells which may be used to house prisoners with severe and enduring mental health problems. These include:

- Ligature free cells designed for those subject to suicide risk management.
- A variety of three and four bed small units variously configured, allowing for vulnerable prisoners to have another prisoner in attendance at all times. In some cases, these units are in quieter locations than would be possible in mainstream halls.
- Some prisons have larger two-person cells which serve a similar purpose: these are sometimes called "buddy cells").

Segregation Units

7.77 In a small number of prisons, segregation units may be used to provide accommodation for prisoners with severe and enduring mental health problems. This is used when it is considered that a prisoner requires time out, or additional observation. Some prisons made it clear that they would not use the segregation for these prisoners.

Accommodation for People Detained for Assessment

7.78 No prison has accommodation specifically for people detained in prison for assessment, which staff generally describe as a "place of safety order". Generally, accommodation is identified within mainstream halls, or in small units or high dependency areas where these exist. In one prison, the only accommodation available is safe anti-ligature cells, which, it is acknowledged are "not always conducive to caring for individuals with severe and enduring mental health problems".

Issues and Problems with Accommodation and Facilities

7.79 The following issues and problems were raised in relation to **accommodation and facilities**:

- In general terms, almost all prisons consider that the physical resources available to them are inadequate to address the needs of prisoners with severe and enduring mental health problems.
- One of the key issues relating to accommodation is overcrowding.
- There are a number of impacts of overcrowding, including the fact that prisoners with severe and enduring mental health problems may be required to remain in their cells for up to 23 hours per day, with little access to activities or stimulation.
- Some prisons find it difficult to find work for prisoners with severe and enduring mental health problems.
- Most prisons have inadequate resources for group work and one-to-one working.
- Overall, there is considerable pressure on physical resources across the SPS: "There's not a cupboard that's not used for something".
- Some staff in segregation units have not received training in mental health issues, even though a proportion of the prisoners under their care may be likely to have either diagnosed or undiagnosed severe and enduring mental health problems.
- Concerns were expressed by prison and community health staff about the removal of healthcare beds. This has had the result that more prisoners who would previously have been located in a healthcare setting are being located in mainstream halls. This can have an impact on other prisoners, and on the regime.
- Even in prisons with high dependency units, the pressure on these means that some prisoners cannot be allocated places, and remain in mainstream conditions.
- Being located in halls makes it difficult for observation to take place.
- Some staff expressed concerns that "buddy cells" cannot be a substitute for either high risk cells, or healthcare beds.
- Some prisons have no facilities for prisoners taking time out, or requiring a quiet location, as would happen in a day centre setting.
- Most prisons have a lack of accommodation which can be used while a prisoner is awaiting transfer to hospital.
- The conditions in the "back cells" in Ross House in Cornton Vale are inappropriate to house prisoners with mental health problems, although they are occasionally used for this purpose.

CONCLUSIONS

7.80 In terms of **resources**, the main conclusions are as follows:

7.80.1 The general pressure on healthcare staff is considered to be increasing, with increasing demands arising from addressing general health issues. Overcrowding is seen to play a major part in this.

7.80.2 The level and nature of healthcare staff, and particularly mental health specialist staff varies widely across prisons. Generally, nursing teams are employed on a Monday to Friday basis, and there is little or no nursing cover on-site overnight or at weekends.

7.80.3 Some prisons are experiencing, or have recently experienced staff shortages in healthcare generally, with a knock-on impact in relation to mental health. Staff turnover is also high in some prisons.

7.80.4 Some prisons have a psychologist in post, some do not. Psychologists are more likely to work on programmes than directly with prisoners with severe and enduring mental health problems. Most prisons have access to a psychiatrist, although for a relatively small number of hours.

7.80.5 Overall, there is concern about the level of specialist staffing resources available, the number of competing priorities, and the extent to which existing arrangements have sufficient resilience to cope with, for example, a member of staff leaving, or periods of sickness.

7.80.6 In all prisons, residential and operational staff have a less well-defined, but still important, and increasing role, to play in relation to prisoners with severe and enduring mental health problems. A number of concerns were raised that staff: lack specific training (and find it difficult to access training); may lack confidence; may feel that they have not had sufficient guidance; may have insufficient time to interact with prisoners and may lack information about the prisoner's problems and the impact of any steps they take in working with them. These can lead to significant amounts of pressure and stress being placed on staff.

7.80.7 Healthcare beds have been phased out in virtually all prisons, which has given rise to concerns both within prisons, and among NHS staff. This means that more prisoners who might have been located in these beds are now located in halls, and it makes observation of prisoners' behaviour more difficult.

7.80.8 Some of the conditions in which interviews and assessments have to take place are inappropriate. Overall, there is a lack of space.

7.81 In terms of **joint working**, the main conclusions are as follows:

7.81.1 The main mechanism for joint working is the MDMHT. In some prisons, the residential unit manager, or individual officers attend, but there were mixed views about the benefits and drawbacks of this. There are variations in the nature and operation of MDMHTs.

7.81.2 The MDMHT's meet to varying schedules, and all discuss a subset of prisoners with mental health problems: in some cases, those giving cause for concern, in others, all prisoners with severe and enduring mental health problems on a rolling programme. There was a strong and consistent view that MDMHTs are a positive initiative.

7.81.3 Joint working takes place within prisons relating to individual prisoners. It involves specialist staff and, in some cases, residential or programme staff. The main concern about this relates to diverging views on information sharing and client confidentiality.

7.81.4 Relationships between hospitals and prisons largely surround the transfer of individual prisoners. There are also examples of joint working groups of which both prison and NHS staff are members. Generally, relationships were described as good by all parties, although in some cases, it is clear that, at least in part, these could be more effective. There are examples of a lack of understanding of each other's roles and constraints. Some psychiatrists considered that they were not afforded sufficient cooperation, or adequate facilities, by some prisons.

7.81.5 There are few difficulties relating to sharing information about prisoners on transfer to hospital, in part because hospital-based psychiatrists may be involved with the prisoner prior to transfer, in some cases for an extended period, and do not, therefore, require access to case notes.

8. RECENT IMPROVEMENTS AND THE USE OF PRISON FOR PEOPLE WITH SEVERE AND ENDURING MENTAL HEALTH PROBLEMS

8.1 This chapter summarises the nature and impact of improvements to the response to severe and enduring mental health problems amongst prisoners in recent years, and also the use of prison for people with severe and enduring mental health problems.

IMPROVEMENTS IN RECENT YEARS

8.2 There have been developments to the services available and to the processes for identifying and addressing mental health needs. There have also been improvements to the basic care provided, and the overall approach. This includes the development of the role of mental health nurses and some of the facilities, as well as a greater recognition of the role of healthcare staff in meeting the range of prisoner needs, and the improved involvement of these staff in addressing other issues. There are also increased options available in some cases, as well as better accommodation and conditions generally. In relation to local and regional secure mental health facilities, there have been changes to the overall forensic estate, which were continuing at the time of the inspection.

8.3 There have been improvements to joint working, with closer working relationships and better co-operation between disciplines. Multi-disciplinary working, positive relationships and the work of the MDMHTs were highlighted as particularly positive initiatives in addressing severe and enduring mental health problems.

8.4 Progress has also been made in throughcare, and in the development of improved communication with external organisations. The level of understanding of mental health issues in prisons has also increased.

8.5 More broadly, there is a growing recognition of the need to address these issues within the prison system:

"We are very slowly starting to recognise that it is in our interests to have positive strategies to address mental health illness and ensure mental health promotion to maintain good mental health."

8.6 The development of knowledge and awareness amongst prison officers is particularly important in this context. Some, but by no means all, officers are now more likely to recognise the potential links between a prisoner's behaviour and mental health problems, and the development of training has had a role in this. Some staff are now talking openly about mental health and want to do more. The changing role of officers was also acknowledged, and more officers now see the provision of care as an aspect of their role, although their involvement in actually addressing mental health problems is limited.

8.7 There is a greater acceptance of the mental health team in prisons than in the past. More generally, the stigma associated with mental health problems has reduced, both inside and outside prison, although there were examples from prisoners of continuing mixed experiences, and of inappropriate attitudes and assumptions from some staff and community members. Stigma remains a major issue. Alongside some changes to attitudes, there is also an increased willingness of those experiencing mental health problems to identify these and to come forward.

THE USE OF PRISON FOR PEOPLE WITH SEVERE AND ENDURING MENTAL HEALTH PROBLEMS

8.8 The use of imprisonment is inappropriate for people with severe and enduring mental health problems. All prisons have concerns about this:

"Prison should never be a place for people with severe and enduring mental health problems. They should never be here."

8.9 Reasons given for this are that a prisoner's primary need is his or her mental health and the appropriate place to address this is in a hospital. Another reason relates to the unsuitability of the environment and the lack of treatment and services available, with concerns that imprisonment can do little to tackle the problems of prisoners with mental health problems. Many examples were given of individual prisoners who had been imprisoned when they required hospital treatment, and concerns were expressed about prisoners who were sometimes "very unwell". It was also suggested that there could be a high risk in trying to manage people who are acutely ill in prison, where there are not facilities for this.

8.10 People with severe and enduring mental health problems may be being sent to prison because there is no viable alternative in the community:

"Care in the community has become care in the prison system."

8.11 Prisoners should receive appropriate care in a hospital setting. It is important to ensure that they receive appropriate treatment outside prison and are not left unsupported in the community, or placed in other inappropriate facilities.

CONCLUSIONS

8.12 In terms of overall **developments and improvements**, the main conclusions are as follows:

8.12.1 There is some positive work taking place with prisoners with severe and enduring mental health problems, despite some of the difficulties and constraints. There is also potential for further developments.

8.12.2 There have been developments to the services available in prisons, in terms of the basic care provided, the overall approach to mental health, and conditions for prisoners. There have also been changes in local and regional secure mental health facilities, in terms of the composition of the overall forensic estate.

8.12.3 Progress has been made in terms of throughcare, and in the development of improved communication with external organisations.

8.12.4 The level of understanding of mental health issues in prisons has increased, and the knowledge and awareness amongst some officers has also increased.

8.12.5 The stigma associated with mental health problems has reduced, both inside and outside prison, but it still remains a major problem.

8.13 In terms of **the use of prison for people with severe and enduring mental health problems**, the main conclusion is as follows:

8.13.1 The use of imprisonment is inappropriate for people with severe and enduring mental health problems. Their primary need is their mental health and the appropriate place to address this is a hospital.

9. RECOMMENDATIONS

9.1 Prison is not the most appropriate environment for a significant number of individuals with severe and enduring mental health problems. Alternative environments which can provide appropriate treatment, intervention and support should be identified.

9.2 Current provision for prisoners with severe and enduring mental health problems in prison is varied and inconsistent and dependent on the resources available to individual establishments. A clear recognition of the extent of severe and enduring mental health problems should be made, it should be afforded a high priority and there should be more consistency in provision across Scotland.

9.3 There is no shared understanding across SPS about the nature and scale of severe and enduring mental health problems. This lack of shared understanding should be addressed.

9.4 Overcrowding affects people with severe and enduring mental health problems, particularly when such prisoners are located in mainstream residential halls. The practice of locating prisoners with severe and enduring mental health problems in mainstream halls should be reviewed.

9.5 The identification of severe and enduring mental health problems in the Reception is not consistent and coherent. An early, systematic, exploration of mental health issues should take place in an environment which supports and enables the disclosure and identification of severe and enduring mental health problems.

9.6 The Multi Disciplinary Mental Health Team is designed to provide an effective forum for discussing prisoners with severe and enduring mental health problems, but not all cases are brought to the meeting. All new cases where severe and enduring mental health problems are suspected should be brought to the MDMHT, and should be regularly and systematically reviewed at subsequent meetings.

9.7 In some prisons, the input of non-healthcare staff is sought as part of the assessment process. This should happen in all prisons.

9.8 Some aspects of the treatment, intervention and support available to prisoners with severe and enduring mental health problems depend on the prison to which they are sent. Minimum standards of treatment, intervention and support should apply to all prisoners with severe and enduring mental health problems, regardless of where they are located, and staff should have relevant training and be provided with information to ensure that they are able to deal with issues arising.

9.9 Prisoners with severe and enduring mental health problems must have access to a regime which meets their needs.

9.10 Structured and sustained support should be provided to both male and female prisoners with severe and enduring mental health problems who are survivors of childhood sexual abuse.

9.11 The Residential Care Unit in Barlinnie is starting to become a de facto national resource. The number of places likely to be required in a high dependency setting similar to that provided in the Barlinnie Residential Care Unit, and the best means of meeting the needs for these places should be established.

9.12 The segregation unit in a prison is sometimes used to house prisoners with severe and enduring mental health problems. This practice must stop and alternatives to holding prisoners with severe and enduring mental health problems for long periods of time should be found.

9.13 Very few prisoners are given the opportunity to identify their own needs and provide feedback. This should be addressed.

9.14 Very few prisoners with severe and enduring mental health problems are aware that they have the right to access advocacy, and not all prisons provide an advocacy service. Advocacy must be freely available and understood.

9.15 Psychiatrists need to have adequate access to prisoners with severe and enduring mental health problems, or to appropriate facilities to conduct assessments.

9.16 Staff in some prisons are unaware of the criteria used by psychiatrists in determining whether or not a prisoner with severe and enduring mental health problems should be transferred to hospital. A clear and well understood policy should be communicated to all staff.

9.17 There is no standardised approach to preparation for release for prisoners with severe and enduring mental health problems. A formal, multi agency planning process should be put in place to identify the needs of prisoners with severe and enduring mental health needs on release, and to ensure that arrangements are made for continuity of care.

9.18 The provision of mental health specialist staff varies widely across prisons. Some prisons have a full time resource, others have little or none. Overcrowding in particular has led to increased pressure on healthcare staff generally. Mental health specialist staff and resources should not be diverted to other duties at the expense of the provision of mental health support.

9.19 Prison staff have an increasing role to play in relation to prisoners with severe and enduring mental health problems, but do not always feel adequately trained or prepared to do so. This can lead to significant pressure and stress. Structured training and support should be provided to prison staff working with prisoners with severe and enduring mental health problems.

9.20 A wide range of conclusions is highlighted at the end of each chapter of this report. All organisations involved in the care, treatment and management of prisoners with severe and enduring mental health problems should take account of these conclusions and develop their own practice to address them.

ANNEX 1

GLOSSARY

Act2Care	The SPS anti-suicide strategy
ADHD	Attention Deficit Hyperactivity Disorder
ASIST	Applied Suicide Intervention Skills Training
CBT	Cognitive Behavioural Therapy
CIP	Community Integration Plans
CJA	Community Justice Authority
CPN	Community Psychiatric Nurse
EACS	Enhanced Addictions Casework Service
ECMDP	Executive Committee for the Management of Difficult Prisoners
GPASS	General Practice Administration Systems Scotland
ICD-10	Integrated Statistical Classification of Diseases and Related Health Problems
ICM	Integrated Case Management
IPCU	Intensive Psychiatric Care Unit
LGBT	Lesbian, Gay, Bisexual, and Transgender
MAPPA	Multi Agency Public Protection Arrangements
MDMHT	Multi Disciplinary Mental Health Team
MHFA	Mental Health First Aid
NHS	National Health Service
PR2	The SPS computerised prisoner record system
PTSD	Post Traumatic Stress Disorder
RCS	Reliance Custodial Services
RMN	Registered Mental Nurse
SAMH	Scottish Association for Mental Health
SLA	Service Level Agreement
SPS	Scottish Prison Service
The Act	The Mental Health (Care and Treatment) (Scotland) Act 2003

ANNEX 2

INSPECTION TEAM

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