**Prison Health Needs Assessment:**

Technical Report

Thematic review 2013: mental health needs and provision across the Welsh prison estate

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**Purpose and Summary of Document:**

This technical document details the Health Needs Assessment of the current mental health needs and service provision within prisons in Wales. In addition this assessment will focus on the process aspects of mental health care delivery. It also contains details of the stakeholder priorities workshop where the report’s findings were discussed and a national implementation action plan agreed.

**An extended summary document is also available.**

**Publication/Distribution:**

- Prison Health Partnership Boards
- National Offender Management Services
- Welsh Government
- Public Health Wales Prison Group
- Prison Health Improvement Network (PHIN)
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<td>ACCT</td>
<td>Assessment, Care in Custody and Teamwork</td>
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<tr>
<td>CAMHS</td>
<td>Children and Adolescents Mental Health Services</td>
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<tr>
<td>CARATs</td>
<td>Counselling, Assessment, Referral, Advice Through-care</td>
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<td>GAD7</td>
<td>Generalised Anxiety Disorder Assessment</td>
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<td>HAD</td>
<td>Hospital Anxiety and Depression scales</td>
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<td>HCA</td>
<td>Healthcare Assistance/Officers</td>
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<td>HIW</td>
<td>Health Inspectorate Wales</td>
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<td>HMI</td>
<td>Her Majesties Inspectorate of Prisons</td>
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<td>HMP</td>
<td>Her Majesties Prison</td>
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<td>HNA</td>
<td>Health Needs Assessments</td>
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<td>IRM</td>
<td>Inter-Department Risk Management</td>
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<td>MAPPA</td>
<td>Multi-Agency Public Protection Arrangements</td>
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<td>MHIRT</td>
<td>Mental Health Inreach Team</td>
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<td>MHM</td>
<td>Mental Health (Wales) Measure</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>NOMS</td>
<td>National Offender Management Service</td>
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<tr>
<td>OMU</td>
<td>Offender Management Unit</td>
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<tr>
<td>ONS</td>
<td>Office of National Statistics</td>
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<tr>
<td>PCMHT</td>
<td>Primary Care Mental Health Team</td>
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<tr>
<td>PHPQI</td>
<td>Prison Health Performance and Quality Indicators</td>
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<td>PHQ9</td>
<td>Patient Health Questionnaire Depression Scale</td>
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<tr>
<td>RtP</td>
<td>Ratio of staff to prisoners</td>
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<td>SALT</td>
<td>Speech and language therapy</td>
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<td>SMI</td>
<td>Severe and enduring mental illness</td>
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<td>SOTP</td>
<td>Sex Offender Treatment Programme</td>
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Introduction

In 2006 Local Health Boards officially took over the commissioning responsibilities for healthcare services for public sector prisons in Wales from the Welsh Government. It was agreed in this, and several previous and subsequent statements, that it was the responsibility of the local NHS organisations to commission health services of the same range and quality as the general public receives in the community. It was therefore the responsibility of the local NHS organisations to assess the health need of the local prison population and commission appropriate services to meet these needs.

However, it is well acknowledged that the healthcare needs of the prison population are different, and greater, than those of the community so simply providing the same level of services would not appropriately meet need. In addition much prison healthcare provision was based on a historic pattern of services which may not necessarily meet the needs of the modern day prisoner and may need re-thinking. Historic patterns of services do not take account of changes that have occurred over time such as the shifts in the patterns of disease and subsequent need due to the aging prison population. Additionally, they often do not allow for the most current services which are based on advances in clinical management, such as new drugs and interventions, and advancing medical knowledge and diagnostics. Finally, they do not account for changes the populations expectations around their healthcare, which may be particularly important for mental healthcare.

A general Health Needs Assessments (HNA) is a requirement by the local Health Board and as such they have been carried out on an approximately three-yearly basis. A Health Needs Assessment is a systematic method for reviewing the health issues facing a given population and leads to a list of agreed priorities and, ideally, resource allocation to improve health and reduce inequalities. There are three main aims of health needs assessment and these are to:

- To estimate the current level of need
- To build a picture of current service provision i.e a baseline
- To plan, negotiate and change services for the better and to improve health in other ways
In 2011 Public Health Wales held a workshop for stakeholders from across the Welsh prison estate to discuss the way HNA were carried out in Wales. At the workshop it was agreed that future HNA should move from the previous model of assessing each prison individually every three years and towards an annual programme of thematic HNA, with a full assessment performed every five years. It was felt that thematic assessments, through examining smaller healthcare domains, would provide more useful feedback on areas of specific concern. Attendees prioritised health areas which they felt required a focused HNA, and it was decided that mental health should be the focus for 2012/13. The first thematic review, examining pharmaceutical care has recently been completed and the other agreed themes included oral health care, substance misuse, and older persons care, followed by a full health needs assessment for each prison.

There are therefore two main distinctions between the current report and previous HNA; they are that the current thematic HNA includes all five prisons in the Welsh prison estate and focuses exclusively on mental healthcare. Further to this, it was decided after consultation with stakeholders that the current needs assessment would focus primarily on the process of providing mental health care including the Donebedian elements of:

- **Needs**
  Population served / previous MH problems / currently symptomatic
- **Structure**
  Ratio of healthcare staff to prisoners / access / services / training / protocols
- **Process**
  Assessments done/ waiting times for assessments/ referrals / waiting times for referrals
- **Outcome**
  Anti-depressant medication / hospital transfers / self-harm / suicides

The justification for this focus was threefold. Firstly, while the lack of services was of clear concern, as illustrated in initial workshop described later, the National Institute for Health and Clinical Excellence (NICE) has recently commissioned guidelines on the effectiveness and cost effectiveness of interventions for the prevention and early treatment of mental health problems in offenders (NICE 2012); therefore it was agreed to be sensible to wait for the
publication of these guidelines before altering services (the publication date for these guidelines is currently not available).

Secondly, after a review of recent Welsh Government, Health and Prison policies it became apparent that a large number of them focus fully, or partially, on the process of mental healthcare; these included:

- Mental Health Measure (Welsh Government)
- 1000 lives health improvement models (Public Health Wales)
- Common mental health disorders (identification & pathway) (NICE)
- Prison Mental Health Pathway (Welsh Government)

Thirdly, as all prisons in the Welsh prison estate have recently migrated from a system of paper medical records to an electronic records system, called SystmOne, it was suggested that a HNA with a focus on the process of mental healthcare delivery, utilising SystmOne, could subsequently provide a template for use in self-audit and evaluation.

1. Descriptions of prisons

The Welsh prison estate consists of five prison establishments in total and a brief description of each is provided below:

**HMP Cardiff**

HMP Cardiff is a Category B Local/Training Prison which holds adult male prisoners, including young adults on remand, who are drawn predominantly from the surrounding court catchment area in South East Wales. It consists of 11 units and wings, some of which are based in the Victorian wings (refurbished in 1996) and other are based in buildings newly build in 1996. HMP Cardiff accepts people remanded into custody from the courts in its catchment area, Category B & C prisoners and stage 1 and 2 lifers. It has an operational capacity of 804 at present (current occupation 804).
HMP Parc and YOI

HMP Parc is a Category B local prison housing approximately 1200 male adults from across the UK (convicted only); it also houses young persons (15-17 years; both convicted and remand), young offenders (18-20 years; both convicted and remand) and Vulnerable Prisoners (both convicted and remand). The prison opened in November 1997 and is the only private prison in Wales, managed by G4S on behalf of the National Offender Management Service (NOMS). HMP Parc has 20 units and wings at present, with an operational capacity of 1,474 (current occupation 1,443), and is due to undergo further expansion to bring the operational capacity up to approximately 2,000 including both adults and young people.

HMP Swansea

HMP Swansea is a Category B Local Prison which holds adult male prisoners, including young adults on remand, who are drawn predominantly from the surrounding court catchment area in South West Wales. It consists of five wings, most housed within its Victorian buildings, and has an operational capacity of 435 prisoners (current occupation 424).

HMP Usk

HMP Usk is strongly links with its neighbouring prison HMP Prescoed. HMP Usk has a long and varied history as a penal establishment, but in May 1990 it became an Adult Category C establishment for convicted Vulnerable Prisoners. It currently has four wings, 3 based in the original Victorian buildings and one based in a new building built in 2003. It currently has an operational capacity of 273 prisoners (current occupation 258). It accepts category C and D prisoners, with a minimum of 9 months of their sentence left to serve.

HMP Prescoed

HMP Prescoed is a purpose built hutted camp erected by prisoner labour and opened in 1939 as an open Borstal. It is currently a Category D open prison of convicted adult males, including sex offenders. It consists of 10 units and wings housed in both the original buildings and also the extension built in 2002. Operational capacity is currently 230 prisoners (current occupation 225).
2. Current policy context

The Mental Health HNA comes at a time when several other changes are being made to relevant policies which may, in part at least, affect mental health service delivery and monitoring. These can be broadly divided into policies developed by Welsh Government, prison specific policies and mental health specific NICE guidelines.

At the end of 2012 the Welsh Government introduced the Mental Health (Wales) Measure (MHM). The MHM was designed to improve mental health care by outlining legally binding pathways and care and treatment plans for mental health care in Wales. The MHM aims to facilitate the provision of mental health services at an earlier stage for individuals who are experiencing mental health problems to reduce the risk of further decline in mental health; both for those experiencing mental health problems for the first time and for those with more chronic or reoccurring problems (National Assembly of Wales 2010). The MHM sets out new statutory provisions in the following four distinct areas (Wales Mental Health in Primary Care 2012):

- Part 1 - Local Primary Mental Health Support Services
- Part 2 - Care Coordination and Care and Treatment Planning
- Part 3 - Assessments of Former Users of Secondary Mental Health Services
- Part 4 - Mental Health Advocacy (Not applicable in a prison setting)

Under Part 1 the measure places a statutory duty on local authorities and Health Boards to work together to expand and strengthen mental health services at a primary care level. Part 2 requires that all individuals assessed as requiring secondary level mental health services receive a detailed care and treatment plan and that the Local Authorities and Health Boards should work together to improve the effectiveness of services. Part 3 makes provision for individuals who have previously received care from secondary services to be able to self-refer back into these services for assessment if they feel their mental health has deteriorated and once again requires treatment. Part 4 acts on evidence that service provision driven by service user advocacy often lead to more appropriate services; however this part of the MHM is currently not applicable to prisons. Parts 1-3 of the MHM are applicable in a prison setting and are likely to influence the services provided and pathways to care.
The MHM forms part of a cross-government strategy for mental health and wellbeing in Wales, Together for Mental Health (Welsh Government 2012a), which was launched in October 2012. The strategy is designed to improve mental health outcomes for individual and their carer/family through a “recovery and reablement approach”. It also recognises the benefits of improving mental wellbeing for people across Wales. The Delivery plan, developed alongside the strategy, covers the period 2012 to 2016 and makes reference to guidance for prisons (Welsh Government 2012b). In this plan there is a commitment to develop Policy Implementation Guidance on Prison Mental Health Services and the current HNA may inform this process.

These guidelines will also link in with the Prison Mental Health Pathway, originally published in 2006, and the Secure Mental Health Services Action Plan for Wales recommendations to improve the provision of secure mental health services across Wales. The action plan called for several changes to service provision, including the development of a wider range of secure accommodation and new specialist services especially for young people transitioning to adult mental health services. The actions within the Secure Mental Health Services Action Plan covered the period from April 2010 to December 2011 and are currently being reviewed in the context of the age-inclusive, cross-governmental aspects of Together for Mental Health. Recommendations as to the next steps will be submitted to the new National Mental Health Partnership Board in the Autumn of 2013.

In recent years the Welsh prisons have used the Health Service for Prisoners Performance and Quality Measures (also known as the Prison Health Performance and Quality Indicators (PHPQI)) (Welsh Assembly Government 2010) to evaluate the healthcare provision. However, in 2012, after consultation with stakeholders, it was announced that the Welsh prisons would move away from the PHPQIs and adopt a 1000 lives plus model of health improvement and service monitoring. In keeping with the 1000 lives plus model, these will focus more on the process aspects of health care and will take advantage of audit and self-monitoring potentially of the recently introduced electronic medical records system for prisons, SystmOne. At the present time the exact measures to be used in the prison healthcare evaluation model have not been finalised.

In terms of mental health guidance, NICE has recently produced several guidelines in the area of mental health care. Of particular interest are the
guidelines: Depression: Treatment and management of depression in adults (NICE 2009); Generalised Anxiety Disorder and Panic Disorder in adults (NICE 2011b); Self-Harm: Longer term management (NICE 2011c); and Common mental health disorders: Identification and pathways to care (NICE 2011a). All sets of guidelines detail the most recent, evidence based, assessment and treatment methods for mental health conditions and it is considered clinical best practice to implement these guidelines whenever possible. In addition, NICE has recently commissioned a review of mental health interventions suitable for use in a prison environment, it is envisaged that this review will be published in ~2 years time and will provide the best evidence on cost-effective evidenced-based practice. Finally, a Self-Harm quality standard (not prison specific) will be introduced in June 2013 (NICE 2013).

3. Mental health and the prison population

A review of recent literature was used to collate information on the prevalence of mental health problems of prisoners; details on the search terms and methods can be found in the appendix. There is a large body of evidence that suggests the prison population is at a substantially higher risk of having or developing mental health problems compared to individuals of similar age and gender in the community. This relationship is likely to develop in both directions, i.e. mental health problems leading to criminal activity or visa versa, often creating a viscous circle of recidivism. For example, a recent review found that reoffending rates for those individuals with mental health problems were increased by 40% compared to offenders without mental health problems (Fazel & Yu 2011). Additionally, high rate of drug use among this population are thought to result from, and play a role in, both the development of mental health problems and criminality.

In addition to an increased risk of both recidivism and drug taking, mental health problems are also known risk factors for suicides and self-harm episodes (Way, Miraglia & Sawyer 2005). Among sentenced prisoners suicide rates have been estimated to be four to five times higher within prisons compared to the general population (Fazel, Grann & Kling 2011). A survey of prisoners found there was a 7% prevalence of recent self-harm and a 20% prevalence of suicidal thoughts in the last year (Office of National Statistics 1997).
Research has shown that rather than a single type of mental health problem being raised in the prison population, there are raised levels across all the three main categories of mental health problems: Personality Disorder, functional psychosis and neurotic disorders (described below). Table 1 below illustrates, using data from the Office of National Statistics (ONS), the stark difference between the burden of mental health within the prison population compared to the general population. It shows approximate comparisons between the prevalence of three broad categories of mental health disorders (Personality disorder, Functional psychosis, and Neurotic disorder) between sentenced male prisoners (ONS 1997), estimated using clinical interviews, and men in a community sample, estimated through self-report (ONS 2000).

Table 1. Comparison of prevalence of the three main categories of mental health disorders amongst the prison population and the general community (ONS 1997; ONS 2000).

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<tr>
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<tbody>
<tr>
<td>Personality Disorder</td>
<td>64%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Functional psychosis</td>
<td>7%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Neurotic disorder</td>
<td>40%</td>
<td>13.5%</td>
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**Personality Disorder**

Individuals with Personality Disorder have personality characteristics that differ significantly from the societal norms, often leading to antisocial behaviour (including criminal behaviour), distress and suffering of both the individual and others. *The offender personality disorder strategy* places a shared responsibility on the NOMS and NHS for the management of individuals with Personality Disorder, illustrating the complex nature of this disorder, and encourages a whole system pathway approach (DoH & MoJ 2011). Knowledge and perceptions of Personality Disorder has changed considerably in recent years, which may affect the comparability of different studies; however, prevalence of Personality Disorder in the prison population is estimated to be about ten times higher than in the general population. The ONS survey, which included 1,254 sentenced male prisoner from across England and Wales and assessed mental health disorders using both lay and clinical interviews, found the prevalence of Personality Disorder to be over 11 times higher than that seen in the
community; approximately two thirds of inmates showing clinical signs consistent with personality disorder (ONS 1997). A study by Lincoln University found that, amongst 173 probationers under the local probation service, 47.4% were “likely cases” of personality disorder (Brooker, Sirdifield & Blizard 2011); nine times the estimated community prevalence. International comparisons are not available for Personality Disorder as a recent review excluded Personality Disorder from its meta-analysis due to the “high hetero-geneity reported in the previous work” which means that the studies are not conducted using comparable methods (Fazel & Seewald 2012).

**Functional psychosis**

The second broad category of mental health problems are functional psychoses, which are severe emotional disorders characterised by personality derangement and loss of ability to function in reality (excluding those attributable to physical problems with the brain). It includes conditions such as schizophrenia and bipolar disorder and is associated with hallucinations, delusions, catatonia and/or thought disorders; all of which can make sufferers agitated and unpredictable. In the sentenced male prison population the rates of functional psychosis are estimated to be 14 times higher than in the community according to the ONS survey (ONS 1997), with one in 14 prisoners meeting the definition for having probable psychosis in the past year. The study of Lincolnshire probationers found a prevalence of psychotic disorders of 8.1%, slightly higher but comparable with the ONS estimate, and 16 times higher than the rate seen in the community (Brooke, Taylor & Gunn 1996).

Looking internationally, a study of French male prisoners found, according to two clinician interviews, that 12.1% could be diagnosed with a psychotic disorder (Falissard, Loze & Gasquet 2006); which is higher still than the prevalence seen in the UK. However, these estimates are substantially higher than those reported in a meta-analysis of worldwide data (Fazel & Seewald 2012), where a combined figure of 3.6% (CI 3.1-4.2%) was reported. It is unclear from the review however whether this figure includes just those who are currently unwell, but even this lower estimate represents a seven fold increase in the rate of psychosis compared to the community.

**Neurotic disorders**

The third category, neurotic disorders, includes conditions such as depression, anxiety and obsessive-compulsive disorder. Although the prevalence of these
disorders is raised to a less extreme extent when compared with the other disorder groups, the occurrence of neurotic disorders is estimated to be three times higher in the ONS survey of the sentenced prison population (40%) compared to the general population (ONS 1997; ONS 2000). It would appear that the grouping of neurotic disorders is not as routinely used as the two previous categories, which makes it more difficult to compare prevalence estimates across studies. However, among probationers in Lincolnshire a similar proportion showed signs of conditions within the category of neurotic disorders, with 15% of participants showing current mood disorders and 21.4% currently suffering with anxiety disorders (Brooke 1996). On an international stage, a study of French male prisoners found, according to two clinician interviews, 21.2% could be diagnosed with a neurotic disorder; this is substantially lower than seen in the UK studies but remains substantially higher than the prevalence seen in the community (Falissard Loze & Gasquet 2006).

**Prisoner age**

There have been a few studies that have looked at mental disorders in respect to specific age groups of prisoners. One small study of 100 15-17 year old males on remand in Denmark found that 69% had a history of a mental health problem in the past year (Gosden, Kramp & Gabrielsen 2003). 36% had a history of probable personality disorder, rising to 66% if conduct disorders are included within the category of personality disorders. 41% were reported as having a substance misuse problem and 4% had a diagnosis of psychosis. These figures are slightly lower than those seen in adult prisoners.

Kakoullis et al (Kakoullis, Le Mesurier & Kingston 2010) performed a review of previous studies looking at the prevalence in older prisoners and found there was very little evidence available and most was from the USA. The overall levels of mental health problems in four British studies of older prisons appeared to indicate lower levels than the general prison population, where 92% met the definition for at least one mental health disorder, including substance misuse (ONS 1997); however it is possible that diagnostic categorisation may account for the difference. Fazel in 2001 found, 53% of those over 60 years of age had some sort of psychiatric diagnosis (Fazel, Hope & O'Donnell 2001); Le Mesurier found a prevalence of mental health diagnosed of 48% in the over 50’s (Le Mesurier 2009); in the same age bracket Kingston et al (Kingston, Le Mesurier & Yorston 2011) found a very similar overall level of mental health problems, with 50% of participating prisoners having a diagnosable mental health problem; finally, in the most recent study (Hayes, Burns & Turnbull 2012) a slightly higher but comparable rate of 61% was reported, for those over 50 years of age.
The prevalence of a diagnosis of psychosis appeared to be relatively consistent with the rates seen across the general prison population at 4.9%, 13.3% and 5% for the Fazel, Le Mesurier and Kingston studies respectively. The rates of depression however seem slightly elevated, with prevalences of 29.6%, 42% and 41.3% reported for the Fazel, Le Mesurier and Kingston studies respectively; this is in comparison to the 19% with Mixed anxiety and depression disorder and 8% with depressive episodes in the ONS survey (ONS 1997) and 0.7% and <0.3% for the same disorders in the community (ONS 2000); this may reflect both a difference in diagnostic categories included and also changes in prevalence over time. Interestingly, the prevalence of dementia was also measured in two studies and ranged from 1-2.5% which is in keeping with community estimates (Alzheimer’s Society 2013).

Finally, in the study of 262 prisoners aged 50 years or older published in 2012 (Hayes, Burns & Turnbull 2012) they found that overall prisoners aged between 50-59 years were significantly more likely to have a mental health diagnosis that those aged 60-69 years; the same pattern was seen for all mental health disorders examined and the trend was significant in the majority of cases.

**Prisoner type (sentenced or remand)**

The ONS survey (ONS 1997) found that, across all three of the main categories, the level of mental health problems was higher in male remand prisoners compared to those who had received a sentence. For Personality Disorder there was a 14% difference, with 78% of remand prisons classified as having Personality Disorder, compared to 64% of sentenced prisoners. For psychosis, 10% of remand prisoners met the criterion for "probable psychosis", compared to 7% of sentenced prisoners; and for neurotic disorders the difference was more pronounced at 59% compared to 40%. All these figures are significantly higher than those found in a separate survey of unconvinced prisoners in England, where 11% were diagnosed with Personality Disorder (using semi-structured interviews conducted by a forensic psychiatrist), 5% with psychosis and 26% with neurotic disorders (Brooke, Taylor & Gunn 1996). However, contrary to both, the international review found no significant evidence that the prevalence of depression or psychosis differed significantly by their remand or sentenced status (Fazel & Seewald 2012).
Additionally, a prospective cohort of newly received prisoners across England (Hassan, Birmingham & Harty 2011) found that, while there was a significant improvement in the general mental state of convicted male prisoners over time (using both the General Health Questionnaire and the Brief Psychiatry Rating Scale), there was no improvement seen for those on remand.

**Under-diagnosis**

The Lincoln study provides clear evidence of under-recording or under-diagnosis of mental health problems, at least amongst the local probation population (Brooker, Sirdifield & Blizard 2011). They found that only 21% of those identified as likely cases of Personality Disorder had been recorded as such in the probation service notes. Similarly, only 33% of those identified as suffering from a current psychotic disorder had been identified. Current neurotic disorders, including mood disorders and anxiety disorders, were slightly better reported with 73% and 47% respectively of those identified by the study actually reported as such in the notes. Alcohol and drug problems were more likely to have been identified and recorded by probation staff, with 79% and 83% of those originally identified having appropriate information in their notes.

There is further evidence of some degree of under-recording in the Count-Me-In census of 258 inmates from across Welsh prisons in 2009 (NEPHO 2011). The census looked at prisoners medical records and found that 33% of prisoners had a record of Personality Disorder, far lower than estimates from surveys involving the medical assessment of prisoners. However, 35% had a neurotic disorder documented, which is in line with other estimates. Interestingly, 18% had a psychotic disorder documented; this is higher than other estimates but it is unclear whether the survey only looked for current or recent disorders as is the case in the majority of other surveys.

**Trends**

A worldwide systematic review of severe mental illness in 33,588 prisoners (Fazel & Seewald 2012) found that high levels of mental health problems had been consistently reported across the world for the past forty years. They found some evidence that the prevalence of mental health problems were higher in middle and low income countries, although the smaller number and scale of studies in these areas prevented any definite conclusions being drawn. Interestingly, they found that there was no evidence of any trend in the prevalence of either psychosis or major depression over time.
The prospective cohort of newly received prisoners across England (Hassan, Birmingham & Harty 2011) looked at the mental health status of prisoners with a diagnosed mental health illness during their stay in prison. The study found that, using the General Health Questionnaire, the mental health state of those with major depression improved significantly over time in a linear fashion; a finding replicated using the Brief Psychiatric Rating Scale. For those with Psychotic disorders there was again an improvement seen for both scales, but in this case improvement was seen after the first week but then levelled off.

4. Inspectorate report findings

A national HM Inspectorate review of the mental health of prisoners in 2007 (Her Majesties Inspectorate of Prisons (HMIP) 2007) and an evaluation of in-reach services by OHRN in 2009 (OHRN 2009) both found major service failures and that often services was under resourced and unable to meet all the mental health needs of prisoners. In 2009 85% of Mental Health In-reach Teams (MHIRT) across England and Wales reported that their teams were not sufficiently well staffed to meet the needs of the prisoners; team leaders of those MHIRT that responded to the survey also indicated that “triage by primary health care was poor due to the lack of resources and a lack of expertise”. One of the main findings of this study was that “the vast majority of prisoners with SMI (severe and enduring mental illness) were not identified or treated by prison mental health in-reach services”. The 2007 report states that “worryingly, those with a high level of need were less likely to be followed-up appropriately by healthcare staff than those with less need”.

Across the Welsh prison estate the HMP Inspectorate reports reveal a mixed picture in terms of mental health care when they were last inspected between 2008 and 2010. Some reports describe mental health services as “very good, with a comprehensive primary mental health service” whereas others were described as “very pressured with insufficient staff” and those mental health care staff there were weren’t “employed predominantly on mental health duties”. There was also both praise and criticism of the relationships between the different elements (formal and informal) of the care pathway:

“Mental health services were very good, with a comprehensive primary mental health service that included counselling and therapeutic day services”

“The primary team had excellent relationships with the mental health in-reach team who provided strong support”
“All prisoners were screened for mental ill health indicators on arrival and at secondary health assessment and there were tight referral processes to enable prisoners with mental health needs to be referred early and appropriately”

“Transfers to secure units managed expeditiously when required”

“There was good awareness [among discipline staff] of particular prisoners at heightened risk of self-harm”

“Any prisoner already known to external mental health services triggered the CPNs to contact the service to discuss them and their care in the community”

“The quality of service had been severely compromised by inadequate staffing levels for some time”

“Healthcare services were not delivered to an acceptable standard”

“Delays of up to 6 weeks for patients waiting for medium and high secure beds”

“Neither discipline staff nor healthcare staff were provided with any mental health awareness”

“Some signs of vulnerability were missed or not pursued”

“A new arrival presenting as in need of support was placed on the waiting list for a full assessment by an RMN but the waiting list had 61 prisoners on it and the average wait was at least a month”

These reports provide a clear indication that some areas of mental health care in the Welsh prison estate require rapid improvement. However, they also indicate that practices within some prisons may provide examples of good practice that would be mirrored by others within the estate.
Methods

A standard Health Needs Assessment tool for use in prisons has been developed and used previously both within Wales and elsewhere (Marshall, Simpson & Stevens 2001). The model suggests three separate elements of data collection: the Corporate, whereby stakeholders views on the needs, services and solutions are canvassed; the Comparative, whereby the prisons under review are compared to a standard; and the Epidemiological, whereby need and service provision and use is estimated using quantitative disease prevalence data.

Permission to conduct the HNA was requested and received from the Governors of all prisons involved, including the comparator prisons. Additionally, checks were made with the Public Health Wales Information Governance Lead to ensure that all appropriate permissions had been sought.

1. Corporate

Workshops

The Corporate element of the HNA incorporated two aspects. Firstly, two workshops were held, to which all key stakeholders were invited. Stakeholder mapping was undertaken as part of the planning process for this HNA. This was done in collaboration with the Public Health Wales lead Consultant for Offender Health and the Welsh Government lead for Offender Health. Through this process a number of organisations and individuals were identified and invited to attend the workshops. These included:

- Prison Governors
- Prison healthcare/mental health Leads
- Public Health Leads for prison HNA
- Local Health Board representatives
- Prison in reach representatives
- NHS Lead for prison health
- Manager for SystmOne
- Health Inspectorate Wales representation
- User representatives: Hafal/Gofal/The Samaritans/ Friends and Families of Prisoners Service
The first workshop took place in the early stages of the process to clarify the proposed direction of the HNA, gain insight into how this may be most effectively carried out and obtain a consensus agreement on this. A prime focus of the workshop was to outline a HNA that would be useful for all five prisons. Thematic analysis was used to group the areas of concern, roughly during the workshop and then more thoroughly afterwards. The second workshop, taking place towards the end of the process, was designed to discuss the recommendations put forward by the HNA and produce a stakeholder agreed prioritised action plan, with agreed timescales and future monitoring mechanisms.

**Stakeholder discussions**

The second aspect of the Corporate element involved informal discussions with the mental health leads at each of the prisons. The purpose of these discussions was to gain insight into the data and also elicit any additional information not captured during any of the formal aspects of the HNA. In order to maintain an informal atmosphere notes were taken during these meetings but they were not recorded verbatim; this method was also preferable given the lack of resource available to transcribe any recorded interviews. The discussions centred on the questionnaire completed by all prisons (discussed further below) and also the epidemiological data (also discussed further below) and a list of key topic areas were covered, these included:

- Facilities available
- Organisation of mental health care (e.g. nurse led, Connection to inreach)
- Staffing levels and specialist mental health in reach support available
- Services available & therapy levels
- Links with education and work etc
- Staff training
- Policies and protocols
- Care pathways (selfcare/informal, primary, secondary)
- Assessments/identification of issues/monitoring
- Medications
- Patient focused care plans
- Waiting times
- Transfers of care
- Mental Health Measure
- Discharges, communications, links to external agencies, reports
- Unmet need
- Other issues
Ideally the views of service users within the prison on their needs and unmet needs would have also been collected. Similar HNA within prisons have attempted to use interviews or questionnaires provided by prisoners themselves. However previous experience within Wales and elsewhere have shown limited success, with low response rates and difficulties in arranging interviews and finding prisoners willing to be interviewed. Therefore this approach was not attempted here.

2. Comparative

The Comparative element of the HNA involved comparing mental health care with two main sets of comparators. Firstly, the five prisons within the Welsh prison estate were compared to each other to see whether adopting set processes across the entire estate could improve mental health care services. Secondly, the five prisons were compared to two exemplars of good practice in terms of mental health care within a prison environment – HMP Liverpool and HMP Nottingham; originally HMP Bristol was also approached but, after initial agreement, it was not possible to collect the data in time for this HNA. Both comparator prisons hold over 1,000 prisoners, are category B prisons and are local prisons housing both remand and convicted prisoners from the surrounding areas; thus making them most comparable to Cardiff Prison.

Data for the Comparative element of the HNA was collected using a specially designed 10 page questionnaire that covered similar areas to those covered in the Corporate element, such as: health care facilities, staffing levels and staff training, services available, policies, practice and care pathways. A copy of the questionnaire can be found in the appendix.

3. Epidemiological

The epidemiological element of the HNA involved using quantitative data, from both the general literature and SystmOne, to estimate the prevalence of mental health problems and symptoms in the prison population, and also to examine service delivery. The epidemiological element of a HNA also often covers a review of effective and cost effective interventions, however this was not done on this occasion as NICE are due to publish guidelines on mental health interventions in the prison population relatively soon.
The majority of information was extracted from SystmOne, the newly installed electronic medical records system. As SystmOne has not been in place in Wales for very long, and modifications were made for the purposes of this HNA, a 3 month period between July and September 2012 was used to trial the changes and aid with data quality and completeness; data was then extracted for the HNA for between October and December 2012.

The different aspects of the epidemiological element are discussed below:

**Prison population**

Population estimates of the total population in HMP Swansea, HMP and YOI Parc, HMP Cardiff and HMP Usk and Prescoed will be extracted and broken down into age bands. This information will be collected as a snap-shot both from SystmOne and through interview/questionnaire.

**Mental health need**

Mental health need will be calculated in three distinct ways. Firstly, published estimates of the prevalence of various mental health diagnoses, retrieved during the literature review, will be applied to the population of each prison to produce an approximate number of individuals likely to suffer with each condition; this will take into account the different ratios of remand to convicted prisoners in each establishment. SystmOne was not used to provide these figures as it was felt that the READ coding for these conditions would be unreliable.

Secondly, the number of prisoners recorded on SystmOne as experiencing symptoms in each of the mental health domains (e.g. sleep disturbances, anxiety) at both initial primary care screen and second screen was summarised.

Finally, the number of prisoners entering with a history of contact with mental health services or a history of self-harm was also estimated.
Time available for help

A snap-shot estimate of churn rates for each prison will be calculated to illustrate the time available for assessing and providing assistance to prisoners.

Current provision

Information on the current mental health services will be collected during interviews/via questionnaire. The number of staff, staff mix and caseloads will also be collected in the same way.

Mental health assessments

Modifications were made to SystmOne to provide information on how many mental health assessments were done at: reception, second screen, primary care, and in-reach. An electronic link was also made between the general assessment form and standardised depression and anxiety measures to allow the proportion of assessments using these measures to be calculated.

Mental health referrals

SystmOne was modified to allow referrals to the primary care mental health team (PCMHT), MHIRT, psychiatrists, psychologists to be recorded electronically. The number of these referrals made can then be summarised. Originally it had been planned to use the same mechanism to look at referrals to other treatments, however this was not possible in the time scale available due to the range of different services provided and the large number of different READ codes potentially used to code for these services.

Waiting times

SystmOne was modified to allow information on how long after either arrival in the prison or referral to PCMHT or MHIRT the prisoner had to wait for the relevant mental health assessments. Waiting times were also calculated between
the time a referral was made to a specialist or treatment and the initial consultation/treatment session.

**Plans**

The number of prisoners currently placed on an ACCT (Assessment, Care in Custody and Teamwork) was retrieved from SystmOne. The number of individuals with a Mental Health Measure care and treatment plan was estimated using the interviews/via questionnaire as this information is not currently easy to extract from SystmOne.

**Adverse events**

The number of suicides, attempted suicides and self-harm events was estimated from interview/questionnaire data. Similarly, the number of transfers to hospital and the waiting times for this were provided by the questionnaire.

Reviews of deaths in custody, provided by Healthcare Inspectorate Wales, examined the impact of mental health care provision on deaths in custody.

**Protocols and pathways**

The types of mental health protocols and pathways used within each prison was investigated using interviews/via questionnaire.
Summary of workshop findings

A full report of the stakeholders workshop can be found in the appendix but below is a brief description of the findings from the day. The workshop was organised and facilitated by Kirsty Little and Judith Tomlinson in order to develop a consensus on the focus and methods to be used during the HNA. The workshop was attended by representatives from PCMHT and MHIRTs as well as user representatives in the form of voluntary groups Gofal and the Samaritans. Also in attendance were representatives from Welsh Government, Public Health Wales, NOMS forensic psychology, and the Children and Adolescents Mental Health Services (CAMHS).

As part of the workshop the group identified areas of mental health care that they felt caused the greatest concern. A further thematic analysis of the comments was conducted after the workshop. The themes are listed below, with individuals points ordered according to frequency with which they were raised.

Lack of services, including:

- Forensic services and secure beds for children in Wales.
- Discharge arrangements and the lack of suitable, supported, premises to release individuals to.
- Counselling and psychological services.
- Speech and language therapy (SALT) services.
- Substance misuse specialists and D.A.T services for children.
- Personality disorder specialist services.
- Learning disability specialist services.
- Primary care interventions

Limited resources, including:

- Secondary care resources.
- Prison staffing.
- Primary mental health care provision.

Missing or unclear processes and pathways, including:

- Insufficient assessments
- Transition from children’s to adult’s services.
- Lack of clear pathways and rapid access to services.
- Lack of distinction between primary and secondary mental health care.
- Inconsistencies in provision and practice between the prisons.

**Broader issues, including:**

- Working over large geographical area.
- Lack of a diversional system for juveniles in Wales.
- Non-compatibility of computer systems and issues with information sharing.
- Disconnect between prison drivers and the mental health service.
- Over management/governance of the service.
- Unresolved mental health issues impacting on prisoners abilities to engage with other prison service programmes, such as risk reduction.

**Lack of Training, such as:**

- Holistic or mental wellbeing training.
- Mental health awareness/service awareness.
- Maintenance of skills base through continuing profession development training.

**Churn issues, including:**

- Limited time available to manage need and put interventions into place.
- Assessment should be focused on.
- Prisoner transfer also affects Listener provision.

**Delays in Transfer of Care**

**Unsuitability of communications**

- Suitability of assessments and literature for individuals with disabilities (e.g. learning difficulties and hearing difficulties) and also those whose first language was not English.

**Prescribing problems**

- Updating of prescribing practices.
- Accounting for multiple concurrent prescriptions when prescribing
- Unnecessary prescribing and the difficulties of avoiding it.

Following the general discussion around these concerned it was agreed that, due to the policy situation, introduction of SystmOne and the future publication of specific NICE guidelines around mental health interventions in prisons, that the focus of the current needs assessment would be around the process of mental...
health service delivery. It was agreed that many of the issues raised would be highlighted by this approach. The tools to be used in the current needs assessment (see appendix) were also reviewed, modified and agreed during this workshop. In line with this it was also agreed that a set of agreed read codes would be used by all prisons to aid data extraction.

Finally, all participants agreed to attend the second workshop, to be held approximately six months later, to discuss the recommendations from the needs assessment and to agree actions plans to take these recommendations forward.
Levels of mental health need

1. Population served

Data on the population size of each of the prisons was extracted from the medical records held on SystmOne on the 16/01/2013. From the table is clear that the total population size at each prison varies dramatically; HMP Usk and Prescoed are the smallest of the prisons, both specialising in a particular prisoner type. HMP Swansea is the smaller of the two local remand prisons and houses approximately half the number of prisoners held in HMP Cardiff, the other local prison. Parc prison is by far the largest prison in Wales, one of the largest in the UK, and is due to be expanded in the near future to hold a capacity of approximately 2,000 prisoners.

Estimates of the age distribution of prisoners held at each prison were also extracted from SystmOne and are displayed in table 2 below. Parc is the only prison in Wales that accepts individuals under the age of 18 years and is currently holding 55 such individuals in its Young Offenders Institute; at Parc a larger proportion of its population also falls into the 18-21 years age bracket compared to the other prisons. In HMPs Cardiff, Swansea and Prescoed the vast majority of prisoners are in the categories of 22-50 years, with prisons seeing approximately 85% of prisoners falling within these bands. At Parc and Usk prisons these figure is slightly lower at just below 70%.

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
<th>Usk</th>
<th>Prescoed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>784</td>
<td>1560</td>
<td>405</td>
<td>260</td>
<td>251*</td>
</tr>
<tr>
<td>&lt;18</td>
<td>0</td>
<td>55 (3.5%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18-21</td>
<td>75 (9.6%)</td>
<td>260 (16.7%)</td>
<td>41 (10.1%)</td>
<td>3 (1.2%)</td>
<td>7 (2.8%)</td>
</tr>
<tr>
<td>22-30</td>
<td>319 (40.7%)</td>
<td>505 (32.4%)</td>
<td>178 (44.0%)</td>
<td>48 (18.5%)</td>
<td>78 (31.1%)</td>
</tr>
<tr>
<td>31-40</td>
<td>238 (30.4%)</td>
<td>337 (21.6%)</td>
<td>126 (31.1%)</td>
<td>55 (21.2%)</td>
<td>86 (34.3%)</td>
</tr>
<tr>
<td>41-50</td>
<td>108 (13.8%)</td>
<td>219 (14.0%)</td>
<td>43 (10.6%)</td>
<td>68 (26.2%)</td>
<td>49 (19.5%)</td>
</tr>
<tr>
<td>51-60</td>
<td>34 (4.3%)</td>
<td>103 (6.6%)</td>
<td>14 (3.5%)</td>
<td>52 (20.0%)</td>
<td>27 (10.8%)</td>
</tr>
<tr>
<td>61-64</td>
<td>5 (0.6%)</td>
<td>36 (2.3%)</td>
<td>1 (0.2%)</td>
<td>11 (4.2%)</td>
<td>3 (1.2%)</td>
</tr>
<tr>
<td>over 65</td>
<td>5 (0.6%)</td>
<td>45 (2.9%)</td>
<td>2 (0.5%)</td>
<td>23 (8.8%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

*age not available for one individual
In prison literature it has been described that, due to the prison environment, that prisoners aged over 50 years suffer from the sorts of ailments that would affect individuals 10 years older in the community and would therefore require older peoples services. Across the Welsh prison estate there are 361 individuals in this age bracket. Most of these individuals are held at either HMPs Parc or Usk, and Parc prison has reported that it is seen a rise in the number of older prisoner in recent years (see Unmet Needs below).

The type of prisoners and the length of sentences differ across the prisons included here. At HMP Cardiff approximately a quarter of prisoners are on remand, with the remainder serving sentences with an average length of two years or less. Similarly at HMP Swansea about a fifth of prisoners were on remand, and although an average length of sentence was not available it is thought to be similarly to that seen in HMP Cardiff, if not shorter. At Parc prison a very small number of remand prisoners are housed, about 4% of the total and almost exclusively those <21 years of age, and although an average sentence was not available for Parc prisoners housed here are on sentences of at least two years, but not life sentences. Both Usk and Prescoed prisons only house sentenced prisoners and at both prisons approximately 70% of prisoners are serving sentences of four years or more.

A high proportion of prisoners received into Welsh prisoner report having been in prison before. In Parc 48% of new prisoners reported being in prison before, rising to 69% at HMP Cardiff and 75% at HMP Swansea. Unfortunately this data was not available for HMP Usk and Prescoed.

Ethnicity of the prisoners was not available for this assessment however the number of prisoners who are unable to speak English was collected. These figures were lower than expected with two individuals in HMP Cardiff, 12 in HMP Parc, two in HMP Swansea, three in HMP Usk and nobody in HMP Prescoed.

2. Time available for help

As can been seen above both the age of prisoners and the average length of sentence varies substantially by prison across Wales. This may have a significant impact on the type of mental health problems seen (see discussion re: remand and sentenced prisoners above) and the duration that they are held in the prison for and therefore the time available to intervene and offer help. As can been
seen from table 3 below the number of new receptions in need of mental health screening is substantial at each prison with HMP Cardiff seeing substantially more new receptions in the period of October to December 2012 compared to the other prisons. Due to their remand status, both HMPs Cardiff and Swansea see more new receptions over a three month period that their total prison capacity; this may have important implications in terms of healthcare staff capacity.

### Table 3. Number of new receptions received between 1st October and 31st December 2012 and duration in prison

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
<th>Usk</th>
<th>Prescoed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total population</strong></td>
<td>784</td>
<td>1560</td>
<td>405</td>
<td>260</td>
<td>251*</td>
</tr>
<tr>
<td><strong>New receptions (October – December)</strong></td>
<td>1033 (344pm)</td>
<td>550 (183pm)</td>
<td>479 (160pm)</td>
<td>88 (29pm)</td>
<td>119 (40pm)</td>
</tr>
<tr>
<td><strong>% New receptions staying &lt; 1 month</strong></td>
<td>48.4%</td>
<td>17.6%</td>
<td>34%</td>
<td>14.3%</td>
<td>18.3%</td>
</tr>
<tr>
<td><strong>Prisoners in &gt; 6 months (% of population)</strong></td>
<td>83 (10.6%)</td>
<td>749 (48.0%)</td>
<td>34 (8.4%)</td>
<td>154 (59.2%)</td>
<td>102 (40.6%)</td>
</tr>
<tr>
<td><strong>Prisoners in &gt; 1 year (% of population)</strong></td>
<td>42 (5.4%)</td>
<td>355 (22.8%)</td>
<td>1 (0.2%)</td>
<td>97 (37.3%)</td>
<td>39 (15.5%)</td>
</tr>
</tbody>
</table>

* include all those registered between 01st October and the 30th November

In addition to a higher number of new receptions in some prisons, there is also a substantial difference in the number of new prisoners staying for a month or less (Table 3); again with higher numbers of short stay prisoners in the be local remand prisons. In Cardiff prison almost half of its population stays less than one month (churn rate), with a third leaving over the same short time period in HMP Swansea; this problem is also seen in HMPs Parc, Usk and Prescoed but to a lesser degree. This gives a very limited time frame for the detection and initiation of treatment for prisoners with a mental health problem making it paramount that any assessments and treatments started are fully documented and can be continued elsewhere.

While in some prisons there is a large turnover of prisoners, it should not be forgotten that some prisoners do remain for a substantial length of time. In HMPs Cardiff and Swansea approximately one in ten prisoners stay for six months or more, allowing time for the initiation of treatment if problems are detected early. In HMPs Parc and Prescoed over 40% of prisoners stay for at least six months, many for over a year, again allowing time for appropriate assessment and intervention. In HMP Usk the majority of prisons stay for a significant length of time, with nearly 40% (almost 100 prisoners) staying for at least one year, which allows a substantial length of time for assessment and treatment.
3. Levels of mental health need

During this assessment it became apparent that using diagnostic data from the prison mental health records was unlikely to give an accurate picture of the mental health need within the prisons. This is primarily because often doctors, both inside and outside prison, shy away from labelling individuals with a mental health diagnosis and avoid recording specific diagnoses in the health records, instead using broader terms; without a specific diagnosis and therefore READ code it is very difficult to extract this information from SystmOne. Therefore, three different elements have been used to build up a picture of mental health need within the Welsh prison estate and are described below.

Estimated numbers using ONS survey

As discussed above a number of researchers have estimated the prevalence of mental health problems within the prison population. While some of these estimates differ in terms of the precise levels of individual health problems they all agree that the prevalence of mental health problems is substantially higher in the prison population than in the community. The estimates displayed here are based on the prevalence of specific mental health problems estimated by the ONS in a survey of the prison population in England and Wales (ONS 1997); the report provided estimates both for remand and sentenced prisoners. These prevalence’s were applied to the population of the Welsh prison estate, divided into remand and sentenced using the proportions provided by the prisons, to produce an estimate of the expect number of individuals with mental health problems within each prison.

Estimates suggest that 21% of remand prisoners and 18% of sentenced prisoners have received treatment or help for a mental health problem before entering prisons. This equates to approximately 127 of the prisoners currently held at HMP Cardiff, 232 of those at HMP Parc, 68 of those held at HMP Swansea, 46 of those at HMP Usk and 41 at HMP Prescoed. Fewer individuals in the ONS survey reported that they had been admitted to a psychiatric hospital, at 233 individuals across the estate (HMP Cardiff (59), HMP Parc (104), HMP Swansea (31), HMP Usk (21) and HMP Prescoed (18)).
Figure 1. Estimated number of prisoners in each of the five Welsh Prisons with selected mental health problems, based in estimated prevalence provided by ONS.
Estimated number of prisoners at Swansea prison with selected mental health problems

- All personality disorders
- Antisocial pd
- Borderline pd
- All Psychosis
- Schizo or delusional disorders
- Affective psychosis
- All neurotic disorders (past week)
- Mixed anxiety and depression
- Generalised anxiety disorder
- Depressive episodes
- Sleep problems (symptom)
- Depression (symptom)
- Anxiety (symptom)
- Suicidal thoughts (past week)
- Suicidal thoughts (past year)
- Suicide attempts (past week)
- Suicide attempts (past year)
- Self harm (current term)
- Hazardous drinking (year prior)
- All drug use (6 main drug types) (year prior)
- Opiate dependence (year prior)
- Below average IQ
Estimated number of prisoners at Prescoed prison with selected mental health problems

- All personality disorders
- Antisocial pd
- Borderline pd
- All Psychosis
- Schizo or delusional disorders
- Affective psychosis
- All neurotic disorders (past week)
- Mixed anxiety and depression
- Generalised anxiety disorder
- Depressive episodes
- Sleep problems (symptom)
- Depression (symptom)
- Anxiety (symptom)
- Suicidal thoughts (past week)
- Suicidal thoughts (past year)
- Suicide attempts (past week)
- suicide attempts (past year)
- Self harm (current term)
- Hazardous drinking (year prior)
- All drug use (6 main drug types) (year prior)
- Opiate dependence (year prior)
- Below average IQ
As can be seen from Figure 1 above, it is estimated that a very large number of prisoners in each prison will have clinical signs of personality disorder, most commonly anti-social personality disorder. Across the Welsh prison estate around 1,800 prisoners are likely to have personality disorder. Like many mental health problems personality disorder can come in varying degrees of severity and may impact on an individual’s life to a greater or lesser degree. The management of offenders with personality disorders is the joint responsibility of NOMS and the NHS under the Offender Personality Disorder Strategy (DoH & MoJ 2011). The strategy details the treatment and management of individuals with severe personality disorder, suggesting it should be psychologically informed and led by psychologically trained staff. NICE also provides specific guidelines for such treatment but do not provide specific advice for healthcare within a prison setting (NICE 2009a). Even individuals with less severe condition may require adjustments to be made to the way in which treatment for concurrent mental health problems is delivered. Additionally, personality disorder is often associated with acts of self harm.

The prevalence of functional psychosis conditions, such as schizophrenia and bipolar disorder, is much lower than that of any of the other main groups of mental health problems. However, it is still estimated that around 200 prisoners in the Welsh prison system have had symptoms of probable functional psychosis in the past year. In many cases symptoms will fluctuate over time and can be control to some degree with appropriate medication. Although these disorders are not considered curable many people recover from the acute stage. A person diagnosed with functional psychosis will require regular monitoring to assess their mental state, compliance with medication and the effectiveness of psychological and pharmacological interventions. Their care usually requires the management of a multidisciplinary team including psychiatrists and psychologists. Also, functional psychosis is associated with several other mental health conditions such as depressions, post-traumatic stress disorder, personality disorder and substance misuse not to mention a great deal a of stigma and discrimination that can lead to social isolation. Again, NICE guidelines are available to guide the monitoring and treatment of individuals with these conditions (NICE 2009c).

Approximately, 1,200 current prisoners in Wales will suffer from a neurotic disorder, such as anxiety, depression and post-traumatic stress disorder. These disorders are relatively common in the community and are often exacerbated by the process and practicalities of imprisonment. As with other mental health problems they varying in their degree of severity and symptoms are likely to fluctuate with time. Self-help, psychological and pharmacological interventions are available and individuals may be managed by either primary or secondary care
depending on severity and co-morbidities. NICE guidelines are available to guide the treatment of all conditions under the category, for example Generalised anxiety disorder (NICE 2011b). Symptoms associated with neurotic disorders are sleep problems, anxious behaviour and depressive and suicidal thoughts. It is therefore important that these symptoms are monitored within the prison environment to allow issues to be identified before they escalate into self harm and suicide attempts; just under 200 self harm incidents and suicide attempts would be expected to have occurred in the past year across Wales.

Alcohol and substance misuse is another large problem which disproportionately affects the prisoners population. Across Wales approximately 1,800 individuals have experienced problems with excessive drinking in the past year, and approximately the same number (not mutually exclusive) will have been using one of the six main drug groups (cannabis, heroin, non-prescribed methadone, amphetamines, crack, cocaine) in the year prior to entering prison. These individuals will require support during the initial stages of detoxification and may be supported through recovery in the correct surroundings. Again NICE guidelines are available to guide these process but may not be completely applicable to the prison environment (NICE 2010; NICE 2007).

Finally, as can be seen from figure 1 above a very large proportion of prisoners are predicted to have a below average IQ. While this may not require the specific attention of the healthcare teams, it is an important additional complexity to consider when assessing, treating and supporting individuals with other mental health problems.

It must be stressed that the survey suggests a clustering of mental health problems within prisoners, with a high proportion of prisoners experiencing more than one of the mental health problems listed. The approximate number of prisoners estimated to be experiencing multiple mental health problems is displayed in figure 2 below; the figure displays actual numbers of individuals so is influenced by the size of the prison population in each prison.
A number of assumptions are made when producing these estimates and as a result they should be considered broad estimates rather than exact figures. The original estimates were made in 1997 which is 15 years before the current estimates; while there is evidence that the prevalence of mental health problems in the prison population hasn’t changed over time (Fazel & Seewald 2012) it is possible that there may be lower level fluctuations, especially in the area of personality disorder where awareness has increased substantially over this time period. Additionally, it is likely that some mental health problems will show geographical trends which will not be represented here, for example it is acknowledge that the use of intravenous drugs is substantially higher in the Swansea area and is likely to have an impact on the prevalence of some mental health problems in this population. Additionally, the prevalence of mental health problems and the types of mental health problems have been shown to differ by age (see previous discussion); the data provided by the ONS survey is not available of different age groups and it was felt to be introducing unnecessary complication, and therefore potentially error, to the estimation process to factor in age from additional studies. Finally, these estimates were not able to allow for the different types of offences and prison security categories which may also have an impact on the prevalence of mental health problems.
Number of prisoners entering prison with previous history of mental health service use

In addition to using the ONS survey to estimate the number of prisoners expected to have various mental health problems, it was also possible to examine the level of mental health need within the prisons by looking at previous history of mental health service use, and influential lifestyle factors; information collected when a prisoner first enters the prison. Unfortunately, as this information is collected at the primary screen, which is only used for those newly entering the prison system, this data was not available for HMP Usk and Prescoed prisons and only for a proportion of prisoners at HMP Parc. Also, it must be remembered that this is unverified data self reported by the prisoners – for some questions this may have resulted in over reported and in some there may be under reporting. The figures discussed are not mutually exclusive and prisoners may appear in a number of categories and individuals who entered prison twice during this three month period and were screened twice will be included twice.

There are some differences across the three prisons in terms of pervious contact with mental health services, but these do not appear to follow any discernable pattern. These differences may indicate real differences in the populations but may also, to some degree, indicate differing levels of detail and accuracy obtained by the prisons at the primary screen. In table 4 below it can be seen that between about a quarter and a half of prisoners who entered either Cardiff, Parc of Swansea prison within the period of October to December 2012 reported that they had previously received medication for a mental health problem; this is slightly higher than the proportion in the ONS survey who reported receiving help or treatment for a mental health problem before entering prison. A similarly high number of prisoners reported having seen a psychiatrist outside of prison (between a fifth and a third of prisoners); however this is a rather vague question including those who were seen many years ago and may include those seen for court requested psychiatric reports. Slightly lower figures are seen for the number of prisoners who have stayed in a psychiatric hospital and this figure matches well with the estimates made by the ONS survey (between 8-11%).
Table 4. Previous history of mental health service use record at the primary health screen during the period of October-December 2012.

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of primary screens</td>
<td>999</td>
<td>99</td>
<td>390</td>
</tr>
<tr>
<td>Has received medication for mental health problems</td>
<td>289 (28.9%)</td>
<td>34 (34.3%)</td>
<td>180 (46.2%)</td>
</tr>
<tr>
<td>Has received treatment from a psychiatrist outside prison</td>
<td>163 (16.3%)</td>
<td>25 (25.3%)</td>
<td>130 (33.3%)</td>
</tr>
<tr>
<td>Stayed in a psychiatric hospital</td>
<td>71 (7.1%)</td>
<td>8 (8.1%)</td>
<td>47 (12.1%)</td>
</tr>
<tr>
<td>Has a psychiatric nurse or care worker in the community</td>
<td>19 (1.9%)</td>
<td>6 (6.1%)</td>
<td>12 (3.1%)</td>
</tr>
<tr>
<td>Feels like Self Harming or Suicide</td>
<td>18 (1.8%)</td>
<td>9 (9.1%)</td>
<td>15 (3.8%)</td>
</tr>
<tr>
<td>Tried to harm themselves in prison</td>
<td>56 (5.6%)</td>
<td>3 (3.0%)</td>
<td>21 (5.4%)</td>
</tr>
<tr>
<td>Tried to harm themselves outside prison</td>
<td>225 (22.5%)</td>
<td>26 (26.3%)</td>
<td>106 (27.2%)</td>
</tr>
<tr>
<td>Intravenous drug user</td>
<td>117 (11.7%)</td>
<td>9 (9.1%)</td>
<td>87 (22.3%)</td>
</tr>
<tr>
<td>Served in armed forces</td>
<td>25 (2.5%)</td>
<td>22 (22.2%)</td>
<td>35 (9.0%)</td>
</tr>
<tr>
<td>Homeless in the past year</td>
<td>112 (11.2%)</td>
<td>9 (9.1%)</td>
<td>112 (28.7%)</td>
</tr>
</tbody>
</table>

Concerningly, about a quarter of the new prison population report that they have been involved in self harm outside of prison (Table 4). Such high rates of previous self harm immediately highlights this as an area that may need attention by the prison healthcare staff, especially during the initial adjustment period. The number who reported trying to self harm within prison are lower and match the figures estimated in the ONS survey (5-7%). The numbers reporting that they currently feel like self harming or are having suicidal thoughts do vary across the prisons, although due to the small numbers and the snap shot nature of the data it is not possible to say whether this is a true pattern; Parc prison receives many newly sentenced prisoners however and it is possible that the increase in self harm/suicidal thoughts seen here represents a real risk group. The ONS survey suggests a relatively large difference between the prevalence of such thoughts between prisoner type, at 12% in remand prisoners and 4% in sentenced prisoners.

In terms of lifestyle factors that may be indicative of, or caused by, mental health problems there appears to be slightly more variation across the prisons, again this might be due to actual variation but may also represent differing level of detail obtained at the primary screen. As expected, due to the location of the prison, Swansea prison receives a higher proportion of new prisoners with a history of
intravenous drug use, at nearly a quarter of all new prisoners; this obviously increases the need for drug services within the prison. Also, and probably concurrent with drug use issues in many cases, HMP Swansea also receives a high number of prisoners who were homeless before entering prisons, a group known to be vulnerable to mental health problems. Parc prison receives substantially more prisoners who have previously been in the armed forces.

**Number of prisoners with signs of mental health problems**

In addition to the number of prisoners entering prison with a history of mental health service use it was also possible to use SystmOne to extract individual signs and symptoms of mental health problems; these may be more readily recorded than mental health diagnoses. In figure 3 below it can be seen that the number of prisoners with alcohol or substance misuse problems can be extracted, as can the number reporting difficulty sleeping, distractibility, delusions or hallucinations – all key signs of mental health problems (Figure 4).

**Figure 3. Number of prisoner receiving a READ code indicating alcohol or substance misuse between October and December 2012**
Unfortunately there are often several read codes for very similar things and in order to be able to extract comparable data all prisons need to be using the same READ codes. It appears from the data that HMP Usk and Prescoed may not be correctly read coding these signs, or may be using a different set of read codes and it was therefore not possible to extract their data. It is also possible that not all occurrences of these signs are being read coded reliably in the other prisons, with both HMP Cardiff and HMP Parc healthcare staff reporting that these figures should be higher in reality; these figures are also significantly lower than would be expected given the ONS estimates. The data is therefore displayed more as an illustration of what could be extracted if read coding was consistently used.

Figure 4. Number of prisoner receiving a READ code indicating mental health symptoms between October and December 2012
Structure of mental health care

1. Health care facilities and organisation of mental health care

All five prisons run a dedicated healthcare wing or unit within the prison where all healthcare staff are based and where assessments and services are delivered. This arrangement allows both general healthcare and mental healthcare staff to work in close proximity, and also allows the PMHCTs to work in close proximity to the MHIRTs; this strengthens relationships between the different teams with several of the teams reporting very good working relationship between primary and secondary care team. Due to recent developments within the ABMU area, whereby a MHIRT is shared between the Swansea and Parc prisons, it is likely that the MHIRT will be based more regularly at HMP Parc and concerns have been raised that this may make communications between the teams at HMP Swansea more difficult.

HMP Cardiff is the only prison within the Welsh prison estate that currently runs an inpatient unit. It has a maximum of 22 beds available. HMP Swansea currently has two crisis beds available but these are seldom used and may be taken out of commission in the near future.

HMPs Cardiff, Swansea and Parc all now have a drug recovery wing, following the opening of the dedicated wing at HMP Cardiff in February 2012 (60 beds, 49 beds, and 98 beds respectively). These wings are designed for prisoners who are opting for drug recovery, so are taking an active step towards recovery. These wings are not specifically designed for acute detoxification and there are differing practices in terms of where prisoners in acute detoxification are housed; in HMP Swansea they are housed in the induction wing, in HMP Cardiff they are usually moved to the wing closest to healthcare and in HMP Parc they are housed on the drug recovery wing. HMP Usk and Prescoed do not currently have specific housing for those in acute detoxification or drug recovery owing to the perceived lower levels of problems in long term prisoners. HMPs Swansea and Parc also support drug-free wings (45 bed and 96 beds respectively) for offenders to move to once they have completed a period on the drug recovery wing.

There is an HMIP expectation that “staffing levels and mix, throughout the 24-hour period, include appropriately trained medical, nursing, administrative, and other
allied health professionals or specialist staff to reflect prisoners’ needs” (HMIP 2012). However, while a 24 hours healthcare service is run within HMPs Cardiff, Swansea and Parc it is not available at HMP Usk or HMP Prescoed; here out of hours GPs cover HMP Prescoed and an on call services is available at HMP Usk. Where 24 hour services are available, Registered Mental Health Nurses (RMN) are not routinely available overnight in any of the prisons; RMNs form part of the overnight rota in HMP Parc and HMP Cardiff so sometimes providing overnight provision, and RMN provision provided until 9pm at HMP Swansea.

All Welsh prisons run a nurse-led mental health care service and on discussions with healthcare staff there was a general feeling that this system worked well and is well respected by the GP’s, Psychiatrists and prisoners. In HMPs Cardiff, Swansea and Parc mental healthcare is divided into primary level care delivered by the PMHCT and secondary level care delivered by the MHIRT, with staff working exclusively for one or the other teams. In HMP Usk and Prescoed however, due to the current low levels of staff, the distinction between the PMHCT and the MHIRT is less apparent, with the MHIRT lead taking on primary care duties when the member of staff responsible for primary care is unavailable. Additionally, it should be noted that Usk and Prescoed prisons share a health care team, who are ordinarily based in Usk prison and visit HMP Prescoed for routine clinics and when required.

All prisons currently run regular meetings between the PMHCT and the MHIRT to discuss their caseloads, referrals received by either team, and cases that are being jointly managed. The regularity of these meetings differs slightly, with Cardiff and Parc prisons running these meeting on a weekly basis and HMP Swansea planning to run meetings on a bi-monthly basis. The team within HMP Usk and Prescoed is small enough not to require formal meetings. In HMP Parc, where they have a clinical CARATs (Counselling, Assessment, Referral, Advice Through-care) team, these individuals are also invited to the meetings when relevant; HMP Swansea also has a bi-monthly SIMS (substance misuse, in-reach and mental health) meeting to discuss dual diagnosis prisoners.

**External comparisons**

When comparing the two comparator prisons it appears that there is no standard facilities in terms of prisons health care. Having a dedicated healthcare wing/unit is not a standard with HMP Nottingham reporting no dedicated healthcare unit; although both prisons report that both the PCMHT and the MHIRT are housed in the same place as is the case across Wales.
Unlike Wales, both prisons have an inpatients unit of sorts and therefore 24 hour healthcare, with HMP Liverpool reporting a 28 bed inpatients unit and HMP Nottingham reporting a “dedicated 24 hour care area on one area of a residential wing” with a flexible number of beds.

Direct comparison of provision for drug rehabilitation services is not possible between England and Wales due to the different funding arrangements in place. However, with this in mind and for information only, HMP Liverpool, like the Cardiff, Swansea and Parc prisons, reported that it runs a detoxification wing with approximately 160 beds; however, HMP Nottingham reports that it does not have a drug detoxification wing.

Both comparator prisons report that regular multidisciplinary meetings take place although at quite different regularity. At HMP Liverpool a MHIRT multidisciplinary meeting takes place every six weeks, while an inpatient meeting takes place on a weekly basis; it is not clear whether meetings between the PMCHT and the MHIRT take place on a regular basis as is the case in Wales. At HMP Nottingham there are twice weekly meetings between both PMHCT and MHIRT and psychiatrists.

2. Staffing levels

Having sufficient staffing, with the appropriate mix of skills, is a vital part of meeting the mental health needs of the prison population. The HMIP expectations echo this when they state that for prisoners with common mental health problems: “Multi-professional primary mental health services are available from staff with appropriate skills” and for those with severe and enduring mental health problems: “multi-professional, secondary and tertiary mental health services (stepped care services three and four) are available from staff with appropriate skills”.

The heads of prison healthcare, or their representatives, were asked to report the number of staff within their department (or fulltime equivalents), by specialty, and also the caseloads of those staff. The former information was provided by all prisons and is displayed below. It includes those posts which are currently vacant: in HMPs Swansea, Cardiff and Parc there are currently two vacancies each in different stages of recruitment and there are no current vacancies at HMP Usk or Prescoed. Unfortunately, information on caseloads was not so easily obtainable and
was only provided by some prisons. For this reason the table below provides the ratio of staff to prisoners (RtP) rather than their caseloads; this measure is less precise than caseloads, as it does not take into account any difference in levels of need between the prisons, but does allow some comparison between the staffing levels within each prison. Unfortunately as it is not a standard measure it does not allow comparison to the standard caseloads for primary and secondary teams in the community.

Table 5. Staffing levels across the prisons and the ratio of staff to prisoners (RtP) for each position

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
<th>Usk &amp; Prescoed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population size</td>
<td>784</td>
<td>1560</td>
<td>405</td>
<td>511</td>
</tr>
<tr>
<td><strong>PCMHT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of RGNs (ratio to prisoner)</td>
<td>11 (1:71)</td>
<td>9 (1:173)</td>
<td>9 (1:45)</td>
<td>7 (1:73)</td>
</tr>
<tr>
<td>No of GP sessions (RtP)</td>
<td>9 (1:87)</td>
<td>11 (1:142)</td>
<td>6 (1:67.5)</td>
<td>3 (1:170)</td>
</tr>
<tr>
<td>No of RMNs (RtP)</td>
<td>10 (1:78)</td>
<td>9 (1:173)</td>
<td>4 (1:101)</td>
<td>0.4 (1:1278)</td>
</tr>
<tr>
<td><strong>MHIRT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of CPN/In reach nurses (RtP)</td>
<td>3 (1:261)</td>
<td>2 (1:780)</td>
<td>1 (1:405)</td>
<td>1 (1:511)</td>
</tr>
<tr>
<td>No of Occupational therapist (RtP)</td>
<td>5 (1:157)</td>
<td>1 (1:1560)</td>
<td>1 (1:405)</td>
<td>0</td>
</tr>
<tr>
<td>No of psychiatrist/forensic psychiatrist session (RtP)</td>
<td>7 (1:112)</td>
<td>2 (2:780)</td>
<td>2 (1:203)</td>
<td>0 (prearranged)</td>
</tr>
<tr>
<td>No of psychologist/forensic psychologist sessions (RtP)</td>
<td>National</td>
<td>6 (1:260)</td>
<td>0</td>
<td>National</td>
</tr>
<tr>
<td><strong>Drug team</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of clinical drug treatment staff (RtP)</td>
<td>1 (1:784)</td>
<td>4 (1:390)</td>
<td>3 (1:135)</td>
<td>0</td>
</tr>
<tr>
<td>CARATs (RtP)</td>
<td>9.6 (1:82)</td>
<td>7 (1:223)</td>
<td>5 (1:81)</td>
<td>5 (1:102)</td>
</tr>
<tr>
<td>Dual diagnosis specialist</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 (TS)</td>
</tr>
</tbody>
</table>

* these figure include vacancies currently advertised

**General primary care team**

The absolute number of registered general nurses (RGNs), who provide general healthcare rather than specifically mental healthcare, are relatively even over the four healthcare teams. However, due to the differing prison population sizes the ratio of RGNs to prisoners varies from 1 per 45 prisoners in HMP Swansea to 1 per 173 prisoners in HMP Parc (Table 5 above). The number of GP sessions provided within the prisons varies more widely, with two prisons (HMPs Cardiff and Swansea) supporting a ratio of one session per <100 prisoners, where as in HMPs Parc and Usk/Prescoed the same GP session would cater for around double the number of prisoners. This is likely to mirror the increased demand on GP services due to initial assessments and transfer of healthcare to within the prison service as both HMP Cardiff and HMP Swansea are remand prisons. At Swansea prison, where
a cautious approach to mental health has been acknowledged and a large number of receptions are referred to the GP, it was not infrequent for routine clinics to be cancelled due to an influx of new receptions; this situation has improved recently however, with an increased number of officers available to escort prisoners to and from the healthcare wing. While this system may pick up problems early and prevent escalation this needs to be balanced against the impact of cancelling routine GP clinics.

During the later stages of data collection it became clear that in addition to the healthcare staff for which information was requested, there are also healthcare assistants/officers employed within the prison healthcare system who undertake some mental healthcare roles. At HMP Cardiff six healthcare assistants are employed along with one hospital officer, Parc and Swansea prisons both employ three healthcare assistants/officers respectively and there is one healthcare assistant employed at HMP Usk and Prescoed. Although this was not routinely asked about during the discussion (due to its late emergence) it was discussed that at HMP Swansea one of the healthcare officers does perform receptions and secondary screenings, under the strict supervision of nurses, and similarly in HMP Cardiff all healthcare workers routinely perform the screening under supervision. At HMP Cardiff it was commented that “the Band 3 health care assistances do a lot of the mental health support work, supervised by nurses. They help the system run smoothly”. While a smooth running service is very important, it might be wise to consider additional training for the healthcare assistants if this is to continue to be a model followed by the prisons to ensure they meet the HMIP expectations that care be provided by appropriately qualified individuals (HMIP 2012). It should also be considered whether Wales wide protocols should be put in place to ensure that correct supervision is provided to these individuals and that the upper bounds of their responsibilities are clearly defined. Such guidelines may be available for HCA working in a community setting (Royal Collage of Nursing 2013).

**Primary Care Mental Health Team**

All prisons reported that the PCMHT were usually able to dedicate themselves to mental health duties, however there were stark differences in the staff provision for the PCMHTs RMNs. Again, the two remand prisoners, who may experience slightly higher demand for mental healthcare (ONS 1997), have the best ratio of staff to prisoners, with one RMN per 78 prisoners in HMP Cardiff and one per 101 prisoners in HMP Swansea. In HMP Parc the ratio is almost double this at one RMN per 179 prisoners (Table 4). In all three of these prisons the staffing levels within the PCMHT were described as good, although in HMP Parc there was more limited time for planning and reorganising services. However, the real concern that emerges is
the RMN to prisoner ratio in the HMP Usk and Prescoed healthcare team; here one part time RMN covers the entire population of the two prisons at a ratio equivalent of one per 1,278 prisoners. This may reflect historic levels of need as the populations of Usk and Prescoed prisons have approximately double since staffing levels were initially assessed. There are additional concerns here as the sole RMN is due to retire in the near future and cover has not yet been arranged which, it is felt, "puts the success of the mental health unit in jeopardy". Three full time RMNs would be required to provide a similar level of coverage to that provided by Parc prison, who also house mainly sentenced prisoners. This effect of this shortage on the distribution of nursing staff can be seen in the figure 5 below:

Figure 5. The distribution of nursing staff type by prison.

Mental Health In-Reach Team

The caseloads of in-reach teams were raised as an area of concern during the first stakeholder workshop. The levels of CPN/mental health in reach lead provision also
varies quite widely. HMP Cardiff has the highest levels of staffing, with three in reach nurses and a staff to prisoner ratio of one to 261 prisoners (Table 5). HMP Swansea has one member of staff and run at substantially higher ratios which has been described as “just about enough” to meet demand. HMP Usk/Prescoed also have one member of staff at this level, however the shortage in PMHCT staff has a knock on effect, with the single member of MHIRT staff covering both primary and secondary care for three days of the week. Parc prison currently has two in reach nurse positions but still runs at the highest staff to prisoner ratio, at one member of staff per 780 prisoners. While no concerns were raised by the healthcare staff about the levels of in reach provision at HMP Parc, this should be carefully considered during the planned expansion of the prison as this is likely to future increase demand on the service. Additionally, some staff mentioned the lack of support and clinical supervision available when working in the prison environment, which increases the stress of working in this environment.

In addition to direct healthcare, certain types of prisoners require additional medical reports to be written, and follow up meetings attended. Prisoners with life sentences and indeterminate sentences require extensive reports, including reports on their mental health, before they can be considered for release or transfer to open conditions. Assessments are also required for the Sex Offender Prevention Orders and these feed into the risk management of these prisoners. In addition Inter-department risk management (IRM) teams may require reports on prisoners who enter the prison with a mental health problem; these reports are an internal version of a Multi-Agency Public Protection Arrangements (MAPPA) report, which are also required for violent or dangerous prisoners. These reports require varying levels of input from the healthcare team and are currently completed on the basis of ‘custom and practice’; in HMP Parc for example the head of healthcare spends approximately 5 hours a week attending to these reports. During the discussions at HMP Usk and Prescoed however, it became apparently that a large proportion of prisoners in these two establishments require such reports with approximately 18 reports required a week. Unlike HMP Parc, these are generally undertaken by the MHIRT and take up approximately half of all in reach time available. Given that there is a considerable resource implication it may be opportune to review the necessity for provision of all these reports in future.

The compilation of the rest of the MHIRT and the other mental health services varies between the prisons. All prisons, other than HMP Usk and Prescoed, have some level of both psychiatry and occupational therapy cover; although the staff to prisoner ratios vary substantially and again are significantly higher in Parc prison compared to HMPs Cardiff and Swansea; having spoken to the healthcare staff at the three prisons their level of coverage was not seen to be problematic, although
again this should be carefully considered during the expansion Parc prison. At HMP Usk and Precoed there is no occupational therapy cover and psychiatry cover is provided on a request basis rather than a routine session. On speaking to staff, this arrangement was not seen as a problem but further increases the reliance of the service on the single lead member of the MHIRT.

Drug Treatment Staff

At the time of data collection all prisons had drug treatment services provided by CARATs staff; although this may be due to change at HMP Usk and Precoed where a new organisation may soon be running their services. The ratio of staff to prisoners follows a trend that would be expected, with the two remand prisons having an increased need and therefore increased provision of CARATs staff. The distribution of clinical drug treatment staff does not appear to directly follow this expected trend, although as would be expected given the higher proportion of prisoners entering with a history of intravenous drug use (IVDU), Swansea prison appears to have a lower staff to prisoner ratio than the other prisons. However, at HMP Swansea, due to the high number of illicit drug users on remand, a whole team approach has been adopted with both RGNs and RMNs complete detox monitoring and CARAT liaison. The SystmOne data suggests that the proportion of IVDU’s are approximately equal between HMP Parc and HMP Cardiff although the staff ratio suggests that HMP Parc has double to clinical drug treatment staff coverage compared to HMP Cardiff; however this may be explained by the short term nature of many of the sentences at HMP Cardiff which do not allow time for the treatment of some drug issues.

External comparisons

In both comparator prisons the coverage of RGNs is in line with coverage seen at HMPs Cardiff, Swansea and Usk and Prescoed; at HMP Nottingham they have approximately 13 RGNs, with a ratio of nurses to prisoners of 1:83, and at HMP Liverpool they have 19 primary care RGNs and 5 inpatient RGNS, with an RtP of 1:62 for primary care. This again indicates that the level of provision at HMP Parc should be reviewed.

In HMP Liverpool they have 7 RMNs in the PCMHT, with a RtP of 1:168, 4 RMNs in the MHIRT (RtP 1:294) and an additional 2 RMNs working in the inpatient unit (RtP 1:196 for MHIRT and inpatients combined). As the provision of RMNs varies significantly across Wales it is difficult to estimate how coverage in HMP Liverpool compares; PCMHT coverage compares well in HMPs Cardiff, Parc and Swansea
while MHIRT coverage appears to be noticeably lower across Wales. HMP Nottingham reported that they have 7 RMNs but this was not broken down into PCMHT and MHIRT.

HMP Nottingham reported that they have six psychiatry sessions a week, with a broad RtP of 1:172, whereas HMP Liverpool reports 3 psychiatry/forensic psychiatry sessions per week, with a broad RtP of 1:391. Again the variation across Wales, and across these two prisons, makes comparisons difficult but it would again appear that psychiatric coverage at Parc prison may be insufficient. In terms of the rest of the MHIRT there are substantial differences between the two comparator prisons; HMP Nottingham reports no psychology support, not dual diagnosis specialists and not personality disorder specialist but does have an occupational therapist. HMP Liverpool on the other hand has a part time clinical psychologist, a consultant psychiatrist with a primary care psychological specialism, two dual diagnosis specialist, a on-referral personality disorder specialist but no occupational therapist. It would appear while there is room for improvement in these provisions across the Welsh prison estate if the aim is to provide top quality services, the current service provision does not lag substantially behind that provided in some prisons in England.

3. Mental health awareness

Mental health awareness among both healthcare and other prison staff is strongly encouraged to facilitate the early detection of mental health problems among prisoners. The HMIP expectations state that: “Custody staff have the appropriate training to recognise and take appropriate action when prisoners may have mental health problems”, implying that all prison staff should have at least a degree of mental health awareness training. It was also raised as a concern during the first stakeholder workshop, where levels of mental health awareness training were thought to need improvement.

All prisons offer both their healthcare staff and wing staff the opportunity to undertake mental health first aid training. Most healthcare staff in all five prisons are thought to have undertaken this training, although at the moment there is no register of trained staff and no set timetable for refreshing the training. Amongst non-healthcare staff the training is voluntary across the prisons and the proportions of staff who have undertaken the training was not available for this report. The general feeling was that coverage was reasonably good across the prisons although again there was no set process for refreshing training. In HMPs Cardiff and
Swansea all, or most, officers placed on the healthcare wing, or the drug recovery wing, had received mental health first aid training. In HMP Parc mental health awareness training forms part of the induction training so all new staff would have has at least some degree of training in this area. In addition to the mental health first aid training, the ACCT training provided within prisons has some degree of mental health training, although this is generally quite limited.

In discussion with the healthcare staff it was generally agreed that having all staff trained in mental health first aid would be of benefit and would help in the early detection of cases. At the moment training is provided by Swansea prison for staff from HMPs Swansea, Cardiff and Usk/Prescoed which would impact on any decision to make training more widely available, but there are moves for HMP Cardiff to be able to supply their own training in the near future. Training in HMP Parc is provided by Gofal who may also be able to provide additional training if required.

**External comparisons**

Only limited details were available about the type of mental health awareness training provided in the comparator prisons. HMP Liverpool reported that mental health awareness training is available for all members of staff on a voluntary basis. At HMP Nottingham one of the prison RMNs provides awareness training to both healthcare and other prison staff as part of the annual prison training day which is likely to be more highly attended than stand alone mental health training.

**4. Protocols and pathways**

HMP Usk and Prescoed reported that in house mental health protocols were up to date and in place; they use the All Wales prison mental health pathway and also have a separate pathway devised for forensic mental health services. Parc prison reported that they do have an in house mental health protocol in place and they use a mixture of separate primary, secondary and learning disabilities pathways. At HMP Swansea the mental health care protocol, based on the All Wales Prison mental health pathway, maps out the pathway from reception to primary or secondary care, but is bolstered by the use of relevant NICE guidelines which have been modified to suite the prison environment; this protocol is regularly updated and adjust through the policy and practice discussions that take place bi-monthly. HMP Swansea is also in the process of developing a separate pathway for MHIRT. Cardiff prison report that their mental health policy and pathways are not up to date, given the recent change in health care set up, and are currently under
development. All prisons report that they felt the pathways they had in place were working well and were well followed by staff; the individual prison pathway guidance can be seen in the appendix.

NICE guidelines on Common Mental Health Disorders (NICE 2011a) recommend a number of ways that access to services can be promoted, including:

- Providing multiple points of access that facilitate links with the wider health care system
- Having clear and explicit criteria for entry to the service
- Having multiple means (including self-referral) to access the services

Despite the differing levels of pathway development, all prisons reported that there are clear and agreed referral pathways and criteria in place which follows a stepped care approach as recommended by NICE and under the Prison Mental Health Pathway; PCMHT refer in to the MHIRT and from here prisoners can be referred in to the psychiatrists if required. During discussions all prisons described a system of very open access to the PMHCT which accepts referrals from the prisoner themselves, wing staff, health care staff and directly from the primary or secondary screen – this is in accordance with suggestions made in the Prison Mental Health Pathway. HMP Swansea in particular described itself as having a “very cautious approach” to mental health preferring over referral to a more restricted pathway into the PMHCT; they also operate a failsafe system whereby a prisoner referred to the MHIRT is automatically booked back into primary care to ensure that the prisoner has been seen.

In HMPs Cardiff, Swansea and Parc primary care was described as the “gatekeepers” of secondary care, with only the PCMHT can refer into the MHIRT, unless a referral is received from an outside agency requesting care be continued. In HMP Usk and Prescoed however, although there is an agreed referral pathway into the MHIRT through the PCMHT, due to the size of the team in reality referrals are taken from all prison departments and they also accept self-referrals.

In addition, in HMP Usk and Precoed a paper system of referrals currently runs in parallel to SystmOne; from speaking to staff, this is because prisoners records are no longer visible once they are transferred or released but the records may still be needed within the prison. This system of dual referrals results in much duplication and may lead to problems if the two systems are not kept completely up to date. It
would therefore be preferable to investigate if a solution for this could be found within SystmOne.

While referral pathways into MHIRTs are clear, HMP Cardiff in particular, reported that there was not such a clear distinction between roles. It was felt that PCMHT staff took on duties, such as looking after inpatients and escorting prisoners to hospital, which were perhaps officially the responsibility of the MHIRT.

**External comparisons**

In both prisons they report clear dedicated mental health care pathways, with HMP Nottingham reporting a similar system to that used across Wales with the PMHCT acting as a gateway into secondary care. In HMP Liverpool however they reported that, in addition to referrals from healthcare, they also accept self-referrals into the MHIRT services.

**5. Chronic disease management registers**

It is considered good practice in the community to maintain a register of all patients with chronic and long-term medical conditions, including mental health problem; this is also one of the indictors of quality included in the former PHPQI guidance.

In terms of mental health, these registers are kept to a varying degrees across Welsh prisons. HMP Swansea maintain a register of all prisoners with severe and enduring mental health problems on a separate system to SystmOne; HMP Usk and Prescoed use SystmOne to maintain a register and were confident that this register was complete; HMP Parc also use SystmOne to maintain a register but conceded that this would only be complete if the READ codes were correctly entered; HMP Cardiff currently do not maintain a register of prisoners with mental health problems.

One of the main uses for such a register in the community is to allow GP’s to recall patients with chronic mental health problems for an annual check, including BMI, blood pressure, alcohol consumption, cholesterol and blood glucose levels, again recommended by NICE guidelines and form QoF indicators (NICE 2009c). This
practice also meets with one of the HMIP expectations that prisoners with severe and enduring mental health problems receive assessments for both mental and physical health (HMIP 2012). At HMP Swansea the annual health checks are built into the register and care coordinators are asked to monitor when health checks are due; similarly in HMP Usk and Prescoed prisoners with mental health problems receive their annual health checks using the register. In HMP Cardiff and HMP Parc annual health checks are not performed, in HMP Cardiff partially due to the short duration in prison for many prisoners, but prisoners with health issues can request staff make them an appointment to see the GP.

Additionally, when in place, the PHPQI suggested that the registers should be used to identify individuals with three or more diagnoses so that those in need of additional support with managing their conditions can be helped. At the moment this does not appear to be common practice across the Welsh prisons and would have warranted a red warning under the only recently replaced performance measures.

In addition to the chronic disease management registers, at HMP Usk and Prescoed an annual audit of mental health services is carried out, covering ACCT’s opened and closed, transfers of care, sectionings, CPA’s open etc, and allow them to monitor services and ensure that pathways are being followed. This would be a useful monitoring tool for all prisons to adopt.

SystmOne should be set up and used correctly to allow prisons to easily extract registers of prisoners with mental health problems, and those with multi co-morbidities. In line with best practice in the community, prisons should maintain, or introduce the practice of annual health checks for those with severe mental health problems. SystmOne could also be routinely used to produce annual audits of the mental health services if the “report types” could be added and the information could be reliably extracted.

**External comparisons**

Both comparator prisons maintain an up to date register of those prisoners with severe mental health problems, with HMP Nottingham reporting that this is done through SystmOne. HMP Nottingham reports that prisoners on this register receive an annual health check, as recommended, while HMP Liverpool reports that prisoners with mental health problems are regular reviewed as part of their care.
plans but do not explicitly report whether this review covers general as well as mental health.

### 6. Mental Health Measure

As discussed earlier the Mental Health Measure was fully introduced in Wales by the end of 2012 and sets out new statutory provisions in the following distinct areas (Wales Mental Health in Primary Care 2013):

- Part 1 - Local Primary Mental Health Support Services
- Part 2 - Care Coordination and Care and Treatment Planning
- Part 3 - Assessments of Former Users of Secondary Mental Health Services

Part 1 is likely to involve change in the range of primary mental health services delivered across Wales, and a mapping exercise has taken place to look at current provision in the community (Welsh Government 2012c). Given this, it is important that the PMHCT within the prisons keep abreast of the changes to services that are likely to occur in the near future and try and insure, where possible, that continuity of care can be provided.

To meet Part 2 of the MHM all individuals receiving secondary mental health care are to be given a detailed care and treatment plan, a year was allowed (ending June 2013) to move secondary care patients onto this system. HMP Usk and Prescoed have reported that all those prisoners on the MHIRTs caseload have had MHM care and treatment plans completed, this is currently estimated at around 25 prisoners. HMP Cardiff reported that 70 of its prisoners are currently on MHM care and treatment plans, with approximately 10 prisoners waiting to be assessed for the plans. HMP Swansea report that all five of their MHIRT caseloads are already on a MHM care and treatment plan, with 10 additional individuals waiting to be assessed. HMP Parc reported that they have started placing people on the care and treatment plans but were unsure how many people are currently on them or awaiting assessment.

A knock on effect of the MHM has been the separation and clarification of the boundary between primary and secondary level care which in some prisons has caused disruption to service delivery; the previous lack of distinction had been
raised as a problem during the stakeholder workshop and concerns had been raised about how services would achieve this. In HMP Parc and HMP Cardiff for example where primary care services have only recently been reconfigured (18 and 4 months ago respectively), the measure has had little impact. In HMP Swansea however they are currently in the process of developing primary care level interventions for services, including anger and anxiety management, that had previously been run, for patients at all level of care, by the MHIRT; following the introduction of the MHM this is no longer possible. In HMP Usk and Prescoed it is not possible to make this clear distinction between services provided by primary and secondary care, due to the staffing and lack of distinction between the two team, and it is felt that “as the mental health services in the prison are working well they are not keen to alter”; this situation is currently not compliant with the MHM, however, MHM care and treatment plans are completed for all those clearly on the MHRTs caseload.

As can be seen in section 4 above (Protocols and Pathways) within all of the Welsh prisons the usual pathway into secondary care is through the PCMHT, this does not meet Part 3 of the MHM whereby those who have previously been under the care of the secondary team can self-refer back into these services if deemed necessary. The current referral pathways meet the expectations placed on the prisons by the HMIP (where it is identified that a prisons has had a previous contact with mental health services in the community, a referral to the mental health in-reach team or stepped care services (one and two) is always made, and information about previous history actively sought and subsequently used) but will need to be altered to meet the MHM requirements.

7. Service provision

A range of services should be provided to meet the needs of individuals with mental health problems who are held within prisons. However, at the stakeholder workshop several concerns were raised about the services available within the prisons and how there was unmet need. Unfortunately, in prisons, as in the community, the specific services that should be provided are not specified; instead they should cover self-help, or self-directed recovery, support, talking therapies and medication. The HMIP have two expectations in this regard:

“Primary mental health services include talking and other appropriate therapies and guided self-help for people with mild to moderate mental health problems.”
“Services are available to prisoners who need additional therapeutic/meaningful support for emotional, behavioural and common mental health problems.”

The Prison Mental Health Pathway recommends that provision should be made for a supportive day care regime and/or a range of activities and therapeutic interventions such as, specialist counselling, anger management, anxiety management, and the development of alternative coping strategies. It is likely that once NICE publishes its guidelines on psychological interventions for prisons that a more specific list of service will be prescribed but below are details of those services currently provided.

**Self-help**

All the prisons operate the step-care approach, on either a formal or informal basis, with self help being the first step. All prisons reported that, ideally, providing guidance and information was the first response when someone presents with a mental health concern; however in reality sometimes the prisoner is not in the right state of mind to receive this information on first presentation and often information is provided alongside an assessment and treatment by the PMHCT. Individuals who access these materials through healthcare staff are also have their condition actively monitored within all prisons. Often though this information is displayed on notice boards or in the clinic so may be read without going through the mental health staff and therefore without initiating follow up.

The prisons use a mixture of books on prescription, Moodjuice NHS self-help guides and leaflets provided by Mind and other mental health charities. These cover a wide variety of topics including: depression, anxiety, panic attacks, OCD, sleep problems, substance misuse, bereavement and post-traumatic stress disorder; although not all prisons appeared to have access to the full range of topics. Additionally, the level of accessibility of this information appeared to vary between prisons. HMP Usk and Prescoed have access, through Monmouthshire Libraries, to a range of audio self-help books, which are excellent for those with limited reading or concentration abilities but not specifically designed for those in prison. HMP Cardiff reported that they would adapt materials for those with reading difficulties. None of the prisons, with the exception of HMP Usk and Prescoed, were currently able to provide this information in a range of languages; this was done through collaboration with the diversity and race relations reps within the prison. Pooling resources between the prisons would provide each prison with the full range of information available and would minimise the effort required to make this
information available to those prisoner with limited reading or English language skills and also ensure all resources are available in Welsh.

External comparisons

In HMP Liverpool and HMP Nottingham a diverse selection of mental health topics are covered by self-help materials, as is the case in Wales. No further information was available for HMP Nottingham but at HMP Liverpool these services were available through the PCMHT and prisoners were actively monitored and followed up after accessing the information, similarly to Wales. HMP Liverpool reported that its materials were available in an easy read format and also that they could be translated on request; this aspect of self-help provision could be improved upon across Wales.

Mental health maintenance and life skills

Maintaining good mental health, or preventing deterioration for those with existing mental health problems, within a prison environment is more challenging than maintenance in the community. Also, not all aspects of maintaining mental health can be addressed by the healthcare staff. For example, the general education and work programmes offered by all prisons may have positive mental health benefits. In addition, each of the prisons offers a small number of life skills courses that may have a positive impact on the mental health of the inmates. Some also offer support living environment which is also likely to have a positive impact on prisoners mental health.

Swansea prison for example, an intensive prison support unit offers cookery, self care and coping skills courses to individuals on the MHIRT caseload, and a daily living assessment has been performed by the occupational therapist. Individuals under the PMHCT can be referred for these services, but would need to be accepted onto the MHIRT caseload. HMP Swansea runs regular groups within the healthcare unit which includes groups whom are likely to require support to maintain good mental health, such as older prisoners and parents away from their families (time for families). However, at HMP Swansea, when well, those with mental health problems are encouraged to integrate into the day-to-day wing routine so the mental health day care facility has been stopped.
At HMP Usk and Prescoed the education department provide excellent social and life skills courses into which the mental health team often refer. These courses cover topics such as *learning life skills and social skills programme, citizenship, communication skills* and *self-esteem*. Due to security risk, no more than five prisoners are allowed in healthcare at any one time so it is not possible to run a day care facility here. However, the prisoners run several other prisoner-led services that are likely to have a positive impact on their mental health, such as Toe-to-Toe (a one to one literacy scheme provided by the Channon Trust), a creative writing group, emerging readers group and a book group, in addition to musical, sporting and religious groups. It was not reported that there were specific arrangements in place for prisons considered particularly vulnerable due to their mental health, although the prison does specialise in prisoners considered vulnerable for other reason.

At HMP Parc a number of thinking and reading skills courses are run by the OMU and available to all prisoners. In addition, when entering the prison all prisoners, irrespective of health problems or official "vulnerability", have the option of entering a *supported living plan* – these are initiated by the nurses, with the full endorsement of the prisoner, and include an individual plan for wing staff to follow to help meet their needs. These are very useful for vulnerable/disabled/ or prisoners with learning disabilities and helps them to maintain good mental health while adjust to prison life. The plan also helps prevent problems escalating. NOMS have expressed an interest in expanding this scheme.

Cardiff prison run a similar “therapeutic landing” for those prisoners classed as more vulnerable, where, in addition to increased monitoring and support from wing staff while they adjust to prison life, they are also offered a range of life skills courses. The learning and skills department also has a one to one learning and support unit for those prisoners with literacy or other educational difficulties; this service runs the toe-to-toe literacy group and a mentoring scheme.

**External comparisons**

Both HMP Liverpool and HMP Nottingham also run services designed to maintain good mental health and prevent deterioration in those with mental health problems. In addition to a wide range of educational and workshop facilities routinely provided to all prisoners, both prisons run additional courses for those considered to be vulnerable prisoners and have mechanisms in place to ease access to these course for those with mental health problems; in HMP Liverpool this is done through a referral from healthcare whereas in HMP Nottingham they have an
access group within education who provide this. Both prisons run regular groups for those with diagnosed mental health problems, the *hearing voices group* and the *Amicus group* respectively.

The services provided seem to mirror the general support provided across Wales, however neither of the comparator prisons mention the use of supported or therapeutic/supported living arrangements, as used in HMPs Parc and Cardiff, although this was not specifically requested.

**Anger management services**

Anger management is an area covered by both the healthcare services and the wider prison regime though the Offender Management Units (OMU). All of the prisons healthcare departments have some provision for anger management, although these are often geared towards those with more severe mental health problems. Anger management is provided through the MHIRT in all the prisons for those with serious mental health problems. The manner in which this is provided is similar between the prisons, one-to-one sessions provided universally, with HMP Cardiff also offering small group sessions to those able to attend. All are run as and when needed, so waiting times are very small, and prisoners are able to attend for as long as required.

In HMP Parc there is also some provision for anger management through group work provided by the PCMHT, although this was not considered to be enough to meet the demand. In HMP Swansea MHIRT anger management courses had previously been available to PCMHT patients in need, but due to the tightening up of the distinction between primary and secondary care this is no longer the case and a new PCMHT service is under development. Some sessions are also provided by the OMU and the probation service and it was generally felt by healthcare staff that anger management was not exclusively a healthcare issue and the provision and use of these services could be increased outside healthcare.

**External comparisons**

Information on anger management arrangements at HMP Nottingham was not provided. At HMP Liverpool they do not provide any programmes or groups specifically designed to deal with anger management however the primary care psychological services assess individual prisoners’ needs and offer appropriate intervention. This appears to be similar to the one-to-one arrangements that occur across Wales, although here provided through primary rather than secondary care.
Anxiety and stress management services

HMP Cardiff MHIRT (occupational therapist) run options of either one-to-one or small group sessions for those with anxiety or stress management needs. The course consists of one two-hour session a week for six weeks and is run on an ongoing basis so the waiting list is low, at around two people, and the waiting time is around 2-4 weeks. These courses can often include an element of relaxation therapy and yoga classes are also available through the education department.

HMP Parc do not run an anxiety and stress management course as such but does offer a range of relaxation therapies such as a relaxation group, yoga group and mindfulness meditation group that are available through the safer custody team for all individuals on an ACCT or those referred by the PCMHT. These run continuously throughout the year so there is no waiting list and no fixed duration of intervention. In addition to this there are one-to-one sessions offered by the PMHCT for anxiety and stress, and this will also be dealt with by the MHIRT if it affects individuals on their caseload.

As with the anger management groups, at HMP Swansea these were routinely provided by the MHIRT with provision made for primary care referrals if necessary. The anxiety groups run six times a year and the intervention lasts for six weeks; there is a maximum waiting time of eight weeks. However, under the MHM this is no longer seen as possible and the PCMHT is in the process of developing a primary care level service to meet this need, with the hope of having it in place by August 2013; it's thought that approximately 15 prisoners will need this service. It is likely to include elements of relaxation therapy.

At HMP Usk and Prescoed the distinction between primary and secondary care is not so clear and all prisoners have access to one-to-one anxiety management sessions, although these are generally managed by the PCMHT. The sessions last for one hour and the intervention usually lasts for 6-8 sessions but can continue for as long as is needed. There is currently no waiting list for these sessions but on average a prisoner would have to wait around two weeks. In addition to this, relaxation therapies are available and the acupuncture sessions, provided by the CARAT team on a fortnightly bases, are available to all prisoners. For those with acute symptoms of anxiety reality orientation work can also be provided.
External comparisons

Like most services across Wales anxiety management in both comparator prisons appears to be primarily the domain of secondary or even crisis intervention teams. Presumably in addition to one-to-one work, HMP Liverpool provides a relaxation and anxiety management group on a weekly basis, with currently no waiting list. HMP Nottingham provides, again presumably in addition to one-to-one work, a *Stop and Think* group on a weekly basis to help with anxiety management.

Depression services

In all prisons depression was generally handled using one-to-one sessions at both a primary and secondary level depending on need. The waiting times for access to this service was not well reported but was generally thought to be within a week but also depends on need, with those individuals placed on ACCTs seen as a matter of urgency. The regularity of the sessions and the number of sessions provided are again determined based on individual need. A general counselling service is available at HMPs Cardiff, Parc and Swansea although this was not reported to be available at HMP Usk/Prescoed.

External comparisons

In HMP Liverpool depression is handled on a one-to-one basis, as is the case across Wales, with primary care psychological services assessing prisoners individual needs and then offering appropriate interventions. No information was available from HMP Nottingham.

Crisis services

All prisons run a crisis response team to who attend emergencies on the wings. In Cardiff prison this team usually comprises of RMNs and responsibility is held with the PCMHT. The service is available for at least 12 hours a day, and can be called during the night when an RMN is covering the night shift. HMP Cardiff was unable to estimate how many incidents they respond to.

Within Parc prison this team is made up of wing staff, an RGN and an RMN; as there is usually RMN cover during the night they are able to provide a response during the night but this service mainly operates during core hours. They reported
being called approximately twice daily to a variety of incidents on the wings including self-harm and prisoners experiencing a deterioration in their mental health.

In HMP Swansea responsibility also falls to primary care and incidents are usually initially responded to by an RGN, but a RMN can be requested. They were not able to estimate the number of incidents they deal with but they do cover a variety.

In HMP Usk and Prescoed both the PMCHT and the MHIRT cover crisis response due to low staff numbers and this service is only available during core hours due to the lack of 24 hour health care. The team is called at least once a week and responds to incidents such as self harm and suicidal or homicidal ideations in addition to bereavements and other emotional events.

External comparisons

Limited information on this was provided by HMP Nottingham, although the service described appeared similar to the services provided in HMP Cardiff, with 24 hour nurse cover. More details were provided by HMP Liverpool who have a crisis team led by one full time RMN (band 6) and supported by two full time RMNs (band 5). This team is available from 7.30am-7.30pm Monday to Friday and also during core hours on the weekend. The team deals with a large range of incidents from attempted suicides, mental health deterioration, antisocial behaviour, confusion and vulnerability and receives around 25 referrals a week. Although limited details are available around these teams, it appears that in HMP Liverpool the formalised approach to crisis care may provide rapid access into mental health services for those who are experiencing acute episodes or rapid deterioration in mental health.

Forensic relapse prevention signatures

At HMP Usk and Prescoed forensic relapse prevention signatures are done routinely with individuals who are transferred in with a history of self harm. Ideally they are done before an ACCT is opened at the prison, unless self harm has already happened within the prison. Forensic relapse prevention signatures involve exploring why a person self harms, what the triggers are for that behaviour and how they can prevent themselves from self harming by acknowledging these triggers. It is thought that working through a relapse prevention signature with a prisoner can reduce the need for ACCTS and can reduce the risk of self harm and
suicides. Research carried out on this technique by HMP Usk MHIRT found that using the signatures prevents future self harm episodes in 70% of those who work through the signatures (Salathial 2013). Relapse prevention work also complements the identification of risks and triggers process highlighted in the Ministry of Justices Management of prisoners at risk of harm to self, to others and from others (Ministry of Justice 2011) and the HMIP expectation that this is done; it is also comparable to relapse prevention work that should be taking place in the community.

**Forensic Psychology**

The NOMS team of forensic psychologists mainly provide treatment for sex offenders across Wales (HMPs Cardiff and Swansea) and are mainly based at Usk prison where the majority of sex offenders are housed. They consist of six forensic psychologists, four psychology assistants and four trainee psychologists. They provide four key courses: the core Sex Offender Treatment Programme (SOTP), the Extended SOTP, Healthy Sexual Functioning, and BNMLBL (becoming new me, better life boost). A similar service is provided privately within HMP Parc.

**Non-healthcare support**

In addition to mental health support provided by the healthcare team there is additional support provided by prisoner, in the form of the Listener scheme, chaplains, charity help-lines and other voluntary groups. These are considered core services and, in terms of those at risk of self-harm or suicide, the HMIP expectations are that "prisoners have access to counsellors, the chaplaincy team, listeners, the Samaritans and the consistent support of their named officer/key worker".

The prisoner led listener scheme was originally established at Swansea prison and is provided across the entire Welsh prison estate; prisoners volunteer to be trained by the Samaritans to provide support to other prisoners in distress. The number of Listeners range from five in HMP Cardiff to 15 in HMP Parc. In all prisons the presence of Listeners was reportedly made clear at reception, often with Listeners themselves present (HMPs Swansea, Usk and Prescoed). In all prisons Listeners are accessible 24hours a day and can be either approached in person or requested via the wing staff. All prisons reported that confidential rooms were available; however in HMP Cardiff these are not available on the some wings. It has previously been raised in the inspectorate reports that confidential rooms are not always available,
and while the facilities are reportedly available, it has not been possible to verify whether these facilities are routine used and easily accessible.

All the prisons provide a multi-faith facility which can be accessed by prisoners for religious worship. Chaplains are available in all prisons and can be seen on request during core hours; most prisons did not provide an estimate on the number of requests but at HMP Parc it was estimated that approximately 30 prisoners request to see the chaplain on a daily basis. In HMP Swansea it was reported that, in addition to the internal chaplaincy service, there is also a team of four community chaplains who provide through care on release; they work with the prisoners for approximately six weeks prior to release and continue to support them for up to 12 months post-release with involvement in the restorative justice scheme, resettlement and reintegration.

In addition to this a number of voluntary organisations provide support, either in person or through help-lines. The Samaritans help-line is available 24 hours a day, free of charge, in all the prisons. During periods when prisoners are in their cells they can either request to use the landing phone (HMPs Cardiff and Usk) or an officer will provide a mobile phone (HMPs Swansea and Parc). While landing phones are covered by hoods to provide some degree of privacy, providing a mobile phone to the prisoner is a more confidential arrangement. Additionally, within HMP Usk and Prescoed the MacMillian Cancer Trust and the Prison Reform Trust help-lines can also be accessed via the landing phone. Cruise, the bereavement charity, Alcoholics Anonymous and the Quakers also volunteer within the prisons, attending Usk prison regularly.

Unfortunately information of named officers or key workers was not collected but forms part of the Prison Mental Health Pathway and the HMIP expectations.

**External comparisons**

Very limited information about these services were available from HMP Nottingham. At HMP Liverpool prisoners run both a listener and an insider service, with listeners available 24 hours a day and insiders available during core hours. Both are available on the wings but there are no arrangements in place to allow for confidentiality. Chaplaincy services are also available on the request of the prisoner, during core hours, but no estimates were available on how many prisoners use these services. Finally, a Samaritans help line was available, with a
mobile phone available that can be requested and used in a prisoners cell to provide 24-hour access and confidentiality.

8. Unmet needs

It was felt by all teams that the mental health services were generally meeting the needs of the prisoners in Wales; this is in slight contradiction to the opinion of unmet need raised during the stakeholder workshop. During discussions, at HMP Usk it was felt that an increase in both general PMHCT staff and general MHIRT staff was needed, and at HMP Swansea, HMP Cardiff and to a lesser extent in HMP Parc it was felt that an increase in MHIRT staff would be beneficial although not essential at this stage. Many of the unmet needs that were expressed were in connection to staff training, as can be seen below.

During the stakeholder workshop it was widely expressed that additional specialist services were needed, particularly in the areas of personality disorder and dual diagnosis. The predicted number of prisoners with this one or both of these disorders also indicates that specialists may be beneficial. At present none of the prisons employ a designated personality disorder specialist or a dual diagnosis specialist, although the lead MHIRT nurse at HMP Usk and Prescoed is able to provide some of these services and the PCMHT lead in HMP Swansea is trained in substance misuse. However, on talking to staff within the healthcare teams this was not seen as a major unmet need. At HMP Usk and Prescoed the lead for MHIRT has previously had training in both personality disorders and drugs and substance misuse and expressed that view that training mental health staff in personality disorder allows them to better individualise their treatment plans to take this additional diagnosis into account. She felt that a lot of self-harm within prisons is due to personality disorder and this too could be better managed through specialist PD training. All members of healthcare staff spoken to agreed that providing training and “skilling up” existing staff was a preferable option to bringing in additional specialists. This approach would be likely to sit well with what have been described as “very enthusiastic” staff, both within the PCMHTs and MHIRTs across the prisons and would also add to the opportunities for continuing professional development that were raised as a concern during the stakeholder workshop. It would also meet the HMIP expectation that “training covers learning disabilities and personality disorders”.

Learning disabilities were also raised by several prisons, and during the workshop, as an area where additional training might be needed. Again it was generally
thought that learning disability specialist would be required but, much like personality disorder, additional staff training would allow for treatment plans to be better tailored to meet the needs of the individual.

At HMP Parc older prisoners mental health was raised as an area likely to see significant rises in the near future. The healthcare team at HMP Parc did not feel like they were currently equipped to deal with conditions, such as dementia, that have previously been rarely seen in the prison environment. Again, it was thought that training provided to the current staff would be more beneficial than bringing in a specialist; although general staffing levels would need to be reconsidered should the demands of this increasing group detract staff from other services.

HMP Parc also raised the needs of the young people as an area in need of improvement. In English prisons speech and language therapist (SALT) routinely work with individuals in young offenders institutes to improve their abilities to communicate and relate to other people. This issue was also raised during the stakeholder workshop as problem. Currently these services are not available in Wales but, especially as the number of young people housed at HMP Parc is likely to reach capacity due to recent changes in England, it is worth investigating these services further.

It was generally suggested, by Parc and Cardiff prisons especially, that they were in need of more general counselling and bereavement services; coupled with this it was suggested that CBT training to be provided to staff. Again these were issues raised during the stakeholder workshop. Currently Cardiff prison has some counselling services provided by trainee psychologists from Cardiff and Newport Universities. Interestingly it was queried whether, given sufficient training and risk assessment, it would be possible for fellow prisoners to undertake some of this work – a super Listener role. While this is not an approach that has been widely used it could prove beneficial to the healthcare teams, prisoners and the super listeners themselves so is worth further thought.

Cardiff prison took advantage of the “unmet needs” table on SystmOne and also indicated that Living Skills and Bereavement counselling would be useful in order to help prisoners maintain good mental health.
9. Links to other services within the prison

The HMIP expectations associated with mental health care reach beyond health care staff and state that “custody staff work effectively with health staff to ensure a prisoners care”. Across Wales there appear to be different degrees of linking between the healthcare teams and the other departments within the prison, such as education and works; although all teams reported good links with offender management unit (OMU). It is possible that many of the services and activities offered by these departments, or potentially offered jointly between the departments, could be beneficial to patients with mental health problems. HMPs Usk, Prescoed and Swansea reported very strong links between the healthcare department and the Education and Works departments and the gym. In HMPs Usk, Prescoed and Swansea the mental health lead also attended a broader multidisciplinary meeting, the IRM board, consisting of security, police and forensic psychology, on a monthly basis to provide advice on all new prisoners seen and also those prisoners due for release. In HMP Swansea formal referrals are now made between healthcare and other departments and representatives from these departments are invited to participate in ACCT meetings. In Parc however, while there were strong links and joint services between healthcare and OMU, the healthcare team felt they were less well connected to the other departments.

10. Patient involvement

Patient involvement in both the planning of health services and their own care is strongly encouraged in both national health care and prison guidance. This is shown by the HMIP expectation on general health care that “there is a patient forum that is representative of the current prison population” and, particularly focusing on the mental health services, that: “Prisoners are encourages to take an active part in their own recovery and in care planning”.

The prisoners forum is the main route through which, with the exception of HMP Swansea, prisoners can get involved in improving the healthcare system. In HMP Swansea there are two routes for prisoner involvement, the first is via the regular meetings between wing representatives and the residential Wing Governor and the second is via the prisoner complaints system which sometimes provides useful information about how services should be adjusted.
In terms of prisoners involvement in their own mental health care plans, all prisons reported that they use a prison focused approach with the prisoner being fully involved. In the community setting families are often also involved in the care planning process, however this is more difficult in the prison environment and none of the prisons reported that this was a routine part of the process. In HMP Swansea families were more likely to be involved for prisoners with a high risk of deliberate self harm and HMPs Parc and Cardiff reporting that families were rarely involved. In HMP Usk the situation is different again, with many prisoners actively denied contact with their families due to the type of offences they have committed.

**External comparisons**

At both HMP Nottingham and Liverpool prisoners are reportedly fully involved in the development of their mental health care plans. HMP Nottingham reports that family members are often involves in the planning of care, while HMP Liverpool reports that they are notified.
Process of mental health care delivery

1. Identification

In all prisons prisoners are made aware of the mental health services available on reception into the prison, this is often done during the mental health section of the reception screen; they are often reminded of these services during the second screen. In HMP Usk and Precoed there are mental health promotion boards where services are also advertised and leaflets are handed out to prisoners detailing the services. HMP Cardiff also advertises its mental health services through wing staff.

Within a prison setting there are several key points when an individual with mental health problems could be identified. These include the primary and second health screens, which are supposed to be performed on the day of entry and within 3 days of entry respectively (HMIP 2012). These screens are designed to detect a number of different mental and physical health problems through the use of both direct questioning and also through general discussions with the prisoner by members of staff who, with the correct training, may be able to detect issues that require further assessment. Prisoners who are transferred in from other prisons should have a transferred in screening, which forms a similar function to the primary screening but often involves more of a review of the medical records rather than the formal questioning of the primary screen. Prisoners transferred in then usually receive a more detailed second screen, although on some occasions this may not be done if the transferred medical records are clear and the prisoner has recently received a second screen in their previous prison.

Primary health screen

Data on when the primary screen was done, in relation to the date the prisoner entered the prison, and the person who performed the screen was extracted from SystmOne; staff names were then matched with their qualification (provided separately); this data is summarised in the table below. HMP Usk and Precoed only receive prisoners from other prisons so do not do primary screens as such.

Nearly 1,000 primary screens were performed in Cardiff prison during the three months from October to December 2012, for 95% of these the dates available on SystmOne were valid (occasionally the date of screen came before date of entry.
making the data invalid and was therefore not included; these figures assume all valid dates were inputted correctly). In HMP Parc 99 primary screens were done, and 96% had valid dates. In HMP Swansea 390 first screens were recorded on SystmOne and 95% of these had valid dates (Table 6). All prisons performed nearly 100% of primary screened on the day of entry, as recommended by PHPQI, with minor deviations from this likely to be due to data quality.

The Prison Mental Health Pathway identifies the primary screen as a key phase for the identification and risk assessment of individuals with known and unknown mental health problems. The pathways highlights that an RMN should be involved in the primary screen process. There was variation across the prisons in terms of the qualifications of the members of staff who perform the primary screen. In HMPs Cardiff and Swansea the majority, but by no means all, of primary screens were done by RMNs (63% and 49% respectively), where as in HMP Parc the majority were performed by RGNs (90%) (Table 6). Unlike HMP Parc, in HMPs Cardiff and Swansea over a quarter of primary screens are being carried out by healthcare assistance/officers (HCA). On discussions with the healthcare staff it is clear that these screens are done under the supervision of the qualified nursing staff, and that only HCA deemed suitable for this work carried out the tasks; however, as one of the main points at which mental health problems may be identified, especially in individuals who are transferred out before receiving their second screen, the ability of screening staff to detect the signs of mental health issues is crucial. It is therefore recommended that if HCA are to continue to carrying out this role then a minimum standard of mental health training should be introduced.

### Table 6. Primary health screens completed between October and December 2012

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of primary screens: Total</td>
<td>999</td>
<td>99</td>
<td>390</td>
</tr>
<tr>
<td>Number of primary screens: valid</td>
<td>947 (94.8%)</td>
<td>95 (96.0%)</td>
<td>371 (95.1%)</td>
</tr>
<tr>
<td>% primary screen done on day of registration*</td>
<td>99.8%</td>
<td>99.8%</td>
<td>100%</td>
</tr>
<tr>
<td>Number done by RGM</td>
<td>64 (6.4%)</td>
<td>89 (90%)</td>
<td>101 (25.9%)</td>
</tr>
<tr>
<td>Number done by RMN</td>
<td>632 (63.3%)</td>
<td>0</td>
<td>189 (48.5%)</td>
</tr>
<tr>
<td>Number done by HCA</td>
<td>302 (30.2%)</td>
<td>0</td>
<td>100 (25.6%)</td>
</tr>
<tr>
<td>Number done by other (specified)</td>
<td>1 (0.1%) GP</td>
<td>10 (10%) LDN</td>
<td>0</td>
</tr>
</tbody>
</table>

*using valid dates

### Transferred in health screen

As mentioned previously, prisoners transferred in from other prisons do not usually receive a primary screen. Instead their medical notes are reviewed by healthcare staff and the HMIP expectation is that prisoners transferred in from another prison
“receive a comprehensive reception screen, including a review of all previous interactions with health services” (HMIP 2012). As with the primary screen, ideally this review should be conducted on the day the prisoner is transferred in to ensure any health problems are picked up swiftly. Unfortunately, due to the way SystmOne is set up and the fact that medical records can be pulled back and fore between sending and receiving prisons, it was not possible to reliably say exactly how many transfers were reviewed on the day of transfer; it appears that this is very often the case however.

As the transfer in screen requires the review of the prisoners medical summary it would be ideal if this could be carried out by a member of healthcare staff with a suitable level of training. In the majority of cases the reviews were conducted by either an RGN or an RMN (Table 7). However, in a substantial minority of cases, like the primary screens, the reviews appear to have been conducted by a HCA. As previously stated, although these reviews are done under the supervision of a nurse and often with a RMN reportedly performing the mental health review, it is possible that a transfer screen reviewed by an under qualified member of the healthcare team may result in important factors going unrecognised. Again, if HCA are to continue to carrying out this role then a minimum standard of mental health training should be introduced.

### Table 7. Transferred in health screens performed between October and December 2012

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
<th>Usk</th>
<th>Prescoed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfers in</td>
<td>54</td>
<td>420 (-0, 4,6)</td>
<td>74 (0, 2,4)</td>
<td>74 (1,3,3)</td>
<td>109 (0,0.2)</td>
</tr>
<tr>
<td>Number done by RGM</td>
<td>3 (5.6%)</td>
<td>2 (0.5%)</td>
<td>17 (23%)</td>
<td>74 (100%)</td>
<td>104 (95.4%)</td>
</tr>
<tr>
<td>Number done by RMN</td>
<td>40 (74%)</td>
<td>381 (90.7%)</td>
<td>55 (74.3%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number done by others</td>
<td>0</td>
<td>36 (8.6%) LDN</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number done by HCA</td>
<td>11 (20.4%)</td>
<td>1 (0.2%)</td>
<td>2 (2.7%)</td>
<td>0</td>
<td>5 (4.6%)</td>
</tr>
</tbody>
</table>

### Second health screen

It is recommended that the second health screen is carried out within 72 hours of the prisoner entering the prison. The second health screen is technically voluntary on the part of the prisoners but it is recommended that all new receptions should receive the screen if they remain in prison for three days or more, as should all transfers; although as previously mentioned this may be less essential if a second
screen was very recently done before transfer and adequate notes were transferred.

Receiving a second health screen was one of the PHPQI used by Welsh Government, with the aim of 100% of prisoners accepting the offer and a red warning issued if less that 90% received the second screen. Unlike primary screens not all prisoners appear to have received a second screen across Wales; with below 90% being screen in HMPs Cardiff, Parc and Usk prisons. However, as it is not possible to distinguish second screens performed on prisoners transferred in from those performed on new receptions it is not possible to say how many of those not screened may have had a recent second screening carried out elsewhere. Additionally, the particularly poor second screening rate in Parc prison may be due to the slower transfer to SystmOne in this prison with prison healthcare staff reporting that an internal audit did not show this level of missed second screens and that SystmOne use was suboptimal during the data collection period.

Of those second screens that were completed, in HMPs Cardiff and Swansea over 90% were carried out within the recommended 72 hours (3 days). At HMP Usk and Prescoed second screens were slightly delayed in taking place with only 36% and 61% occurring within the recommended window respectively; although this was improved upon at one week post entry. At HMP Parc SystmOne appears to show not only a lack of second screens but also a lack of timeliness, with over 50% of those completed being done over a week after entry into the prison. HMPs Usk, Prescoed and Parc should all look at improving the timeliness of their second screens in order to catch mental health problems before they escalate.

Table 8. Second health screens performed between October and December 2012

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
<th>Usk</th>
<th>Prescoed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number eligible for second screen*</td>
<td>1013</td>
<td>503</td>
<td>452</td>
<td>81</td>
<td>114</td>
</tr>
<tr>
<td>Total second screens (% of eligible)</td>
<td>899 (88.7%)</td>
<td>317 (63%)</td>
<td>438 (96.9%)</td>
<td>68 (84.0%)</td>
<td>104 (91.12%)</td>
</tr>
<tr>
<td>Invalid dates (% of eligible)</td>
<td>25 (2.5%)</td>
<td>3 (0.6%)</td>
<td>19 (4.2%)</td>
<td>1 (1.2%)</td>
<td>3 (2.6%)</td>
</tr>
<tr>
<td>Completed &lt; 1 day (% of screened)</td>
<td>297 (34.0%)</td>
<td>0 (0.0%)</td>
<td>1 (0.2%)</td>
<td>18 (26.9%)</td>
<td>56 (55.4%)</td>
</tr>
<tr>
<td>Completed &lt; 4 days (% of screened)</td>
<td>810 (92.7%)</td>
<td>49 (15.5%)</td>
<td>417 (95.2%)</td>
<td>24 (35.8%)</td>
<td>62 (61.4%)</td>
</tr>
<tr>
<td>Completed &lt; 7 days (% of screened)</td>
<td>867 (99.2%)</td>
<td>138 (43.5%)</td>
<td>417 (95.2%)</td>
<td>54 (80.6%)</td>
<td>98 (97.0%)</td>
</tr>
<tr>
<td>Number done by RGM</td>
<td>78 (8.7%)</td>
<td>26 (8.2%)</td>
<td>233 (53.2%)</td>
<td>67 (98.5%)</td>
<td>100 (96.2%)</td>
</tr>
<tr>
<td>Number done by RMN</td>
<td>608 (67.6%)</td>
<td>32 (10.1%)</td>
<td>205 (46.8%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number done by HCA</td>
<td>212 (23.6%)</td>
<td>259 (81.7%)</td>
<td>0</td>
<td>1 (1.5%)</td>
<td>4 (3.8%)</td>
</tr>
<tr>
<td>Number done by other</td>
<td>1 (0.1%) GP</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* Includes all newly incarcerated prisoners in for >3 days plus transfers in for > 3 days (all assumed to require second screening)
This screen is designed to look in more detail at the prisoners health and should include a substantial review of the prisoners mental health. For this reason the second health screen should be done by an RMN. All prisons appreciated the importance of mental health assessments being carried out by suitably trained staff and reported that they were always carried out by RMNs, unfortunately it was not clear if the second screen was considered a mental health assessment by all. The data from SystmOne suggests that second screens are not routinely carried out by RMNs in all prisons. In Parc prison a large proportion of second screens are recorded as being carried out by HCAs, with a substantial minority of second screens in HMP Cardiff also carried out by HCAs. It is important to acknowledge the reported high level of supervision of HCA and the reported sharing of the second screen, with RMNs coming in to do the mental health aspects, which may not be captured on SystmOne. However, the second screen represents probably the most important point of contact in terms of detecting health issues in prisoners, including mental health problems, and it is questionable whether HCA, even with supervision, should be carrying out this role. It is important that the mental health aspect of the screen is conducted by an RMN and it would be useful if SystmOne could be modified to allow prisons to monitor this.

Other routes of identification

Due to the high levels of staff awareness about mental health that all prisons reported, wing staff, reception staff and education staff all refer individuals in for mental health assessments; HMP Cardiff reported “a very positive attitude towards mental health in the prison”. This means than many issues are picked up promptly and health care staff at HMP Parc reported that they “receive a lot of referrals and see very few late presentations”, a sentiment echoed by the other prisons.

In addition to general staff awareness, individuals with mental health issues can been identified at HMP Parc during the exit board meeting, when a prisoner has been in the prison for one months and is exiting the induction wing.

External comparisons

At both HMP Liverpool and HMP Nottingham, as is the case across Wales, prisoners are initially made aware of mental health services on reception – both verbally and via leaflets. Both comparator prisons, like the Welsh estate, reports that RMNs from either the PCMHT or the MHIRT perform all mental health assessments, although
again it is unclear whether this includes the primary and second health screen. In both cases these assessment cannot be done on a 24hour basis. Information on the timeliness of these screens is unfortunately not available for the comparator prisons.

2. Assessments

The Prison Mental Health Pathway specifies that mental health assessments should be done by an appropriately qualified member of nursing staff; all prisons reported that RMN’s performed the mental health assessments within the prison. As mentioned previously there is limited mental health cover during the night, for this reason only Parc prison reported that mental health assessments could be conducted 24hours a day.

The use of a standardised tool for the assessment of depression is one of the process measures used by the PHPQI assessment in an effort to improve the identification and management of depression; the assessment of depression severity by primary care using a validated tool is also one of the QOF mental health indicators and forms part of the Prisons Mental Health Pathway in Wales. All prisons reported that they routinely use a standardised tool to assess and diagnosis anxiety and depression disorders, and also in some case to monitor those going through detoxification or prison adjustment issues. The table below shows usage data for these tools, extracted from SystmOne; it is known that Parc prison has only recently starting recording routinely on SystmOne, previously scoring individuals on paper and then scanning this into the system. Also it has been reported that there are problems with SystmOne extracting this data from HMP Usk and Prescoed which explains the very small numbers for these prisons below; on discussion with mental health staff at the prison all referrals to either PMHCT or MHIRT are assessed using a standardised tool.
Table 9. The use of validated depression and anxiety scales between October and December 2012

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
<th>Usk</th>
<th>Prescoed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validated depression scales used</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BECKS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>229</td>
<td>54</td>
<td>245</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>GAD7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>42</td>
<td>4</td>
<td>60</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>HAD anxiety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>22</td>
<td>26</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>HAD depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>22</td>
<td>24</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PHQ9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>160</td>
<td>21</td>
<td>132</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

As can be seen from both table 9 and figure 6 below four different tools are routinely used and coded within the prisons; the Becks depression scale, the Generalised Anxiety Disorder Assessment (GAD 7), the Hospital Anxiety and Depression scales (HAD) and the Patient Health Questionnaire Depression Scale (PHQ9). It was noted by several prisons that this use of a variety of similar tools across the Welsh prison estate was not conducive to providing continuity of care. The results from different tools are not easily comparable and therefore when prisoners are transferred from one prison to another there are no transferable baseline data and the prisoners progress cannot be well monitored. All prisons were in agreement that moving towards the universal use of a single tool would be preferable and beneficial to patient care. This would also be in keeping the with QOF indicator whereby a patient with depression should be reassessed for severity within 4-12 weeks after the initial assessment. All of the validated scales used across Wales are supported by NICE and they do not specify a preference, although 1000 lives plus discuss using the PHQ9 in a clinical setting (1000 lives+ 2012). The PHQ9 appears to be by far the most used depression scale although this does not include Usk and Prescoed prisons where the BECKS is widely used (as reported through discussions with healthcare staff). There appears to be a less prominent choice of anxiety scale and this could be further discussed between healthcare teams.
It was raised by one of the prisons that many prisoners are being transferred in on medication for mental health problems, depression in particular, but with no depression assessment on SystmOne. Data displayed here clearly shows that more prisoners are currently receiving antidepressants than have received a recent depression assessment using a standardised tool. However, it is unclear whether the prisoner has been placed on medication without an assessment having taken place, or whether the assessments are not being recorded on SystmOne correctly. Having discussed pre-prescription assessments with Parc prison it seems likely that both of these factors play a role, with patients being assessed pre-prescription depending on how they seem at presentation; additionally all patients on antidepressants would be reviewed by the GP, but it is unclear whether formal assessment tools are routine used and recorded here. Often the notes of a transferred prisoner contains reference to the assessment being done but none of the details are available. Again this makes monitoring progress difficult and may impact on the continuity of care.

It has additionally been suggested that a standardised self harm and suicide tool could be adopted across the Welsh prison estate and that this be introduced into the primary or second health screen to help reduce the risk of serious incidents. This would be in line with the Prison Mental Health Pathway which suggests that the identification and assessment of those prisoners at risk of self harm and/or suicide
should be done on the day of reception. Tools have been developed and trialled at HMP Usk and Prescoed but are thought to be suitable for use across the prison estate (Salathial 2013); additional tools have been developed by the Oxford Suicide Unit and are in use in some prisons. It was suggested that forensic mental health training for staff might open up a range of other useful tools and techniques more suitable to the prison environment.

In addition the PHPQI’s recommended that 100% of prisoner should be screened using AUDIT, or another validated tool, for signs of harmful, hazardous and dependent drinking. While it is currently not possible to extract data on the number of prisoners screened for alcohol use it appears that there is poor recording of alcohol abuse, with 200 cases reported across Wales compared to an estimated number of 1,800 using national estimates (discussed in the Number of prisoners with signs of mental health problems section). This would imply that this is either not a routine part of the mental health screening or that it is not being recorded adequately on SystmOne; in Swansea prison for example the AUDIT screen forms part of the second health screen but it was not possible to extract this from the system.

**External comparisons**

As mentioned above, both comparator prisons report that only RMNs perform mental health assessments. Both prisons report using standardised tools to diagnose both depression and anxiety, with the PHQ9 and the GAD7 respectively used at HMP Nottingham; at HMP Liverpool the “Core” tool is used to measure psychological distress rather than depression or anxiety separately.

**3. Follow up, referrals and waiting times**

It was generally agreed across the prisons that patients with mental health problems were regularly followed up. It was also generally agreed that the frequency of this follow up would depend on the severity of the illness/individual needs with prisoners for whom there were no immediate concerns usually followed up approximately monthly; those with more immediate problems were followed up more regularly and those who were very unwell housed within healthcare at HMP Cardiff and followed up daily at the other prisons. At HMP Usk and Prescoed a distinction was made between follow up regularity by the PCMHT and that by the MHIRT; this is likely to be a patterned mirrored across the prisons.
It was anticipated that, through the use of SystmOne it would be possible to extract activity data for all elements of mental healthcare including PCMHT, MHIRT, psychiatry and psychology. Unfortunately, due primarily to the lack of SystmOne usage by the psychiatry and psychology teams, and the use of paper prescriptions for things like exercise referral and books on prescription, it has not been possible to produce a reliable picture of their activity levels. It is worth encouraging the individuals to work with SystmOne and also considering whether drop down menus or tick boxes could be introduced onto systmOne to help with future audit work in this area. However, below are outlines of the activity of the PCMHT and the MHIRT; although it is important to stress that the accuracy of SystmOne data in these areas is still variable.
Table 10. SystmOne recorded PCMHT Activity between October and December 2012

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
<th>Usk</th>
<th>Prescoed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of patients referred to or seen by PCMHT</strong></td>
<td>228</td>
<td>111</td>
<td>328</td>
<td>65</td>
<td>22</td>
</tr>
<tr>
<td><strong>Of whom:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred to and seen by PCMHT</td>
<td>65</td>
<td>0</td>
<td>61</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>Median number of referrals (Range)</td>
<td>1 (1-6)</td>
<td>-</td>
<td>2 (1-4)</td>
<td>1 (1-3)</td>
<td>1 (1-2)</td>
</tr>
<tr>
<td>Median number of visits (Range)</td>
<td>1 (1-3)</td>
<td>-</td>
<td>1 (1-5)</td>
<td>3 (1-8)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Median wait for visit* (Range)</td>
<td>9 days (0-30days)</td>
<td>-</td>
<td>15 days (0-52)</td>
<td>5 (0-19)</td>
<td>13 days (4-42)</td>
</tr>
<tr>
<td><strong>And:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seen without referral (chronic cases?)</td>
<td>20</td>
<td>2</td>
<td>71</td>
<td>31</td>
<td>5</td>
</tr>
<tr>
<td>Median number of visits (Range)</td>
<td>1 (1-2)</td>
<td>1 (1)</td>
<td>1 (1-9)</td>
<td>2 (1-8)</td>
<td>1 (1-2)</td>
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<tr>
<td><strong>And:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred but deducted before seen</td>
<td>96</td>
<td>18</td>
<td>192</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Median number of referrals before deducted (Range)</td>
<td>1 (1-3)</td>
<td>1 (1)</td>
<td>1 (1-4)</td>
<td>-</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Median wait before deduction (Range)*</td>
<td>19.5 days (2-107days)</td>
<td>34.5 days (2-90)</td>
<td>38.5 (1-117)</td>
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<td>11 (4-38)</td>
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<td><strong>And:</strong></td>
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<td></td>
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<tr>
<td>Currently waiting to be seen</td>
<td>47</td>
<td>91</td>
<td>104</td>
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<td>6</td>
</tr>
<tr>
<td>Median number of referrals (Range)</td>
<td>1 (1-5)</td>
<td>1 (1-2)</td>
<td>1 (1-6)</td>
<td>1 (1-2)</td>
<td>1 (1-3)</td>
</tr>
</tbody>
</table>

*from first referral
The data for Cardiff prison (Table 10) was agreed to be reasonably accurate by the healthcare staff. In total 228 prisoners were either referred to and/or seen by the PCMHT between October and December 2012. This could be broken down into 65 prisoners who were referred to and seen within this time period, with an average of one referral and one visit per person, and they waiting an average of 9 days between the first referral and there first visit. In addition to this 20 prisoners were seen during this period without a referral being recorded, these individuals may either be acute cases seen immediately, follow up appointments made after previous referrals or referrals unrecorded on SystmOne. There were also 96 individuals who were referred to see the PCMHT but were transferred out of the prisons prior to their appointment; these individuals were waiting for a median of 19.5 days between being referred and being transferred which may reflect that they were seen as less urgent cases; the healthcare team agreed this was likely to be the case with the majority of urgent cases reportedly seen within three days. Finally, there were 47 individuals who were awaiting their appointments at the end of December 2012; this figure has reportedly improved since December.

For Parc prison the data was of poor quality and having discussed the results displayed above with healthcare staff it was agreed that they were not representative of PCMHT activity at the prison but did represent the under use of SystmOne. The use of the system has reportedly improved dramatically since this data was extracted. It was also reported that a different set of read codes had been used within the prison, but it was agreed that uniform use of read codes would be beneficial and that the team would following the standard codes for Wales.

In Swansea prison data quality appears to be good and was agreed to be reasonably accurate by healthcare staff. A total of 328 prisoners were either referred to and/or seen by the PCMHT between October and December 2012. Of these 61 were referred to and seen within this time period, with an average of two referral and one visit per person, and they waiting an average of 15 days between the first referral and there first visit. In addition to this 71 prisoners were seen during this period without a referral being recorded, these individuals were thought by healthcare staff to be mainly self referrals and follow up appointments. There were also 192 individuals who were referred to see the PCMHT by were transferred out of the prisons prior to their appointment; these individuals were waiting for a median of 38.5 days between being referred and being transferred and the healthcare team thought that many of these may have not attended their appointments or may have been follow up appointments deliberately made for the future. This may again reflect that they were seen as
less urgent cases and it would be useful to know if this delay was by design. Finally, there were six individuals who were awaiting their appointments at the end of December 2012.

The PCMHT at HMP Usk had 65 prisoners referred to and/or seen by them between October and December 2012 and this was thought to be a reasonable reflection of the caseload calculated internally. Of these 26 were before referred and seen during this period, with an average of one referral and three visits per prisoner, and waiting on average only 5 days. In addition to this 31 were seen without a referral being made during this period and were seen twice on average – as with the other prisons these are likely to represent a mixture of acute cases and follow up appointments. Nobody was deducted before they were seen by PCMHT at HMP Usk and at the end of 2012 there were eight individuals waiting to be seen.

Finally, at HMP Prescoed eight people were referred to and seen between October and December 2012; these individuals waited an average of 13 days to be seen and were only referred once on average. There were an additional five individuals who were seen without referral and they were seen once on average. In addition three individuals were deducted before they were seen by PMHCT after waiting an average of 11 days. At the end of 2012 there were six prisoners waiting to be seen.
Table 11. SystmOne recorded MHIRT Activity between October and December 2012

<table>
<thead>
<tr>
<th></th>
<th>Cardiff</th>
<th>Parc</th>
<th>Swansea</th>
<th>Usk</th>
<th>Prescoed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of patients referred to or seen by MHIRT</td>
<td>296</td>
<td>89</td>
<td>56</td>
<td>119</td>
<td>19</td>
</tr>
<tr>
<td>Of whom:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred to and seen by MHIRT</td>
<td>17</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Median number of referrals (Range)</td>
<td>1 (1-3)</td>
<td>1 (1-2)</td>
<td>2 (1-4)</td>
<td>1 (1)</td>
<td>-</td>
</tr>
<tr>
<td>Median number of visits (Range)</td>
<td>2 (1-11)</td>
<td>1 (1-6)</td>
<td>2 (1-3)</td>
<td>1 (1-2)</td>
<td>-</td>
</tr>
<tr>
<td>Median wait for visit* (Range)</td>
<td>17 days (1-74 days)</td>
<td>4 (1-28)</td>
<td>16 (6-36)</td>
<td>16 (0-23)</td>
<td>-</td>
</tr>
<tr>
<td>And:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seen without referral</td>
<td>36</td>
<td>55</td>
<td>5</td>
<td>105</td>
<td>14</td>
</tr>
<tr>
<td>Median number of visits (Range)</td>
<td>3 (1-12)</td>
<td>2 (1-17)</td>
<td>1 (1-6)</td>
<td>1 (1-11)</td>
<td>1 (1-3)</td>
</tr>
<tr>
<td>And:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred but deducted before seen (includes inappropriate referrals)</td>
<td>151</td>
<td>9</td>
<td>31</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Median number of referrals before ded(Range)</td>
<td>1 (1-3)</td>
<td>1 (1)</td>
<td>1 (1-5)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Median wait before deduction (Range)*</td>
<td>27 (0-107)</td>
<td>38 (2-93)</td>
<td>32 (3-115)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>And:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently waiting to be seen (includes inappropriate referrals)</td>
<td>92</td>
<td>20</td>
<td>15</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Median number of referrals (Range)</td>
<td>1 (1-2)</td>
<td>1 (1-3)</td>
<td>2 (1-3)</td>
<td>1(1)</td>
<td>1.5 (1-2)</td>
</tr>
</tbody>
</table>

*from first referral
In terms of the MHIRTs, as would be expected, the level of activity is much lower than at primary care level. Again there are some issues around data quality and consistent use of SystmOne (Data displayed in Table 11 above). There are relatively low numbers of prisoners, across all prisons, referred to and seen by the MHIRT during the three month period examined here, illustrating the higher threshold for addition individuals to the secondary care case load. For these individual the waiting time was on average about 16 days in HMPs Cardiff, Swansea and Usk and was quicker in HMP Parc at just 4 days. The relatively large number of individuals seen without a referral may indicate that a lot of the consultations are repeat consultations with individuals with ongoing mental health issues; In HMP Usk this may also include individuals for whom reports are being written. The relatively high number of individuals referred to and either still waiting or deducted before being seen at HMP Cardiff may illustrate a bottleneck in the mental health care system, with either a low threshold for referral or insufficient MHIRT staff to receive the referrals; the PCMHT in HMP Cardiff was undergoing development during the period of data collection and it is highly likely that this picture illustrates a period of adjustment. Ideally, regular audit of this activity would show a decrease in the numbers waiting/deducted while waiting.

It was mentioned by healthcare staff during the review of the SystmOne data that several elements do not lend themselves to monitoring waiting times. Firstly, it is relatively common practice for follow up appointments to be booked quite far ahead, this would appear in the figures as a large waiting time but in reality was a planned part of care. It was suggested that perhaps, in such instances, individuals could be classed as under “ongoing care” rather than referral. In addition, SystmOne currently has no way of recording if a referral to MHIRT has been classed as inappropriate and referred back to primary care – this would have been a valuable facility for monitoring the effect of the Mental Health Measure. Finally, it would be useful to note whether an appointment has been made for an individual but that individual has not attended, and the reason for that none attendance.

Care planning is an important part of mental health service prevision and is highlighted in several of the key guidelines such as the Prison Mental Health Pathway, the HMIP expectations and the MHM. However, as the current needs assessment coincided with a shift from the Care Programme Approach to the Mental Health Measure care and treatment plans, it was an inappropriate time to look in detail at this aspect of care. Additionally, it is currently routine practice in some prisons for care plans to be completed by hand and then scanned into SystmOne, again making the extraction of date difficult. Extending SystmOne to
allow this to be easily done and READ coded would be highlight beneficial both in terms of continuity of care and auditing/monitoring of the service.

**External comparisons**

Although SystmOne data was not available for the comparator prisons they did report, as was reported across Wales, that the regularity of follow up depended on patient need; HMP Liverpool stated that on average patients with mental health problems were followed up on a weekly basis.

### 4. Discharge

The key aspects of discharge for patients with chronic conditions, such as mental health problems, are set out in a driver diagram produced for the PHPQI team; in short this include providing prisoners with details of any appointments made for them in the community, providing an adequate supply of medication, notifying the GP and other healthcare providers and forwarding on relevant information. Many of these aspects are repeated in the Prison Mental Health Pathway, with an additional specification that a multi-disciplinary/agency pre-discharge meeting should be arranged and an aftercare plan should be developed and circulated for those with more severe mental health problems.

Discharge arrangements were raised by some at the stakeholders workshop as an area of concern, although during discussions with healthcare staff all prisons reported that they had good relationships with the relevant community mental health teams and other services, such as Drug Aid, HAFAL and veteran support. Additionally, at HMP Usk and Prescoed, and possibly other areas, the CARATs team provide a Transitional Support Service for those prisoners with Alcohol or Drug problems; they work with those with less than 12 months left on their sentence and continue working with them after release. All teams felt that discharge arrangements worked well and that they had experienced not particular problems with this aspect of the system, although often very little time was made available to plan discharges.

It is worth noting that the discharge arrangements and post-release support between the different types of prisoners differ quite significantly, with the long term prisoners held predominately at HMPs Usk, Prescoed and Parc often
handled by an inter-department risk management (IMR) teams who link in with the MAPPA committees. Such prisoners need to attend parole boards, where their mental health may be considered, and they are likely to be passed to the probation services. In addition, many of the longer term prisoners held at HMP Usk and HMP Parc are from outside the area so discharge might potentially be more difficult to manage; however, healthcare staff reported that follow up is successfully put in place for all prisoners, irrespective of location, and all prisoners are discharged with a forensic prison mental health pathway.

**External comparisons**

HMP Liverpool reports running similar discharge arrange to that reported across Wales, with the relevant GP, CMHT and/or drug services contacted depending on the diagnosis and level of support required upon release. At HMP Nottingham, in addition to case workers making the appropriate contacts with community servicers, they have an outreach service who begin working with prisoner whilst they are still in prison and then continue to provide support once they have been released – similar to the Transitional Support Service mentioned above but expanded to all those with mental health problems rather than focussing on those with drug and alcohol problems.
Outcome of mental healthcare

1. Antidepressants

As might be expected given the different classifications of the prisons within this HNA there was a considerable difference in terms of the levels of in-possession medication. In HMP Usk and Prescoed all prisoners are in possession of their own medications, in HMP Parc and HMP Cardiff between half and two thirds of prisoners are in possession of their own medication (56% and 60% respectively), whereas in HMP Swansea a third of prisoners are in possession of their own medication.

The stakeholder workshop raised several concerns about prescribing practices in the prisons, with concerns raised about both over prescribing and old fashioned prescribing patterns. The prescribing element of SystmOne is currently not being used within Wales so it was not possible to extract this data directly from the medical records. However, an audit of prescribing practices across the Welsh prisons was carried out during September 2012 (Richards 2012). One of the six medications audited was Mirtazapine, an anti-depressant. A summary of the findings from the audit are displayed in figure 7 below and indicates a large discrepancy in prescribing practices across the prisons; 25% of the prison population at HMP Swansea are currently receiving Mirtazapine compared to 4.5% at HMP Prescoed.

![Figure 7. Monthly Mirtazapine prescriptions and % of prison population currently receiving medication.](image-url)
There the use of antidepressants was enquired about during this HNA; during the stakeholder workshop it was raised as a potential areas where prison services were not keeping up with services in the community. On discussion at HMPs Parc, Swansea and Cardiff it was acknowledged that antidepressants are currently used as a safety net to prevent suicides and in the latter two prisons it was agreed that this was a pattern of prescribing adopted following a spate of suicides. All three agreed that this was not an ideal approach and that they were moving towards a watch and wait approach and encouraging staff to use NICE guidelines and try self-help and non-pharmacological treatments first. However, the issue was raised at Swansea prison that during the remand phase of a prisoners journey, and if they have substance misuse issues, then this approach is not always straightforward.

The PHPQI’s, in accordance with NICE guidelines for Common Mental Health Disorders, suggest that antidepressant medication should not usually be recommended as the first line of treatment for those with mild to moderate depression. Instead they recommend using a stepped care approach starting with watchful waiting and low intensity psychological or self-help interventions. For those with moderate to severe it is recommended that antidepressants should be provided in combination with high-intensity psychological therapy.

Additionally, NICE, in one of their quality statements, recommends that individuals prescribed antidepressants are followed up and are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment (NICE 2011d). However, in addition to the ready prescribing of pharmacological interventions, it was noted and acknowledged that, HMP Swansea in particular but probably both HMP Parc and HMP Cardiff too, needs a better system of reviewing antidepressants prescriptions when a prisoner is past that initial adjustment phase. At HMP Parc it was reported that medication reviews are done as required not on a routine basis.

HMP Usk and Prescoed, which receive a large number of prisons from all three prisons have noticed an issue with antidepressant prescribing. It was reported that many prisoners transferred into HMP Usk and Prescoed are on anti-depressants but without any signs of depression and without and documented depression assessment (see Assessments section above). In one particular case a prisoner was transferred into HMP Usk, having been in seven other prisons including two in Wales, on anti-depressants and anti-psychotics but with no evidence of a diagnosis, assessment or medication review. On further investigation it transpired that this prisoner had invented their diagnosis when
they first entered prison and had been receiving medications unnecessarily for several years. This may be an extreme example but non-validation of diagnosis is reportedly a regular occurrence in prisoners transferred from Welsh prisons as well as elsewhere and it illustrates that practices around medication reviews need to be tightened up, in addition to the necessary improvement in undertaking/recording assessments.

**External comparisons**

At HMP Nottingham there were reportedly 250 prisoners with a depression diagnosis but only 176 (16.6% of total population) currently taking pharmacological treatment for depression; while it was not explicitly requested this would imply that alternatives to medication are more extensively used here than is the case in at least some of the Welsh prisons. Similar information was not available for HMP Liverpool.

**2. Transfers of care**

The HMIP is very clear that “prisoners with serious and enduring mental health problems are transferred under the Mental Health act to specialist secondary and tertiary care is clinically indicated” (HMIP 2012); however it states that they should be transferred “expeditiously, within the current relevant government department’s target for transfer” rather than stating their own maximum acceptable period.

An important aspect of organising such a transfer from within a prison is to have a set protocol in place to facilitate the transfer of care to a mental health hospital should a prisoners mental health deteriorate – guidance on this is provided in the Prison Mental Health Pathway. All prisons reported that that set prison protocols were used, but there was a noticeable difference in the ease at which staff reported being able to arrange these transfers. This correlates with the concerns raised about transfers of care during the stakeholder workshop, with some representatives expressing serious concerns about the time taken to get seriously unwell individuals transferred.

There are quite large variations in the number of prisoners who require transfers of care on the grounds of mental health between the Welsh prisons. HMP Usk
and Prescoed have approximately two patients transferred to hospital on mental health grounds. Around eight transfers were made out of Swansea prison, around 10 from HMP Parc and between 15 and 20 from HMP Cardiff.

The waiting times for these transfers averaged two to four weeks. It was however noted that the duration of this waiting time was highly dependent on the urgency of the transfer, with the most urgent case extradited. HMP Swansea reported that they were able to arrange an urgent transfer if needed (within 48 hours), while at Parc prisoners were moved to the safer custody wing while they waiting for transfer and at HMP Cardiff they were moved to the healthcare wing. As HMP Usk and Prescoed has no facilities for 24 hour care, an additional four prisoners annually are transferred on the grounds of mental health to prisons with inpatient facilities.

These rates are likely to be a reflection of several factors include the type of hospital to which a prisoner can be transferred, the local arrangements/procedures for transfer and also the mental health facilities and treatment available within the prison. For example prisoners from HMP Parc are often transferred to medium or low secure hospitals, although problems have been reported with using low secure hospitals, while transfers from HMP Usk would need to be houses in maximum security hospitals. Additionally, it was reported at more than one of the prisons that official waiting times may not be representative as they depended on when the sectioning order was signed – in many cases most of the arrangements for transfer were made before this was signed, thus reducing the official waiting time.

External comparisons

HMP Nottingham reported that approximately 20 prisoners per year were transferred to hospital on the grounds of mental health, with slightly fewer (around 18) reported by HMP Liverpool. This is roughly in line with the levels seen at Cardiff Prison, although HMP Cardiff houses fewer inmates. Average waiting times for these transfers were comparable with that seen in Wales, at approximately 21 days at HMP Nottingham and within 28 days at HMP Liverpool and both had clear protocols in place for coordinating this. As was expressed in Wales, it is likely that the duration of wait will be influenced by the urgency of the transfer. Additionally, HMP Liverpool makes use of its inpatient facility regularly to provide care for those experiencing mental health problems, with an average of 300 prisoners transferred to prison inpatients on the mental health grounds annually.
3. ACCTs, self harm events and Suicides

Suicides are perhaps the most extreme measure of the effectiveness of a mental health service. There is quite a noticeable difference between the rate of suicide attempts and completed suicides across the different prisons – this is likely to be due both to the mental health care provided within the prison and importantly also the type of prisoners held (length of sentence, type of crime).

In Usk and Prescoed prisons there have been no completed suicides in the past 10 years, although there are on average five attempts made annually at HMP Prescoed and high levels of self-harm at HMP Usk due to the type of prisoner held there, with approximately one self-harm incident across the two prisons weekly. However, due to the fact that all prisoners with a history of self-harm receive individual help only 3 prisoners across both prisons are currently on ACCTS (according to SystmOne data).

At HMP Cardiff there were six attempted suicides in 2012 with four prisoners completing the act. It was noted that no ACCTs were open on the individuals who died, indicating that they had not been detected as showing signs of depression or suicidal intentions before they died. Also it was noted that three of these individuals were imprisoned for acts of domestic abuse, so this was added to the risk factors consider for ACCTs. HMP Cardiff also reported having approximately 100 self harm incidence annually and has approximately 60 prisoners currently on ACCTS (according to healthcare staff reporting) and 36 recorded on SystmOne.

HMP Swansea reported an average of one completed suicide per year and around 40 self harm incidence, including those that may have been suicide attempts. This correlates well with the SystmOne estimate of approximately 50 prisoners on open ACCTs.

HMP Parc reported 10 attempted suicides on an annual basis, with no completed suicides last year. They also reported 730 self-harm incidents of varying degrees of severity; there are approximately 100 prisoners currently on ACCTS at Parc prison but this discrepancy could be due to either data coding issues, use of
SystmOne, the severity of the self-harm incident or the age difference between the populations held at each prison.

**External comparisons**

HMP Liverpool reported four completed suicides annually, with an additional 14 attempted suicides. They also reported approximately 118 self harm incidents on an annual basis. Information is not available of suicide rates at HMP Nottingham but they report approximately 20 self harm incidents per month. These figures place it approximately in line with Cardiff and Swansea prisons (allowing for size differences). The levels of self-harm appear to be noticeably higher at Parc prison, and although this may be due to severity clarifications it is worth further investigation and possible additional self-harm reduction work at the prison.

**4. Death in custody reviews**

Between January 2011 and the end of February 2013 there were 19 deaths in custody in Wales, all of which were reviewed by Health Inspectorate Wales (HIW). Thirteen of these were deemed to be due to natural causes, five were recorded as suicide and for one it was not possible to ascertain. HIW kindly provided a summary of these reports and the key features in relation to mental health care are summarised below.

All five suicides were by means of hanging and occurred in men aged 26 to 45 years of age. Four occurred in Cardiff prison and one in HMP Swansea. The unascertained death occurred in a man in his 20’s housed at HMP Parc but as this death was not ruled a suicide it will not be further discussed here. The recommendations from the reviews fall into seven broad categories, some of which were reported on more than one occasion:

- **Initial health screens:** It was recommended that a full self-harm and/or suicide risk assessments should be performed as an integral part of the second health screen. A recent history of self harm should be fully taken into account when considering opening an ACCT and the process should identify risk indicators and triggers. Should a secondary health screening not be completed for any reason then healthcare staff should ensure that a follow up process is put in place.
• **Record keeping:** In addition to performing the risk assessments it was recommended that record keeping of these, and other assessments, required improvement and that attention should be drawn to the NMC guidance for Records and Record Keeping. Records should be made in a clear and timely fashion. Following on from this it was recommended that the self harm/suicide assessment should be flagged within the notes for easy access. These comments were made before the full introduction of SystmOne but adaptations to the system could ensure both compulsory assessment and the prominence of the results in the electronic record.

• **Communication of risk:** A lack of communication between the risk assessor and the wing staff was also noted. It was recommended that a protocol for notifying wing staff of prisoners at risk should be strengthened and should also include clear procedures for notifying them of any change in the prisoners risk status.

• **Emergency response:** On one occasion it was noted that the emergency response procedure was in need of improvement. It was recommended that a strict protocol with identified roles and responsibilities, both routinely, such as the regular checking of response equipment and during an incident, such as calling the ambulance, should be instigated.

• **Staffing and training:** Staffing levels needed to be considered in one prison to ensure that a timely mental health assessment could be performed. Also, although no blame was placed, it was also suggested that having more highly trained individuals performing the assessments may allow more indicators and triggers of mental health problems to be detected in the early stages of custody.

• **Care pathways and planning:** It was recommended that several elements of the care pathway were reviewed; including the arrangements in place to allow the fast tracking of mental health assessments should a prisoners mental health be noted as deteriorating or of concern on the wing. Also a more systematic care and treatment planning process for those prisoners presenting with mental health problems and/or changing medications should be introduced. They also recommended reviewing and clarifying the discharge process from HCC to ensure the HCC Psychiatrist undertakes a comprehensive assessment and a discharge plan is in place that includes the sharing of information with receiving staff.

• **Develop a clinical audit:** It was recommended that a clinical audit process would enable progress to be monitored and improvements made.
Many of these recommendations have already been acted on by the prisons concerned and in one of the most recent death reviews, where very little fault could be found in the system, it was commented on that “HIW are pleased to note that further to previous clinical reviews of deaths in custody..... there have been a number of improvements in the areas of clinical practice and professional development and a number of initiatives and developments in the areas of emergency procedures, mental health and suicide prevention”. However, ensuring all these recommendations are being followed across the Welsh prison estate may prevent future deaths in custody.
Discussions

The aim of this HNA was primarily to review current levels of mental health disorders across the Welsh prison estate, document the services currently provided, and examine the process by which mental healthcare is currently delivered. The recommendations that follow cover all aspects of the report, however a few key points have been drawn out for discussion below.

Using the ONS estimated prevalence of mental health problems in the prison population it was possible to produce estimates of the number of prisoners in each prison likely to be suffering with a variety of mental health problems. These figures indicate a very high level of need across all prisons with approximately 2,600 prisoners across Wales suffering with one or more mental health problem. 70% of the prison population are estimated to have Personality Disorder of some degree, 70% are estimated to have a history of substance misuse, 60% are estimated to have a history of alcohol abuse and 80% are estimated to have a below average IQ. All of these factors contribute to the difficulties involved in treating prisoners with mental health problems in a prison environment and mean that it may be difficult to fully implement NICE guidance that is not specifically designed for a prison setting.

In connection with the specialised population housed within the prisons, across the prisons there have been calls for additional training to be provided primarily to allow staff to cope with the difficulties of treating prisoners with additional problems such as personality disorder or substance misuse issues. Such training would put staff in a better position to be able to adjust current guidelines and practices to more appropriately meet the needs of the prisoners. In addition, while all prisons report a good attitude towards mental health across all levels of prison staff, the level of mental health training is not known. It is suggest that this good attitude, and high levels of awareness, could be further harnessed if mental health training was made compulsory for all staff.

In terms of the provision health care staff, in most cases prison healthcare teams felt that they had sufficient mental health staff to meet the needs. However, staff issues were raised in two prisons. In HMP Usk and Prescoed the current level of mental health staffing is significantly below that of the other prisons and it would appear that the team is only meeting the needs of the prisoners through the enthusiasm and dedication of the team members; who are
worryingly now reporting feeling “underappreciated by the prison service”. There is a significant risk that when the only member of the PCMHT retires later this year that both primary and secondary care for both HMP Usk and Prescoed will rest on a single member of secondary care staff. This is unsustainable and there is a significant risk that mental healthcare at these prisons will suffer considerably if staffing provision within the mental health teams is not urgently reviewed. In addition, while the staffing levels at Parc prison are reportedly coping with the current level of need, it is vital that this is seriously considered as part of the planned expansion of the prison.

The HNA has also brought to light the extensive use of healthcare assistants/officers in some prisons; there is currently no documentation on the level of mental health training received by these individuals. It could be potentially dangerous to place responsibilities on them, such as performing secondary health screens, that require a higher degree of training. The second health screen is a vital point of identification and should be treated as any other mental health assessment and performed by a suitably qualified member of staff.

The services currently provided have been discussed and in the majority of cases they are thought to meet the needs of the prison population. However, this HNA has not focused on recommending evidenced based services to meet the specific needs of the prison population of Wales. Primarily this is because NICE are currently in the process of producing guidance on mental health services specifically for use in prison. Therefore, while no specific services are currently being recommended it is important that all prisons commit to implementing the NICE guidelines once they are published. Additionally, over the next year or so there are likely to be changes to the services provided by primary care in the community, driven by the Mental Health Measure, and services within the prison will have to evolve alongside those in the community in order to provide continuity of care. To adapt to both these changes will require a proactive approach from both the PCMHT and also the MHIRT.

The effect of short stays in prisons (churn) on the provision of mental health services has been raised by many as a problems; often very little time is available to the prisons to assess and begin treatment on prisoners. However, if the Welsh prison estate could move towards a unified system of assessment, and possibly treatments, the effect of churn could be minimised. The universal use of the same validated assessment tools would allow prisoners mental health to not only be better monitored within individual prisons, but would also allow
for continuity of care when they are transferred out. In addition, a move towards the more regular and systematic review of patients on medication for mental health problems such as depression, as NICE guidance suggests, could result in a significant decline in the use of antidepressants and a significant cost saving.

The Mental Health Collaborative which was launched in 2002 but disbanded in 2005 may be a useful avenue for both primary and secondary care teams to explore. The collaborative may provide a suitable forum for staff to keep up to date with changes to services in the community and also the services recommended by NICE. The collaborative could also be used to provide the various training programmes that have been suggested and allow mental health staff more opportunities for continued professional development and mutual support. Additionally, it could prove a useful conduit for discussing the standardisation of mental health care across Wales.

**Limitations**

There are a number of limitations to this HNA that should be mentioned. Firstly, during this report it was not possible to ascertain the actual level of mental health need across the prisons. Other assessments have used one of two ways of calculating actual level of need. On some occasions a review of medical records has been conducted to retrieve actual number of individuals with each diagnosis; however, as was discussed earlier, recording of mental health diagnoses is known to be less accurate that physical health problems. On other occasions prisoner have been surveyed and assessed specifically for the purpose of achieving accurate assessments, as was done for the ONS study used here. However, using self report alone is unlikely to provide a reliable representation of mental health across the prison and is likely to under-represent those with the most serious diagnosis. The use of medical assessment coupled with self-report is an ideal methods but is extremely time consuming and expensive. Therefore it was decided that applying prevalence estimates, obtaining using this method, to the population of the Welsh prisons was an acceptable method. It must be remembered though that these are estimates only and do not take into account the variation that is likely to occur across the prisons.

Much of the report is based on data collected using SystmOne and, as has been seen acutely for some aspects of the assessment, the quality of the data does not reliably reflect what is happening within the prisons. All healthcare teams had been using SystmOne for a number of months prior to data being extracted for this report, and a three month period of adjustment was allowed after
additional modifications to the system were made to try and maximise the quality of the data. Additionally, the data extracted from SystmOne has been discussed with healthcare staff and where it is not deemed to be an accurate representation of reality this has been indicated. However, it is important that data quality be carefully considered when using this data. The data provided illustrates how SystmOne, once used to its full capacity could provide accurately the information displayed in this report which could be used for internal auditing and monitoring purposes. If used to its full potential SystmOne could also be used to provide the register of individuals with mental health problems, aiding a move to provide annual health checks for these individuals. Additionally, it could be used to highlight when medication reviews are needed to help the prison teams in reducing the number of unnecessary prescriptions.

Unfortunately, it was not possible within the scope of this HNA to look specifically at the mental health needs of different subgroups within the prison population. In particular it would have been beneficial if it had been possible to look at the mental health needs of the young people at HMP Parc or at the provision of CAMHS. However, the Royal College of Paediatrics and the Royal College of Psychiatrists, in partnership with the Youth Justice Board, have developed Healthcare Standards for Children and Young People in Secure Settings in the UK; these are due to be launched on 10th June 2013 and may provide guidance for mental health service provision for young people. The provision of mental health services for the aging prison population would also have been useful.

An additional limitation of the current HNA is that it was not possible to bring service users into the discussion. This is a significant limitation of the report but reflects previous reports of significant difficulties in undertaking this aspect of a HNA within a prison setting.
Recommendations

1. Pathways/procedures

- Clear procedures should be put in place to ensure that any changes in the prisoners risk or mental health state are conveyed to wing staff in a timely manner.

- It is recommended by the health needs assessment and the HIW reviews that regular audits be carried out in order to monitor the effectiveness of the mental health service delivery within all prisons.

- Alterations need to be made to the pathway into MHIRT care, to allow for the legal requirements set out in the MHM whereby individuals who have previously received secondary care can self-refer back into secondary services should they feel their mental health is deteriorating.

2. Staffing

- Healthcare staffing levels at HMP Usk and Prescoed are in urgent need of review. The PCMHT in particular has a significant staff deficit compared to the other prisons. Additionally, due to the extensive paperwork involved in mental health care in this team additional MHIRT staff and/or administrative staff should be considered.

- A review of staffing levels at HMP Parc should form an integral part of the expansion arrangements as current staffing levels are unlikely to be able to meet this increase in demand, especially within the MHIRT and psychiatry.

3. Treatment/services

- A commitment should be made to implement the NICE guidelines on the provision of mental healthcare in prisons across the estate once they are published.

- The services provided in the community should be monitored and internal services adapted to provide a degree of continuity of care.

- A standard method of recording care plans, with a minimum acceptable level of detail would aid in transfer of care across the prison system.

- Recovery work, or relapse prevention signatures, should be carried out, in collaboration with the safer custody teams, with anyone who presents with a
history of self-harm or has been placed on an ACCT. This may be particularly important at HMP Parc, where levels of self-harm seem comparatively high.

- The Supported Living Plans used in Parc prison (similar to the therapeutic landing system in HMP Cardiff) provides additional support for vulnerable individuals, improves their transition into prison life and may prevent mental health problems escalating. Similar systems should be considered in across the estate.

- Counselling services have been requested and would be beneficial to help maintain good mental health in the prison population.

- SALT services have been requested, especially for the under 18’s, and would bring Wales in line with the services provided by prisons in England.

- GP coverage should take into account the amount of time required for both the assessment of new receptions and also routine clinics.

- Pooling self-help resources between the prisons would provide each prison with the full range of information available and would minimise the effort require to make this information available to those prisoner with limited reading or English language skills.

- Anger management courses could be considered as a collaboration between healthcare and prison services where it is currently not available or not available to all.

- Specialist services for older people with mental health problems should be considered, especially at Parc prisons.

- An expanded role for the crisis teams may allow for rapid access into mental health services, as is the case in HMP Liverpool

### 4. Training

- Personality disorder training for the PMHCTs would be beneficial to help them deal with the high numbers of individuals with personality disorder, especially the large proportion with additional mental health problems.

- Substance misuse training for the PMCHT would also be beneficial to help them deal with individuals with dual diagnoses.

- Mental health awareness training/first aid should be made available for all prison staff to aid with the early detection of mental health problems on the wings. Recent awareness raising incidents have resulted in improved detection and is likely to have resulted in earlier treatment.
Healthcare assistants/officers who are going to be carrying out primary and secondary health screens should receive increased training in mental health. The level of this training should be universally agreed across the prison and should be made mandatory.

5. Assessments

Universal assessment tools should be used across the Welsh prison estate, and recorded on SystmOne, to allow long term monitoring and seamless care; this is particularly important given the short duration that some individuals stay in local remand prisons. In particular universal tools for anxiety, depression, alcohol use, self-harm and suicide should be agreed upon and adopted.

Depression assessments should be performed, and recorded on SystmOne, before prescribing antidepressants and regular reassessments and prescription reviews should be performed.

Self-harm and/or suicide assessments should be considered for any individual who scores highly on the depression scale.

Self harm and/or suicide assessments should be added to the primary or second health screen so they are carried out systematically and early.

It should be considered as a matter of urgency whether Healthcare assistants are appropriately qualified to perform primary and second health screens.

In line with best practice in the community, prisons should maintain, or introduce the practice of annual health checks for those with severe mental health problems.

HMPs Usk, Precoed and Parc should all look at improving the timeliness of their second screens in order to catch mental health problems before they escalate.

6. SystmOne

An agreed template of read codes should be agreed across the Welsh prison estate to allow the easy transfer and understanding of medical records between the prisons and to allow for auditing and monitoring of the health care systems.

Improvements should be made to SystmOne to allow the more effective auditing of waiting times by connecting referrals to appointments, allowing
for care planning and advanced appointments (possibly with an “ongoing care option“) and an option to record those who do not attend/no longer require.

- A routine method of recording “inappropriate“ referrals to MHIRT would be beneficial
- A facility for the standard recording of care plans would be beneficial.
- SystmOne should be set up and used correctly to allow prisons to easily extract lists of prisoners with mental health problems in need of annual health check, as is done in HMP Nottingham.
- It would be useful if a register of “recently deducted” individuals was easily accessible
- For monitoring purposes it would be useful if it was possible for authorship of the mental health aspect of the second health screen could be reported separately.
- Use of SystmOne remains suboptimal among members of the extended MHIRT (psychiatrists and psychologists predominately) and it is possible that additional improvements of the system, with tick boxes and drop down menus may improve usage and aid future audits.
- Self-harm and/or suicide assessments should be flagged on SystmOne.

7. Research

- The use of a universal set of read codes across the Welsh prison estate would allow the more accurate estimation of number of individuals experiencing mental health symptoms in prison.
- If the introduction of relapse prevention signatures across the Welsh prison estate is agreed it would be important that a formal evaluation be conducted so that additional evidence on the effectiveness of this technique in the prison population can be gathered and shared.
- If the universal use of validated assessment tools across the Welsh prison estate is agreed, and SystmOne properly used, then there were be a rare opportunity to monitor the effect of prison on the mental health of individuals. It would also open up the possibility of further evaluating any additional services that are suggested in the forthcoming NICE guidelines.
**National Action Plan**

A list of seven recommendations felt to be of the highest priority for the Welsh Prison Estate were agreed during a stakeholder workshop and the actions required to achieve these prioritise and the agreed timescale is displayed in the prioritised national action plan below:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Action</th>
<th>Lead Organisation/individuals</th>
<th>Outcome</th>
<th>Timescale</th>
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<tr>
<td>3.1: A commitment should be made to implement the NICE guidelines on the provision of mental healthcare in prisons across the estate once they are published.</td>
<td>Implementation of guidelines following Welsh Government approval</td>
<td>Health Boards</td>
<td>Specific outcomes need to be set following the publication of the guidelines but it is anticipated that they will focus on improved detection of mental health problems and early treatment</td>
<td>Pending publication</td>
</tr>
<tr>
<td>4.1: Personality disorder training for the PMHCTs would be beneficial to help them deal with the high numbers of individuals with personality disorder, especially the large proportion with additional mental health problems.</td>
<td>To arrange personality disorder awareness training, either electronically or in person, for all relevant healthcare staff.</td>
<td>Heads of healthcare</td>
<td>100% of nurses to have received personality disorder training Assessed by heads of healthcare and reported to prison partnership board by March 2014</td>
<td>March 2014</td>
</tr>
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<td>5.3: Self-harm and/or suicide assessments should be considered for any individual who scores highly on the depression scale.</td>
<td>1. To agree a universal self-harm and suicide tools for use across Wales. 2. To add these tools to SystmOne</td>
<td>Working group</td>
<td>100% of individuals scoring above a set threshold to have received a self-harm and/or suicide assessment Assessed using internal audit and reported to prison partnership board by December 2014. Also assessed as part of 1000 lives</td>
<td>December 2013</td>
</tr>
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</table>
### 3. To routinely record self-harm/suicide assessments on SystmOne

### 4. To audit use as part of the 1000 lives plus evaluation

#### 5.1: Universal assessment tools should be used across the Welsh prison estate, and recorded on SystmOne, to allow long term monitoring and seamless care; this is particularly important given the short duration that some individuals stay in local remand prisons. In particular universal tools for anxiety, depression, alcohol use, self-harm and suicide should be agreed upon and adopted.

| 1. | HMP Usk and Prescoed to move towards using the PQH9 |
| 2. | Working group to agree other universal tools/practices to be used |
| 3. | Tools to be added to SystmOne |

#### 5.5: It should be considered as a matter of urgency whether Healthcare assistants are appropriately qualified to perform primary and second health screens.

| 1. | Mental health section of second screen to be completed by a qualified member of nursing staff. |
| 2. | SystmOne to be |

| 1. | Heads of healthcare |

| 1. | Heads of healthcare |

| 1. | Heads of healthcare |

| Overall improvements in the continuity of care, specifically: |

- 100% use and recording of chosen tools. |

Assessed using internal audit and reported to prison partnership board by December 2013.

**28 March 2013**

**Version: 1.3**

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### 6.1: A universal list of READ codes should be agreed across the Welsh prison estate to allow the easy transfer and understanding of medical records between the prisons and to allow for auditing and monitoring of the health care systems.

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<tr>
<td>1.</td>
<td>Working group to agree a universal list of READ codes</td>
<td>Heads of healthcare to nominate attendees. PHW mental health Lead to be invited to chair working group</td>
<td>100% compliance with universal list Assessed using internal audit and reported to prison partnership board by December 2013</td>
</tr>
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#### December 2013

### 3.5: The Supported Living Plans used in Parc prison (similar to the therapeutic landing system in HMP Cardiff) provides additional support for vulnerable individuals, improves their transition into prison life and may prevent mental health problems escalating. Similar systems should be considered in across the estate.

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<tr>
<td>1.</td>
<td>To discuss current arrangements within each prison at the next PHIN meeting.</td>
<td>1. Heads of healthcare to nominate attendees.</td>
<td>Production and implementation of prison specific plans and reported to prison partnership board by March 2014</td>
</tr>
<tr>
<td>2.</td>
<td>To implement any appropriate improvements to the current arrangements</td>
<td>2. Heads of healthcare and Governors to implement any necessary changes</td>
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</table>

#### March 2014
References


Appendix

1. Workshop summaries

Workshop 1: Developing consensus and agreement on the focus and methods of the thematic Mental Health Needs Assessment for the Welsh Prison Estate

FACILITATED WORKSHOP 22.6.2012 summary v2.doc

2nd Facilitated Workshop Summary 15.04.13.doc

2. Quantitative survey

Comparative needs assessment questionnaire v2 WP.doc

3. Prison referral pathways

Parc referral pathway.ppt  Swansea referral pathway.doc  Cardiff referral pathway.pdf