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Introduction

This report has been prepared by Mick Burns, NHS England/Improvement Offender Personality Disorder (OPD) Co-Commissioner and Neil Piggin, Her Majesty's Prison and Probation Service OPD Co-Commissioner with support from Jo Harris and Holly Cade, Secure Service Involvement Leads (Yorkshire and Humber). The report was commissioned by Julie Dhuny, NHS England/Improvement Head of Health and Justice Commissioning for the North of England and Alison Cannon, Head of Mental Health for the North of England. The report summarises findings from 3 workshops held over the summer of 2019 with providers of prison Mental Health and in-patient secure Mental Health services and 2 workshops with service users managed within separate prison and hospital based Mental Health settings. The purpose of the workshops was to scope opportunities for closer working between providers and commissioners of prison based Mental Health services and hospital based secure Mental Health services.

Background

As of 27th September 2019, there were 83,766 people in prison in England and Wales (79,907 men and 3,859 women). There are 35 prisons in the North of England: 5 in the Long Term High Secure Estate (LTHSE), 5 in the North East, 9 in Yorkshire and The Humber, 12 in the North West and 4 in the Women's Estate. The northern prisons account for in excess of 30% of the total prison population in both the male and female estates.

The most recent assessment by the National Audit Office (June 2017) estimated that 37% of the prison population will experience a Mental Health problem. In March 2017 7917 people were receiving active intervention for a Mental Health problem within the prison system. It is generally accepted that that prisoners are more likely to experience Mental Health problems than the general population. NICE report that the incidence rate for psychotic disorder in prisoners is 7% for sentenced prisoners and 10% for remand prisoners as opposed to 0.5% for the general population.

NHS England spends in excess of £150m annually on healthcare for individuals who come into contact with the Criminal Justice System across the North of England. Approximately 60%

of this figure is spent on prison health care of which 40% is spent on Mental Health care. There are approximately 2100 secure Mental Health beds in the North of England. NHS England spends approximately £330m on these services annually. NHS England Health and Justice Indicators of Performance in recent years have highlighted significant variation in numbers of prisoners being subject to the Care Programme Approach (both on reception and during sentence/remand) and significant delays in prisoners with mental health problems accessing secure hospital beds. Typically, approximately 100 prisoners a year will be identified as needing transfer into a secure hospital bed. Less than 30% of these transfers will take place within the 14 days identified in national guidance as being best practice.

Workshop Structure

Three separate workshops were held for providers across the North of England;

- 11th June – Preston
- 17th June – Durham
- 18th June – Leeds

The workshops were chaired by Julie Dhuny and facilitated by Mick Burns, Neil Piggin, Jo Harris and Holly Cade. The workshops included presentations from NHS benchmarking and TEWV NHS FT Clinical Teams and three interactive sessions (including interactive voting) which focussed on identifying priority areas for improvement across the system.

Two further workshops were held with service users on 19th August at HMP Durham and Roseberry Park Hospital in Middlesbrough. The workshops were facilitated by Jo Harris, Holly Cade and Mick Burns and followed a ‘drop in’ methodology which allowed service users to contribute to a graphic identifying issues that occurred at different stages of the pathway for them and how they felt at these times.

The workshops were well attended on all 4 dates, 86 members of staff from Mental Health provider organisations (both prison health and secure Mental Health) and NHS England participated in the provider workshops. Of the 15 service users available across the two sites visited 9 individuals contributed to the graphic produced. Direct care staff in both settings (both clinical and operational) were also given the opportunity to contribute to the graphic.

Workshop Themes

North West

The following priority issues were identified by participants in the workshop held in the North West;

- Fragmented System
- Prisons considered a place of safety
- Poor environments within prisons (incompatible with good Mental Health care)
- Lack of appropriate treatment options available in prison
- Late referrals close to sentence end
- Lack of knowledge in the system (prison providers unaware of who to refer to in secure Mental Health system)
- Complexity of client group
- Geographical distance from prison to access assessor (for out of area cases)

Participants were asked to sum up the issues identified in the workshops. These are represented in the graphic below.

what are your top 3 words to describe the issues?

Mentimeter

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It was clear from participants that they experienced the system as being fragmented, poorly served by communication and inconsistent.

North East

Participants at the North East workshop identified the following key themes;

- Access to beds (capacity)
- Lack of appropriate pathways for remission
- ‘Blockage’ of secure Mental Health beds (length of stay)
- Lack of understanding re. thresholds for admission to secure services
- Prisons being seen as a place of safety
- Expertise contained within secure Mental Health Services doesn’t always ‘get into’ prison

Participant summary of the issues is highlighted in the graphic below;

Participants highlighted fragmentation and poor communication as being key issues along with lack of capacity for mental health treatment within both prison and in-patient elements of the system.

Yorkshire and the Humber

The following priority issues were identified by participants in the workshop held in Yorkshire and the Humber;

- Communication between organisations and agencies needs to improve
- Too many service providers are involved/not working together
- Models of care in prisons are poorly defined and inconsistent
- Community provision doesn't link to courts or prisons effectively
- Lack of pathways for remission and for acutely unwell people (prison and hospital)
- Mental Health Act and National Policy contradict each other
- Information Sharing requirements across organisations prevent good pathway working

Participant summary of the issues is highlighted in the graphic below;

what are your top 3 words to describe the issues?

Mentimeter

communication
frustrating
fragmented
pathways
provision
inconsistent
improvement
inconsistency
ideology
ignorance
complex
breakdown
barriers
commissioning
perverse incentives
time
knowledgeable
processes
environmental
collaboration
continuity of care
too many providers
poor practice
information
private provision
traumatising
silos
spoil the broth
care models
cost
courts
investment
bureaucratic
inappropriate
need a strategy
consistency
availability
risk
no action
special
inconsistent
stressful
time restraint
it
providing
confusion
boundaries
evidence
neglectful
support
disappointed
medicalised
challenging
culture
systems
treatment
assessments
laziness
sharing
public pressure
deterioration
money
consistency lack of
leadership challenges
lack of communication
relationships
engagement
realistic
different priorities
too many cooks
lacking
understanding of mhact
workforce leakage
unsafe
no communication
biomedical
big dogs vs nursing care
systemic fragmentation
mental health act
poor
relapse
delays
resources
frustrated
revolving
fractured
insular practice
knowledge
capacity

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The feedback was consistent with that received in the North East and North West with fragmentation and poor communication again being highlighted.

In the follow up workshops in each hub participants were asked to identify how each of the issues identified in the previous workshop could be addressed at each discrete area of the pathway;

Management in Prison

General Themes

- Physical Environment
  - There is a lack of appropriate 'therapeutic space' to support individuals with Mental Health difficulties within the HMP estate, this applies to models for residential care and day care.
- Organisational
  - Mental Health is seen in isolation not as part of an integrated system, there needs to be better joint working with HMP staff and with other agencies in the prison. This work '*needs genuine partnership'*
  - Systems are not co-terminus. Prisoners are often out of area (health wise) so it is hard to identify who the appropriate secure Mental Health providers are in respect of completion of access assessments which determine whether someone meets the threshold for admission to a secure hospital bed.
  - Health models in prison are always reactive rather than proactive. There needs to be more thinking about the relationships between trauma, mental health and offending behaviour within prison-based health services.
- Resources
  - There is a sense that Mental Health investment in prisons has shrunk and that teams are unable to work in the way they want
- Potential Solutions
  - In reach from secure Mental Health providers (through new Forensic Outreach Liaison teams) to help jointly manage/care plan for the most complex cases that don't meet the threshold for hospital transfer

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Prison to Hospital Transfers

General Themes

- Issues with assessment and access
  - There is a lack of consistency/transparency in respect of clinical decisions/thresholds for admission to secure Mental Health care.
  - Long waiting times for beds and lack of ongoing support during that wait
  - There is a lack of understanding amongst prison Mental Health teams about the timescales and reason for the delays in access to secure beds
  - There is confusion about the types of in-patient services available (both clinical speciality and security level)
  - Particular issues were highlighted in respect of consistency and transparency when trying to access to high secure Mental Health beds
- Potential Solutions
  - Better liaison between secure Mental Health Services and HMP based health services.
  - More secure Mental Health beds
  - More consideration needs to be given to treatment options whilst someone is in prison. HMP Durham ISU Service provided in partnership with TEWV NHS FT was felt to be a model worth exploring in other localities.
  - Focussed transitional work with people waiting for admission to secure beds from secure Mental Health providers was felt to be a sensible option (it was suggested that this would reduce Length of Stay in secure beds longer term)
  - Mental Health Case Management (provided by NHS England Specialised Commissioning Teams) needs to be more effectively involved with prison-based cases.
  - Royal College of Psychiatry Quality Networks for secure Mental Health and prison based Mental Health services within the Royal College should integrate and look at transfer to and remission from hospital as part of their peer review process.

Management in Hospital

General Themes

- Closer working is needed between HMP Mental Health Teams and Secure Hospitals:
  - Hospital focus should be on stabilisation and remission not providing a whole pathway
  - Hospital admission should have clearly defined goals
  - Prison Offender Management Units should remain involved whilst prisoner is an in-patient to ensure in-patient stay is reflected in sentence planning.
  - Cases needing transfer should be managed under a 'joint responsibility' arrangement between HMP Mental Health teams and hospital based in-patient teams, not seen as the responsibility of one service or the other.
  - Prisoners who have longer term pathways through secure Mental Health services need a clear rationale for this.
  - Information needs to be used more effectively, there needs to be more consistency with respect to section 117 of the Mental Health Act, the Care Programme Approach and the role of the Care Coordinator.
  - Participants were clear that they felt the model in operation at HMP Durham (I Wing) and Jay Ward (TEWV NHS FT - Roseberry Park Hospital) should be implemented in the North West and Yorkshire and the Humber.

Hospital to Prison Remittals

General Themes

- The current Prison Service Instruction in respect of remittance from hospital to prison which requires the remission to take place via the nearest 'local' prison is not fit for purpose.
- The relationship between NHS providers and prisons is poor at organisational/strategic level
- The section 117 process (Mental Health Act) needs to be used more effectively
- Work on risk in hospitals is not currently recognised by the Criminal Justice System

Potential Solutions

- Focus some Mental Health investment into key prisons to help transition back into prison-based services
- Increased input to the process is needed from prison-based Offender Management Units and community-based Offender Managers to ensure work completed within hospitals is reflected in sentence planning and subsequent reports to the Parole Board
- Use the new 'localism' agenda within the secure Mental Health system to better link prisons and secure Mental Health hospitals together (connect prisons with provider collaboratives, ensure providers of secure Mental Health Services are invited to sit on Health and Justice Partnership Boards etc.)

Transitions from Secure Accommodation to the community

Main Issues

- NHS Commissioning of Health and Justice Services, secure Mental Health Services and community Mental Health Services is fragmented. This fragmentation is then reflected in service provision.
- Clinical Commissioning Group involvement in New Care Models and new provider collaboratives is unclear
- Local Authorities are not properly linked into the system

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- Local agencies (housing, benefits, employers etc.) don't routinely link into health and justice based secure facilities before release/discharge to support transition in to the community
- Community Team thresholds routinely exclude people with Forensic histories
- Problems occur at the end of statutory supervision, Criminal Justice agencies *'just walk away'* leaving other statutory organisations left managing difficult situations
- All services are too risk averse both secure and, in the community, this frustrates 'move on' and rehabilitation

Potential Solutions

- Forensic Outreach Liaison Services that are currently being piloted as part of the national review into secure Mental Health provision should work into prisons as well as secure hospitals to support transition across both elements of the pathway. This may require more investment than is currently available.

Service User Feedback HMP Durham ISU and Jay Ward Roseberry Park Hospital

Management in Prison

- Mental Health Care in prison is poorly linked to the community
  - There is no support from Community Mental Health Teams *'when we go to prison we are cut off'*
  - None of our basic needs are met when we go back into community – *'we are straight back into same situation – drugs and bullying, we need to be able to get a clean fresh start'*
  - Things are left until the last minute, stress of not knowing what is happening
  - Things are done to you not with you *'disinvolvement'*
  - We don't have much contact with family – there are stereotypes and stigma about Mental Health

- Prison Environments
  - Not good for people with Mental Health problems, they are too big, there are too many drugs, prison staff don't know enough about Mental Health – some prisons are worse than others *'the ISU is cushty though'*
  - It is stressful in prison – this doesn't help Mental Health
  - There is not enough Mental Health support in prison (we only get to see the Doctor once a fortnight)
- Experience in Prison
  - *'Racism to me'*
  - Stereotypes about Mental Health from other prisoners – there is a real stigma
  - It is stressful and frightening, there are too many drugs

Prison Transfers and Remittals

- Communication
  - There is not enough information provided about where you are going
  - There should be brochures showing you what it is like
  - Staff from hospital should come to see you before you move so you know someone when you move
  - They never stick to the plan (on remittal) communication with the main prison is poor (staff shut the hatch on you)
  - Probation are hopeless, they don't keep in contact when you are in hospital, OMU don't link in, sentence plan should include what you do in hospital, feels like we are forgotten about
  - We never know what's happening in advance – staff are not *'up front'* with you
- Experience in Hospital
  - I feel safer, it's quieter, there are less people and more staff

- There is stigma – big stigma about moving to a *'loony bin'*
- It's quieter but sometimes it's boring, there is not enough to do
- Staff are good, the food is good, the place is nice and clean
- Observations can be intrusive, there are more restrictions in hospital than in prison *'you can't have a shave when you want and I can have a kettle in my pad in prison'*, lots of things in hospital are banned/controlled.
- There are not enough opportunities to practice life skills *'you can get institutionalised'*

Links to Community on release/discharge

- Accommodation
  - Is not good enough *'hostels are awash with drugs you go straight back to where you were'*
  - I just need somewhere decent to live *'I'd be alright'*
  - There is no support from Mental Health Services on release *'I got recalled cos of psychosis – was really angry'*
  - People living in the community *'can be in a mental prison'*

What would make things better?

- In Prison
  - Better wings – single cells, more to do (acupuncture, mindfulness and other things that focus on well-being)
  - More staff training about Mental Health problems and how to speak to people with Mental Health problems
- In Hospital
  - More activities on and off the ward, it is boring sometimes

- More support with transitions – to and from prison and also to the community, Health Care Support Workers and prison operational staff should support with this.

- In the community
  - Somewhere decent to live
  - Support from Mental Health services and Probation

Recommendations

- Participants in the three provider workshops gave very positive feedback about the content and format of the meetings. They reported the process as inclusive and helpful, allowing issues to be discussed between providers and commissioners from both secure hospital and prison settings in a supportive environment. NHS England Health and Justice and Specialised Mental Health Commissioners should provide time and space for clinical and operational staff in these services to continue discussions.
- The workshops delivered in HMP Durham and at Roseberry Park Hospital were also well received. Using a 'drop in' format allowed participation from a significant proportion of the service users in each service. Staff in services remarked that they had never seen one of the participants talk so much. It was evident that the service users enjoyed contributing to this work. Providing an opportunity for individuals accessing Mental Health Services in prison to be involved in work at a strategic level has the potential to benefit the system generally as well as providing significant benefits for those individuals directly involved.
- It is clear that clinical and operational staff from both Specialist Mental Health and Health and Justice based services find the current system difficult to negotiate. Poor communication and fragmentation are the most frequently reported issues. There are current forums for providers and commissioners in both aspects of the system (Health and Justice Partnership Boards, Specialist Mental Health Provider Collaboratives etc.). There is a strategic role for Health and Justice providers and for Specialised Mental Health providers in the corresponding forums. This should be formalised allowing Health and Justice providers to contribute to the development of the new provider collaboratives in the

Specialised Mental Health system and allowing Specialised Mental Health providers to contribute to Health and Justice Partnership Boards.

- NHS England employs Mental Health Case Managers to support pathway working and the Quality agenda within secure Mental Health services. We would suggest that this role could be extended to allow those individuals to work into the Health and Justice system providing a conduit between the two.
- It was clear in all three provider workshops and through discussion with service users at HMP Durham and Roseberry Park Hospital that there was significant support for both the Integrated Support Unit (ISU) model and a dedicated ward environment for transferred prisoners. We suggest that resource is made available to replicate this model within the North West and Yorkshire and Humber areas.
- NHS England is currently making significant investment in the development of community services to help manage pathways in and out of secure Mental Health services. We think there is a clear role for these services to support transition between prison based and secure Mental Health services and to support prison-based staff in managing people with complex difficulties when those individuals don't meet the threshold for admission via a consultancy model.
- There are clear inconsistencies between the way local Mental Health services retain contact with individuals who come into contact with the Criminal Justice System. It is a significant concern to hear individuals report that they have been recalled to prison due to a deterioration in mental health and to hear prison-based staff report that prisons are used as a place of safety by the courts due to inability to negotiate suitable packages of care in local Mental Health services. When these situations occur, we believe they should be investigated under the auspices of a Serious Untoward Incident (in the same way that admission of children and young people to adult Mental Health beds are). NHS organisations (both provider and commissioning) should agree a compact to prevent these issues occurring going forward.
- We suggest that some thought should be given to models of Mental Health care in prison. The link between trauma and the development of Mental Health difficulties and offending behaviour should be made explicit within these models as should Mental Health promotion and awareness (to try and reduce stigma). Workforce development within prisons should

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include Mental Health awareness training for all staff, including those employed by the National Probation Service.

- It is clear that there is significant work to do in the community to help individuals who have had contact with Mental Health services within prison to resettle safely. Whilst this is out of scope for the project we have been asked to undertake we would suggest that work needs to take place within local systems to better link HMPPS agencies (prisons and probation) with local Mental Health and Social Care agencies (this could be achieved through the emerging provider collaboratives). We believe that there is significant transferable learning from the Offender Personality Disorder (OPD) Pathway Services (particularly Intensive Intervention and Risk Management Services) that would support this initiative.

We hope these recommendations are helpful, we recognise that the issues identified reflect the inherent complexity within the system, however we detected a tangible desire from all staff in the workshops and from the men in receipt of Mental Health provision that we met to 'make things better'. Finally, we would like to thank Julie Dhuny and Alison Cannon for inviting us to coordinate this work. We thoroughly enjoyed spending time with staff in all three workshop settings and with the men accessing the ISU at HMP Durham and Jay Ward at Roseberry Park Hospital.

Mick Burns, Neil Piggin, Jo Harris and Holly Cade October 2019