

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

**Learning from  
PPO investigations**

# **Prisoner mental health**

January 2016

# Learning from PPO investigations

## Prisoner mental health

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### The role and function of the PPO

The Prisons and Probation Ombudsman (PPO) is appointed by and reports directly to the Secretary of State for Justice. The Ombudsman's office is wholly independent of the services in remit, which include those provided by the National Offender Management Service; the National Probation Service for England and Wales; the Community Rehabilitation companies for England and Wales; Prisoner Escort and Custody Service; the Home Office (Immigration Enforcement); the Youth Justice Board; and those local authorities with secure children's homes. It is also operationally independent of, but sponsored by, the Ministry of Justice (MOJ).

The roles and responsibilities of the PPO are set out in his office's Terms of Reference (ToR). The PPO has three main investigative duties:

- complaints made by prisoners, young people in detention, offenders under probation supervision and immigration detainees
- deaths of prisoners, young people in detention, approved premises' residents and immigration detainees due to any cause
- using the PPO's discretionary powers, the investigation of deaths of recently released prisoners

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** we do not take sides

**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity



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# Contents

<b>Foreword</b>	<b>3</b>
<b>Executive summary</b>	<b>5</b>
<b>Lessons</b>	<b>6</b>
Identification of mental health issues	6
Provision of Care	7
<b>1. Mental health and prisoners</b>	<b>8</b>
Prisoner mental health in numbers	8
History of prison mental health services	9
The road to more consistent, high quality mental health care	11
<b>2. Methodology and sample</b>	<b>12</b>
PPO fatal incident investigations	12
Data collection	12
Sample	12
<b>3. Themes</b>	<b>14</b>
<b>3.1 Identification of mental health issues</b>	<b>14</b>
Reception	14
Prison transfers, sharing information, and continuity of care	16
Making referrals	18
Assessments	21
Mental health awareness	22
<b>3.2 Provision of care</b>	<b>24</b>
Treatment	24
Medication	25
Sharing information with prison staff	27
Coordinated care	29
Assessment, Care in Custody and Teamwork (ACCT)	30
Transfer to secure hospital	31
Dual diagnosis	33
Personality disorder	35
<b>Conclusion</b>	<b>38</b>
<b>Endnotes</b>	<b>39</b>



# Foreword

Mental ill-health is one of the most prevalent and challenging issues in prisons and is closely associated with the depressingly high rates of suicide and self-harm in custody. This thematic review considers the lessons learned from my independent investigations into deaths in prisons, where the prisoner had been identified as having mental health needs before their death. The report considers the deaths of 557 prisoners who died in prison custody between 2012 and 2014.

Research indicates that a high proportion of the prison population has mental health needs. These needs range from mild forms of depression, which can be treated with appropriate medication and support, to serious and enduring conditions, such as psychotic illnesses and severe personality disorders, which can be much more difficult to manage.

The first step in providing appropriate care to someone with mental health problems is the identification of their needs. Without accurate diagnosis, it is very difficult to provide appropriate treatment and support. Unfortunately, some mental health conditions cause sufferers to present difficult and challenging behaviour, which staff may deal with as a behavioural rather than a mental health problem. When this leads to a punitive rather than a therapeutic response, this may only worsen the prisoner's underlying mental ill-health.

All prison staff, not just those in healthcare, need to be able to recognise the major symptoms of mental ill-health and know where to refer those requiring help. Staff training is, therefore, crucial but, too often, my investigations have found that staff lacked the necessary mental health awareness training, and, as a result, the mental health needs of prisoners were missed.

Identification is the first hurdle, but once mental health needs are recognised, the response should be prompt and well planned. When staff work together to develop an effective care plan and to deliver appropriate treatment, medication and support, prisoners may be able to overcome their mental health difficulties, or at least learn to manage and live with them. A number of investigations came across staff who clearly cared deeply about the prisoners in their care and did their best to help them.



While there were many examples of very good practice, there were also too many cases where practice could and should have been better. Issues ranged from poor monitoring of compliance with medication and lack of encouragement to take prescribed drugs, to inappropriate care plans which were not reviewed and updated, and did not include meaningful actions. Unfortunately, there have also been investigations in which we have found that the provision of mental health care was simply inadequate.

Given the scale of mental ill-health in prison and the pressures in the system, it is perhaps not surprising that this review identifies significant room for improvement in the provision of mental health care. I hope that the learning from this report will help support improvement and inform best practice.

A handwritten signature in black ink, appearing to read 'Nigel Newcomen'. The signature is written in a cursive, flowing style.

**Nigel Newcomen CBE**  
Prisons and Probation Ombudsman



# Executive summary

This report examines deaths in prison custody that occurred between 2012 and 2014, which were investigated by the Prisons and Probation Ombudsman (PPO), and where the deceased had been identified as having mental health needs.

The report begins by outlining the context of mental health care in prisons and provides a brief overview of developments over the last two decades. It goes on to explore the relationship between mental health issues and both self-inflicted and natural cause deaths. One homicide is also discussed.

A major theme throughout the report is the importance of identifying mental health issues. A number of concerns are discussed about factors which have caused prisoner's mental health issues to be overlooked. These include poor information sharing, failure to make referrals, inappropriate mental health assessments, and inadequate staff training.

The report reviews the standard of care received by prisoners whose mental health needs had been identified. In a number of investigations, we found a lack of coordinated care. At times there was little evidence of prison staff and healthcare staff working together, or there was a lack of joined up work between primary healthcare, mental health in-reach, and substance misuse services. Issues such as length of sentence and IT literacy were found to be barriers to treatment.

Another common obstacle to effective treatment was non-compliance with medication. Prisoners with mental health needs sometimes find it difficult to understand the importance of taking their medication, and some of our investigations found that staff did not always remind or encourage them to do so.

Prisoners with mental health needs can sometimes be very difficult to manage. Commendably, our investigations found impressive examples where staff went to great lengths to ensure that prisoners in crisis received excellent care. However, the identification and treatment of mental health issues remained variable, and many areas for improvement were apparent. A number of lessons are included in this report, which aim to promote positive change and the provision of improved mental health care across the prison estate.



# Lessons

## Identification of mental health issues

### Reception

Lesson 1: Reception staff should review all the documentation that a prisoner arrives with, and ensure that all relevant information is then passed onto the health professional responsible for the reception health screen.

Lesson 2: The health professional responsible for the reception health screen should ensure that all of the information they receive about a prisoner is given due consideration when making an assessment, including any existing SystemOne records.

### Prison transfers, sharing information, and continuity of care

Lesson 3: All staff who use SystemOne should be fully trained in its use.

Lesson 4: NHS England should ensure that community GPs provide comprehensive details of a prisoner's health records when asked by a prison healthcare team for this information. This should include details of the prisoner's history of both physical and mental health problems.

Lesson 5: When a prisoner with known complex mental health problems is transferred between prisons, the mental health team in the sending prison should ensure that they provide a comprehensive handover to the receiving prison's mental health team.

Lesson 6: When a prisoner with known complex mental health problems is transferred between prisons, the mental health team in the receiving prison should ensure that they request and obtain a comprehensive handover from the sending prison's mental health team.

### Making referrals

Lesson 7: Staff have a responsibility to make a mental health referral any time that they have concerns about a prisoner's mental health.

Lesson 8: Mental health assessments should be carried out promptly after a referral is received, to ensure that necessary care and treatment can be put in place as soon as possible.

Lesson 9: Prisons should ensure that they have a clear and consistent process for prison staff to refer prisoners directly to the mental health team, and that prison and healthcare staff have a shared understanding of this process and how to make urgent referrals when necessary.

### Assessments

Lesson 10: Mental health assessments should take into account all relevant information, use standard mental health assessment tools, and be compliant with NICE guidelines.

Lesson 11: NHS England should produce guidance for prison healthcare to advise them on best practice for the selection and use of existing validated assessment tools.

### Mental health awareness

Lesson 12: Mental health awareness training should be mandatory for all prison officers and prison healthcare staff, to provide them with necessary guidance for the identification of signs of mental illness and vulnerability.

## Provision of Care

### Treatment

Lesson 13: At a minimum, all prisoners should have access to the same range of psychological and talking therapies that would be available to them in the community. These services should be adapted for use in a prison environment where appropriate.

### Medication

Lesson 14: Prison and healthcare staff have a responsibility to talk to prisoners and young people who fail to collect or take their medication, to try to ascertain why they have chosen not to comply, and to encourage them to begin taking it again.

Lesson 15: Prison healthcare leads should ensure that a robust system is in place for flagging non-compliance with medication, and that there is clear guidance for healthcare staff about the management of medication and dealing with non-compliance.

Lesson 16: Compliance with all medication should be monitored and encouraged as part of an up-to-date care plan for prisoners with mental health problems.

### Sharing information with prison staff

Lesson 17: All healthcare professionals have a responsibility to share with prison staff any information that might affect a prisoner's safety, within the boundaries of medical confidentiality.

### Coordinated care

Lesson 18: All healthcare teams involved in the care of a prisoner should communicate with each other and share information, to ensure consistency in diagnosis and a collaborative approach to treatment.

### Assessment, Care in Custody and Teamwork (ACCT)

Lesson 19: The mental health team should attend or contribute to all ACCT reviews for prisoners under their care, and should be fully involved in any important decisions about location, observations, and risk.

### Transfer to secure hospital

Lesson 20: Prisons need to be extra vigilant about the care of prisoners who are being considered for, or are awaiting transfer to a secure hospital. Segregation should be avoided for such prisoners, unless there are clearly recorded exceptional circumstances.

### Dual diagnosis

Lesson 21: Mental health and substance misuse teams should work together to provide a coordinated approach to prisoner care. This should involve the use of agreed dual diagnosis tools to assess prisoner needs and regular meetings to discuss and plan joint care.

Lesson 22: Details of all interventions from substance misuse services should be recorded in a prisoner's SystemOne health record.

Lesson 23: Prisoners undergoing treatment for substance misuse should not be prevented from accessing secondary mental health services.

### Personality disorder

Lesson 24: When a prisoner is moved to a standard prison wing, from a secure mental health hospital or a specialist prison unit for those with severe personality disorder, their reintegration should be supported and their progress monitored. They should initially be allocated a healthcare practitioner with experience of personality disorder and be given appropriate care in line with an agreed care plan.

Lesson 25: The risks presented by all offenders with severe personality disorder who face long periods in prison should be identified and managed through informed sentence planning and suitably structured regimes.

# 1. Mental health and prisoners

## Prisoner mental health in numbers

Determining the prevalence of prisoners with mental health issues is not a straightforward exercise. Many mental health conditions go undiagnosed, and individuals can be cautious about disclosing mental health information. A narrow definition of mental health problems might be limited to formal psychiatric diagnoses, whereas a broader definition could incorporate additional issues, such as alcohol and substance misuse problems.

A number of studies have attempted to capture data related to the prevalence of prisoners with mental health problems.

A national survey conducted in 2005 and 2006, which looked specifically at newly sentenced adult prisoners in England and Wales who had been sentenced to four years or less<sup>1</sup>, found that:

- 61% of the sample were identified as likely to have a personality disorder, 10% a psychotic disorder, and over a third reported significant symptoms of anxiety or depression
- 21% of the sample reported feeling that they needed help or support with their mental health<sup>2</sup>

A 1997 survey of psychiatric morbidity among prisoners in England and Wales sought to determine the prevalence of mental health issues across the prison population as a whole. It found that:

- Nine out of ten prisoners had one or more of the five psychiatric disorders studied (psychosis, neurosis, personality disorder, alcohol misuse and drug dependence)
- Seven out of ten had two or more disorders<sup>3</sup>

This study is now 18 years old, but is still widely referenced in current literature about prisoner mental health. There is a need for a more up-to-date study, as comprehensive in scope. For example, the prison population has not only grown over the last two decades, but has also aged, which in turn has led to increased age related mental ill-health<sup>4</sup>. There is certainly room for new research to fill the knowledge gap about the current prevalence of mental health issues.

Although some of the data is now fairly old, it is widely accepted that the prevalence of mental health issues in the prison population is considerably higher than in the general population. The scale of this disparity can be seen in Figure 1 below, taken from the Bradley report<sup>5</sup>, and is based on data from two studies by Singleton et al.

It is clear that a high proportion of the prison population have mental health problems, for which they need appropriate care and support. The prison environment can be particularly tough for those with mental health problems, as factors such as distance from family and isolation can make coping particularly difficult. With the stresses of prison life, and obvious disparity in the prevalence of mental health problems compared to the community, it is essential that prisons are properly equipped to provide comprehensive mental health care.

**Figure 1: Comparison of the prevalence of mental health issues across the prison population and the general population**

	Prisoners	General population
Schizophrenia and delusional disorder	8%	0.5%
Personality disorder	66%	5.3%
Neurotic disorder (e.g. depression)	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%
Source	Singleton et al 1998	Singleton et al 2001

## History of prison mental health services

For some time, it has been recognised that there is room for improvement and greater consistency in the standard of mental health care in both prisons and the community. Historically, the Home Office was responsible for prisons and healthcare provision for prisoners. From the early 1990s, discussion began about the potential merits of the NHS providing prison healthcare services. The 1992 Reed review<sup>6</sup>, a review of health and social services for mentally disordered offenders, indicated that contracting-in services from the NHS could potentially improve mental health care for prisoners. This was followed by similar findings in reports from HM Chief Inspector of Prisons in 1996<sup>7</sup>, and the Department of Health in 1999<sup>8</sup>. These led the way for the transfer of the responsibility for prison health services from the Prison Service to the NHS<sup>9</sup>. The transfer of clinical healthcare services was completed in 2006 for public sector prisons in England<sup>10</sup>, and followed later for private prisons in 2013<sup>11</sup>.

In 1999, the NHS published a National Service Framework for Mental Health (NSF)<sup>12</sup> which set national standards for the provision of mental health services and detailed how these standards should be delivered. The Framework was designed with the aim of driving up the quality of mental health services and removing the wide variation in service provision. The standards apply equally to prisoners as to the wider community, in accordance with the 'equivalence of care' principle which has been embedded into government policy since 1990<sup>13</sup>. Prisoners should receive the same level of health provision in prison as they could expect in the community. However, the NSF made no specific mention of prisons and how best to apply the standards within a prison setting. The prison population is very different from the population as a whole. As well as a considerably higher prevalence of mental health issues, a much higher proportion of prisoners have experienced a lifetime of social exclusion compared with the general population<sup>14</sup>. A model designed for use in the community is therefore unlikely to be suitable for use in a prison, without being specifically adapted to meet prisoners' needs.

In 2001, the Department of Health introduced a strategy<sup>15</sup> to develop and modernise the mental health services delivered in prisons, in line with the NSF. It stressed that prisons should move away from housing prisoners with mental health problems in prison healthcare centres. Instead, the strategy advocated greater use of day care and wing based treatments, mirroring the situation in the community, and providing prisoners with "greater opportunities to participate in a purposeful regime and other activities".

The strategy outlined a range of types of care that should be available in prisons, including primary care services, mental health promotion, wing-based services, day care, transfer to NHS facilities and through-care. Further, it required the extension of the Care Programme Approach<sup>16</sup> (CPA), continuing care planning for those receiving CPA support before going to prison, and providing CPA support to other prisoners who were identified as being of sufficient need.

In 2005, the Department of Health published '*Offender Mental Health Care Pathway*'<sup>17</sup> a best practice guide to help inform those who deliver and commission prison mental health services. It was intended as a broad framework to guide the management of an offender's mental health needs along the criminal justice pathway, including pre-prison, first night and induction, prison transfers and aftercare. The guidance was developed around the principle that prisons should be safe places for people suffering from mental health problems<sup>18</sup>.

In conjunction with the NHS taking over the responsibility for prison healthcare, a substantial investment was made towards developing mental health in-reach services, and mental health in-reach teams were introduced into prisons<sup>19</sup>. These teams were created to provide services similar to Community Mental Health Teams (CMHTs), including CPA support, and were designed to be the main agent for improvements in mental health services for prisoners<sup>20</sup>. Guidance on their operation was deliberately non-prescriptive, to allow the services provided to reflect local need.

Following the transfer of prison healthcare to the NHS, a number of reviews were conducted to evaluate the effectiveness of prisoner healthcare. The Offender Health Research Network (OHRN) conducted an evaluation of prison mental health in-reach services<sup>21</sup>. This evaluation found that there was a lack of clarity about the role of in-reach teams, and that there was a need to streamline all other mental health service provision in prisons before they would be able to function appropriately. For example, the review found that primary care mental health input was often inadequate or missing, and so in-reach teams were unable to concentrate their attention specifically on those with severe and enduring mental illness (SMI). It was initially envisaged that in-reach teams would work only with prisoners experiencing SMI, but their role has become more all encompassing.

A 2007 report from HM Inspectorate of Prisons (HMIP) also reviewed the care and support of prisoners with mental health needs<sup>22</sup>. The review concluded that there was no clear blueprint for delivering mental health care in prisons. It found that, in particular, there was a gap in the organisation and provision of primary mental health care for those who fall beneath the threshold of severe and enduring mental illness. It also found that mental health in-reach teams were often working in isolation, poorly integrated with other services, such as substance misuse teams and residential staff, and with minimal guidance and support structures. The report called for the development of a blueprint for the delivery of mental health services in prison, including appropriate external support and governance, and internal integration with other prison staff and services.

One of the most notable reviews of prison healthcare, following the transfer of prison healthcare to the NHS, was carried out in 2009 by Lord Bradley<sup>23</sup>. He was commissioned by the government to conduct an independent review to consider the extent to which offenders with mental health problems or learning disabilities could be diverted from prison to other services. The findings stressed the importance of early identification of mental health needs and recommended the development and improvement of Liaison and Diversion Services. These are designed to identify offenders with mental health issues, substance misuse problems or learning disabilities, at their first point of contact with the criminal justice system, resulting in more informed charging, prosecution and sentencing decisions, and helping to direct more offenders to appropriate care in the community, rather than receiving a prison sentence.

After the publication of the Bradley Report, a 2010 government green paper, 'Breaking the Cycle'<sup>24</sup>, set out proposals for the reform of sentencing, punishment and rehabilitation of offenders, and listed the national roll out of Liaison and Diversion services as a priority. Since then, funding has been announced for mental health nurses and other mental health professionals to work with police stations and courts to help ensure that correct support is provided as early as possible to people with mental illness and other vulnerabilities. Street Triage schemes have been piloted, in which mental health professionals support officers with incidents where police believe that someone needs immediate mental health support. Further, a number of national bodies have signed the Mental Health Crisis Care Concordat<sup>25</sup>. This national agreement establishes how organisations, with particular emphasis on the police, will work together to try to ensure that people get the help they need when they are having a mental health crisis, ideally preventing unnecessary detention and escalation to mental health crises.

Another area considered by the Bradley report was resettlement. When prisoners with mental health problems have received treatment and support while in prison custody, it is important that they continue to engage with treatment when they are released into the community. Probation Services can help to organise and encourage such engagement, but until recently, only those sentenced to a year or more or who were under 21 received supervision from the Probation Service on release. This led to a recommendation in the Bradley Report that NOMS and the NHS should jointly develop a national strategy for rehabilitation services for those leaving prison who are not subject to supervision from the Probation Service, but who have mental health problems or learning disabilities<sup>26</sup>.

In 2013, the Ministry of Justice published their strategy for the reform of rehabilitation services<sup>27</sup>, which led to the roll out of the Government's Transforming Rehabilitation (TR) programme. The reforms abolished the 35 existing Probation Trusts and replaced them with a single National Probation Service, responsible for the post-release management of high-risk offenders. In addition, contracts were awarded for the running of 21 Community Rehabilitation Companies (CRCs). CRCs were given responsibility for the post-release management of low to medium risk offenders, and for providing post-release support for those whose sentence was less than 12 months, for the first time.

The idea behind this new structure is that providers work in partnership with local authorities, Police and Crime Commissioners (PCCs), and other local services to bring together the full range of support for those released from prison. This includes, but is not limited to, support for housing, employment advice, drug treatment and mental health services<sup>28</sup>. The aim is to rehabilitate ex-offenders, to support them with reintegration back into life in the community, and to prevent reoffending.

These new providers only began delivering their services from 1<sup>st</sup> February 2015, so it is perhaps premature to assess their impact. However, it is positive that the need for a continuation of support services, including mental health support, has been identified for prisoners post-release, and that steps are being taken to help ex-offenders with mental health problems to continue to receive the treatment and support that they need in the community.



## The road to more consistent, high quality mental health care

While important steps have been made to identify and support offenders with mental health needs, and to divert them away from custody, where appropriate, many offenders with mental health problems will spend time in prisons. As noted above, a high proportion of the prison population have one or more mental health issues. In recognising this, the Bradley Report also made recommendations about improving mental health provision within prisons. These included improvements in health screening to facilitate better identification of mental health needs at reception into prison, and the development of a robust model for primary mental health care services.

In 2014, the Centre for Mental Health reviewed the progress that had been made, in their report 'The Bradley Report 5 years on'<sup>29</sup>. They identified some improvements, including prison mental health services developing a broader focus, and progress in access to hospital care for prisoners requiring specialist treatment. The review also illustrated that there was still much further to go, and that many of the original Bradley recommendations were yet to be addressed. The absence of a national strategy was identified as a key challenge, and a new recommendation was made that the NHS should develop a standardised operating model for prison mental health. This reiterated the call from the 2007 HMIP report for the development of a clear blueprint for delivering mental health care in prisons<sup>30</sup>.

Following the implementation of the Health and Social Care Act 2012, the NHS Commissioning Board, which later became NHS England, was given responsibility for commissioning health services and facilities for all prisoners in England<sup>31</sup>. Commissioning is led by ten teams across four regions (North, South, Midlands and East, and London), supported by a small national Health and Justice team. One of the key goals behind the changes to the commissioning arrangements was to facilitate a consistent, high quality approach to healthcare delivery in prisons. The objective was a reduction in health inequality and the establishment of consistent high standards of healthcare delivery across the prison estate<sup>32</sup>.

Another development towards a more standardised approach to prison healthcare came in June 2015 when the Royal College of Psychiatrists published a set of standards for prison mental health services<sup>33</sup>. These standards provide the basis for a new, national Quality Network for Prison Mental Health Services. It is envisaged that the network will allow prison mental health teams to measure their performance against these best practice standards. It will aim to provide a support framework to facilitate and encourage mental health teams from different prisons to share good practice and learn from each other.

The Department of Health have also initiated the development of new resources, for example in 2012 making a topic referral to the National Institute for Health and Care Excellence (NICE) for the production of guidance on improving the mental health of people in prison. NICE is a Non Departmental Public Body (NDPB) responsible for developing guidance and quality standards to improve health and social care. Once the new prison specific guidance is available, it should provide an additional resource to prison mental health providers, with a particular emphasis on interventions for the prevention and early treatment of mental health problems of offenders<sup>34</sup>.

## 2. Methodology and sample

The learning included in this report is based on findings from PPO investigations into deaths in custody. This section will briefly describe the investigative process, before detailing how data is collected as part of an investigation. It will then detail the sample used for analysis, and provide some information about the prevalence of mental health issues in the sample.

### PPO fatal incident investigations

The Prisons and Probation Ombudsman's fatal incident team investigate all deaths of prisoners, young people in detention, residents of probation approved premises, and immigration detainees. The purpose of the investigation is to understand what happened, to help inform the family of the bereaved and answer any questions they might have, to assist the coroner with the inquest, and to identify how the organisations whose actions we oversee can improve their work in the future.

After notification of a death, an investigator is appointed to lead the investigation. The investigator will find out as much as possible about the circumstances surrounding the person's death. This involves examining all the relevant documentation and policies. The investigator has access to the deceased's prison medical records and prison records (including security information reports), and can request any other information they may need. They interview prison staff, healthcare staff, and serving (and released) prisoners, if necessary.

A clinical review is commissioned by NHS England or, in the case of deaths in Wales, the Healthcare Inspectorate Wales. They appoint a suitably qualified clinician to review the healthcare provided to the deceased and produce a report, which is used as evidence in the PPO's investigation.

Once the PPO investigation is complete, the Ombudsman issues a report outlining the findings of the investigation. As appropriate, this will include recommendations for improvement.

### Data collection

The data in this report was collected by PPO investigators, who complete a data collection form for each fatal incident. The data collection forms allow some standardisation of the information obtained during the investigations, making it possible to make some comparisons. However, not all information is available or recorded in all cases.

The forms are split into a number of sections and cover most aspects of prison life. Some of the questions vary depending on whether the death was self-inflicted or natural causes. The section on mental health diagnosis and treatment is particularly relevant to this thematic. This section is more comprehensive for self-inflicted deaths, as a much higher proportion of those who died by self-inflicted means had been identified as having mental health needs, and were receiving treatment and specialist care.

### Sample

The sample for the data in this report was 557 prisoners who died in prison custody between 2012 and 2014 and whose deaths were investigated by the PPO. This includes 199 self-inflicted and 358 natural cause deaths. It represents 89% of all prisoner deaths investigated by the PPO during that period. Some deaths were not included in the sample, because of ongoing investigations and data collection.

Just over two in ten (22%) of the prisoners in the sample who died from natural causes were identified as having mental health needs. Perhaps unsurprisingly, a considerably greater seven in ten (70%) of those who died from self-inflicted means had been identified with mental health needs.

These statistics are lower than might be expected, given the very high prevalence of mental health issues that previous studies have uncovered, but there are a couple of factors which explain this, at least in part. Firstly, these figures refer exclusively to the prevalence of mental health problems, and do not incorporate alcohol or substance misuse issues as others studies have done. Secondly, the nature of a PPO investigation may also play a part. An investigation takes place after a death and the PPO has to rely on mental health diagnoses, as recorded in health records from the prison and the community. As mental health problems frequently go unrecognised and undiagnosed, the prevalence of mental health issues found in PPO investigations is likely to be an under-representation.

Investigators who investigate self-inflicted deaths are asked to record whether any concerns about mental health problems had been expressed by a professional, such as police, probation or court staff, and flagged at the time of reception. While our investigators found that 70% of those whose death was self-inflicted had been identified as having mental health needs by the time of their death, concerns about mental health problems had only been flagged at reception in just over half of these cases.

One of most commonly diagnosed mental health issues among both natural cause and self-inflicted deaths was depressive illness. Unsurprisingly, those whose deaths were self-inflicted were eight

times more likely to have been identified as having thoughts of suicide or self-harm before their death, than those who died from natural causes. They were also considerably more likely to have been diagnosed with a personality disorder or with anxiety, phobia, panic disorder or obsessive compulsive disorder. In addition, at least 17% of those whose death was self-inflicted had been identified with a severe and enduring mental illness<sup>35</sup> (bipolar affective disorder, schizophrenia, or another delusional disorder), compared with only 6% of prisoners who died from natural causes. In natural cause deaths, dementia was the only mental health issue with a higher prevalence than in self-inflicted death cases (natural cause deaths often being associated with age related conditions among an ageing prison population)<sup>36</sup>.

**Figure 2: Prevalence of identified mental health issues**

	Natural Cause Deaths	Self-inflicted Deaths
<b>Base</b>	N=358	N=199
<b>Anxiety / phobia / panic disorder / OCD</b>	4%	22%
<b>Thoughts of self-harm or suicide</b>	5%	40%
<b>Depressive illness</b>	10%	38%
<b>Excessively withdrawn</b>	0%	4%
<b>Schizophrenia / other delusional disorder</b>	5%	14%
<b>Bipolar affective disorder</b>	1%	3%
<b>Eating disorder</b>	0%	1%
<b>Dementia</b>	2%	0%
<b>Personality disorder</b>	1%	10%
<b>Other</b>	3%	6%
<i>Average number of identified mental health issues per person</i>	0.3	1.4

The number of mental health issues identified per individual was also considerably greater for self-inflicted deaths than natural cause deaths. The average number of identified mental health issues per person was only 0.3 for prisoners who died from natural causes, compared with 1.4 for those whose

death was self-inflicted. Many prisoners at risk of suicide and self-harm are battling with multiple complex issues, with 42% of prisoners who died from self-inflicted means identified as having two or more mental health issues.



## 3. Themes

This section will explore a number of key themes related to mental health which have been recurrent in our investigations into deaths in custody, and about which we think there are important lessons to be learned. Themes have been identified in a number of ways. Firstly, by reviewing all of the recommendations that the PPO has made regarding prisoner mental health in the last few years, and identifying problem areas where we have commonly made recommendations for improvement. Secondly, by looking for trends in the data we have collected about the mental health of prisoners whose deaths we have investigated, and identifying any areas for concern that the data highlights. Themes have also been included based on particularly serious or interesting issues which our investigations have uncovered, and which we think provide scope for useful learning.

Themes have been organised into two sections. The first looks at issues involved in the identification of mental health problems. This section includes discussion and learning regarding, among other things, reception processes, information sharing, making referrals, and conducting mental health assessments. The second section focuses on the provision of mental health care. It examines issues around treatment and medication, and issues relating to collaborative approaches to care, including coordination between healthcare and prison staff, between staff from different healthcare teams, and between healthcare staff and other service providers, such as substance misuse teams. This section also considers some of the specific challenges associated with prisoners who have personality disorders, and prisoners whose mental health problems are so severe that they require a transfer to a secure hospital.

Throughout the discussion of themes, a number of case studies have been included to provide examples of particular issues and to help to illustrate problem areas where improvements can be made. These case studies have been selected because we feel they offer a good representation of the issue being discussed. Each case study looks at a specific aspect of prisoner mental health. They are short accounts intended to demonstrate a particular point, and do not always give a holistic picture of all of the issues related to that individual's mental health. Data collected from our fatal incident investigations has also been included where possible, to provide additional evidence to help illustrate our findings.

Finally, a number of lessons have also been included throughout this section. These lessons are drawn from problem areas identified by our investigations. They are designed to prevent the same mistakes

from happening again, and to promote better mental healthcare provision, with the aim of contributing to safer, fairer custody.

### 3.1 Identification of mental health issues

The care and support of prisoners with mental health issues is the responsibility of both prison officers and healthcare staff. They should work together and share information in order to identify mental health needs, ensure appropriate referrals are made, monitor prisoner behaviour, provide care and treatment, and safeguard against suicide and self-harm.

#### Reception

Arrival at prison can be a particularly stressful time for many prisoners. Some may be in shock about receiving a custodial sentence, while others face the uncertainty of entering prison on remand or being recalled on licence. The sudden separation from family can be difficult to cope with, and many new arrivals are also suffering from drug or alcohol withdrawal symptoms.

Those who are in prison custody for the first time can find the experience especially intimidating, as few will know what to expect. In addition to their immediate needs, going to prison can cause problems relating to the life they have left behind. These factors can have a substantial impact on the short and long term mental health of the prisoner.

Early identification of mental health issues when prisoners arrive can be vital to ensuring that they receive the care and support they need to help them to cope with their early days in custody. Documentation should arrive with the prisoner, which will be received by officers working in prison reception areas. The information received will depend on the individual's circumstances and where they have arrived from.

All prisoners should arrive with a Person Escort Record (PER). This document is designed to give all staff transporting and receiving detainees essential information about that individual, such as known risks and vulnerabilities, and any significant events that occurred between the police station, court and prison. Other information might include a copy of the prisoner's police custody record, a remand warrant, and, if previous concerns have been identified about a prisoner, a suicide and self-harm warning form to alert prison staff to that prisoner's risk.

Prison staff should review this information to help assess whether the prisoner has any immediate needs, or poses a risk to themselves or others. For confidentiality reasons, officers working on reception do not have access to prisoner health records, so it is particularly important that they read the documentation that they are provided with, in order to make themselves aware of any known areas of concern. Unfortunately, our investigations have found that the documentation received is not always consistent, can be unclear, and is not always referred to during the reception process. The PPO has previously reported that there can be an over reliance on the prisoner providing information, and how they present, rather than considering documented risk factors<sup>37</sup>.

All newly arrived prisoners should have an initial health screen, in accordance with Prison Service Instructions. PSI 2015-07, Early Days in Custody, includes the following mandatory requirement to ensure an appropriate assessment of a prisoner's health needs is completed:

*“All incoming prisoners must be medically examined, in private if possible, by a qualified member of the Healthcare team, or a competent and trained Health Care Assistant, who has been trained in ACCT procedures, to determine whether they have any short or long term physical or mental health needs, including disability, drugs or alcohol issues, and ensure that any follow up action is taken, that anyone who needs to know about individual prisoners’ ongoing healthcare requirements is informed, and that actions taken are recorded in the appropriate record.”*

This health screen is often the first opportunity to assess the mental health needs of the prisoner. Prison receptions can be very busy places, and the screen is not intended to be a thorough health assessment. It is fairly quick and is used to detect health needs which are immediately relevant. It should always be followed up by a general health assessment at a later time<sup>38</sup>. To conduct the screen, most prisons use a standardised health reception screening tool, for example the Grubin tool, although some prisons have modified the tool to meet the specific needs of their offender populations<sup>39</sup>. The screen is conducted by a health professional, usually a nurse, and involves a standard set of questions, including whether the prisoner has any diagnosed mental health issues or has had interaction with mental health services in the past.

The nurse or other health professional conducting the health screen should review any relevant documentation received at reception (which should be passed on by reception officers), so that this information can be considered in conjunction with the

prisoner's responses. The health professional should then record the information collected on SystmOne. This is an electronic medical record, which is used in all prisons. It was first rolled out to a small number of prisons in 2005, and was in place in all prisons in England and Wales by 2012. If a prisoner has been in prison before and has an existing SystmOne health record, healthcare staff should be able to access this on their arrival (although we find that many reception nurses are not aware of this). Any information already on SystmOne should be considered in the initial health screen. If relevant, a prisoner's medical records should also be requested from their community GP practice.

During the screen, the health professional should review all the information available to them and, if required, refer the prisoner to a doctor or other health specialist. When a thorough review takes place, which takes into account all relevant sources of information, this can help to ensure that warning signs are identified, and that referrals are put in place when further assessment or care is required. When the health professional is not provided with or does not access all of the information available, this can lead to important factors being missed.

## Case study A

Mr A's mental health issues were identified from the time of his first court appearance. Court staff were worried about his mental health and had him assessed by the court's Forensic Mental Health Practitioner. Police had also recorded on his PER that he had a history of mental health problems.

When he was remanded to prison, a nurse recorded at his initial health screen that Mr A had a history of mental health issues, but appeared to be mentally stable. She referred him to the prison's mental health team, but he was moved to another prison before they could see him.

At a court appearance three days after first arriving in prison, Mr A's hearing was adjourned, and he was remanded to a different prison. Court officers noted on his remand warrant that he was vulnerable and should be located in a prison 'hospital wing' because of his mental health problems.

A nurse completed his initial health screen at the new prison. She did not see the remand warrant, so missed the warning that he was vulnerable, had mental health problems, and might be best placed in a prison healthcare unit. The nurse did not access his health records from the previous prison. They would have been accessible on

SystemOne (a prisoner's computerised medical record), but she wrongly thought that these had to be released by the sending prison and were not yet available to her.

In the absence of any records, the nurse based her assessment largely on Mr A's presentation and what he told her. She determined that his mood was depressed, but that he had no mental health risks, and she did not refer him for mental health support or further assessment.

A couple of days later, the prison received the report from the Forensic Mental Health Practitioner who had examined Mr A when he was in court. On receipt of this report, Mr A's case was discussed at a mental health team meeting. No urgent need for intervention was identified, but the team decided to refer him to the prison consultant psychiatrist for a routine psychiatric assessment. The clinical reviewer considered this was an appropriate response based on how Mr A was presenting at the time.

Sadly, Mr A was found hanging in his cell a few days before he was due to have the psychiatric assessment.

In the case of Mr A, we were concerned that not all relevant records were made available to the reception nurse to inform her assessment of his immediate health needs, particularly when the remand warrant suggested that he might need admitting to the prison's inpatient unit, due to his mental health needs. An admission to the inpatient unit might not have been necessary, but this warning should at least have prompted an early mental health assessment.

Once the forensic mental health report was received, the need for an assessment was quickly identified and the man's mental health needs were appropriately discussed and addressed by mental health professionals in the prison. Had a report not been received from the court's mental health practitioner however, this might not have been the case. Sadly, although appropriate action was taken after receipt of the report, this did not prevent Mr A's suicide. We cannot know whether the outcome would have been different had the report been available at the time of reception and he had had an urgent mental health assessment.

## Lessons to be learned

### Lesson 1

Reception staff should review all the documentation that a prisoner arrives with, and ensure that all relevant information is then passed onto the health professional responsible for the reception health screen.

### Lesson 2

The health professional responsible for the reception health screen should ensure that all of the information they receive about a prisoner is given due consideration when making an assessment, including any existing SystemOne records.

## Prison transfers, sharing information, and continuity of care

Sharing information between prisons helps to ensure continuity of care and support for when a prisoner is transferred from one prison to another, or returns to prison after a period in the community.

The prison electronic medical record system, SystemOne, offers a platform for health records to be shared between prisons, so that information can be easily accessed by all prison healthcare staff when needed. Unfortunately, our investigations have found, as noted in the case of Mr A above, that staff do not always understand how to use SystemOne effectively. This leads to it being completed incorrectly and documents (such as hospital letters) not being uploaded when they should be. This, in turn, can cause vital information about a prisoner's mental health to be missed.

## Case study B

While in prison, Mr B had been identified with mental health problems. He received a diagnosis of a possible psychotic illness, was receiving antipsychotic medication, and had attempted suicide.

Mr B was transferred to a second prison, where the reception nurse conducted an initial health screen. This nurse had recently retired but was working as a bank shift worker. He was unfamiliar with SystemOne, as it had been introduced after his retirement. Although he asked for help, he accidentally set Mr B up as a new patient on SystemOne, which blocked access to his previous records.

As his records were blocked, the nurse had to rely on Mr B's account of his medical history. He disclosed previous episodes of self-harm and that he had received medication for mental health problems. As the nurse was not able to access his previous SystmOne records, he could not see that Mr B had attempted suicide, anything about his diagnosis, or that he had been prescribed antipsychotic medication. The nurse referred him to the primary mental health team, but the referral was not received or actioned. There is no evidence that his medication was continued.

It was only after a member of the mental health team from the sending prison called the receiving prison to discuss Mr B, that the mental health team at the receiving prison became aware of him. The nurse who took the call added Mr B to the list of mental health in-reach referrals for consideration at the mental health team's next meeting. A mental health practitioner went to see Mr B to complete an assessment in preparation for the meeting. She recorded that it was difficult to determine any mental health issues, and that she intended to discuss her assessment with the team at the next meeting. This meeting was later cancelled and Mr B had no further contact with the mental health in-reach team. Less than three weeks after arriving at the second prison, Mr B hanged himself in his cell.

For SystmOne to be used to its full potential, and for vital information to be shared effectively, staff need to have a solid understanding of how to use it. This includes all staff who use the system, including bank or agency staff and visiting specialists. In the case of Mr B, he responded well to the antipsychotic medication he had been receiving in the first prison. If this had been identified and his prescription continued in the second prison, this might have helped him to cope.

## Lessons to be learned

### Lesson 3

All staff who use SystmOne should be fully trained in its use.

SystmOne allows medical information to be shared between prisons. In addition, when a prisoner who has complex mental health needs is transferred to another prison, it is also important and helpful for a handover to take place. Communication between health professionals in both establishments can

help to ensure that important information is not overlooked, and allow appropriate continuity of care.

Interruptions in care can be particularly disruptive and distressing for prisoners with mental health problems. Continuity of care from prison to prison, and also between the community and prison, can help prevent any disruption to a prisoner's treatment.

Community health services, including hospitals, have a responsibility to share information with prison healthcare teams. In NHS general practice, a patient's medical records are passed from one GP to another. In the case of a prisoner, the prison can request information from a prisoner's GP surgery or other services they have been in recent contact with, who will then send an abbreviated record. This record should include key information about the prisoner's known health issues and requirements, so that the prison is aware of any ongoing treatment and can continue to provide it.

## Case study C

Mr C had a long history of anxiety and depression and had been prescribed medication by his GP in the community. On his reception into prison, his low mood and depression were quickly identified during the health screen. Ongoing treatment was immediately set up, and he was referred to the mental health in-reach service. Soon after, a mental health nurse and a psychiatrist assessed him.

The prison requested information about Mr C's medical history from his community GP, who wrote a letter referring to his history of anxiety and depression, and the medication he had been prescribed. However, the letter included little information about the depth of Mr C's isolation and how poor his mental health had been before he went to prison. No details were provided about threats of suicide he had made in the community, or that he had received care and treatment in a mental hospital. While prison staff were quick to identify and act upon Mr C's mental health needs, more complete information from the GP might have helped identify the severity of his problems.

Several months into his sentence, Mr C was transferred to another prison. Even though Mr C was seen by a psychiatrist during his time in the first prison, and was prescribed anti-depressants for severe depression and referred to a psychological support group, no clear handover for his mental health care took place when he was transferred. There was almost no communication



between the mental health teams at the two prisons. Mr C had also been referred for counselling at the first prison and was said to be looking forward to this, but there is no record this was considered at the second prison.

At his initial health screen at the second prison, Mr C was referred to a GP who continued his medication for depression but took no further action. Two weeks later, he saw another prison doctor. He said he felt low and had not been eating or sleeping well, and the doctor increased his dosage of anti-depressants, but made no mental health referral. Two days after that, wing staff raised concern about his level of depression, and another doctor saw Mr C. This time the doctor did refer him to the mental health in-reach team, but Mr C's medical records suggest it then took three weeks for them to see him for the first time. They saw Mr C a further two times over the next fortnight, before deciding that they would not take him onto their case load and that he should remain under the care of the GP. A week later Mr C hanged himself in his cell.

The initial prison health screen can be very effective in identifying an appropriate response to a prisoner's mental health needs. The more information that the health professional conducting the screening has to go on, the more appropriate the assessment they can make.

In the case of Mr C, the clinical reviewer was concerned about the lack of information shared by the GP, and considered there would have been a better handover of information between services in the community. The actions of community GPs and other community services are not within the PPO's remit, but a thorough exchange of information is important for continuity of care and to help identify risks. We strongly encourage community GPs to pass on all relevant information about a prisoner's medical history to prison healthcare teams.

## Lessons to be learned

### Lesson 4

NHS England should ensure that community GPs provide comprehensive details of a prisoner's health records when asked by a prison healthcare team for this information. This should include details of the prisoner's history of both physical and mental health problems.

The clinical reviewer also identified flaws in the communication between prisons. While it would have been difficult for prison staff to have predicted or prevented Mr C's actions on the morning that he died, a faster or more complete handover of information might have led to better support and earlier input from the mental health in-reach team into his care.

## Lessons to be learned

### Lesson 5

When a prisoner with known complex mental health problems is transferred between prisons, the mental health team in the sending prison should ensure that they provide a comprehensive handover to the receiving prison's mental health team.

### Lesson 6

When a prisoner with known complex mental health problems is transferred between prisons, the mental health team in the receiving prison should ensure that they request and obtain a comprehensive handover from the sending prison's mental health team.

## Making referrals

When there are concerns that a prisoner might be suffering from mental health problems, a referral should be made to the appropriate healthcare professionals. The referral might be made by the health professional who conducts the initial health screen in reception, or by a prison GP. Primary care services in prisons are often delivered by GPs, who hold routine clinics to identify and treat a range of health conditions<sup>40</sup>. They may treat mild or moderate conditions and work with other primary care staff to provide suitable interventions related to mental health needs, including prescribing medication. When required, they can refer prisoners to specialist secondary services, including mental health in-reach teams.

Prison staff who are concerned about a prisoner are also able to make referrals to mental health teams. Mental health issues can be missed at reception, or can manifest themselves later during a prisoner's time in custody, so prison and healthcare staff should be vigilant to potential symptoms. Prison staff on the wing are most likely to have day to day contact with prisoners and are in a good position to notice changes in behaviour that might indicate a decline in the prisoner's mental wellbeing.

Mental health in-reach teams are often reliant on prison staff to refer potential patients to them. This can be problematic if prison staff identify only those who cause problems on the wing, as those with severe and enduring mental health issues often keep a low profile and can be overlooked.<sup>41</sup>

It is crucial that prison staff have good multi-disciplinary working arrangements with healthcare staff and feel able to make a referral when they have any indication that a prisoner appears to be unwell. Mental health awareness training can provide prison staff with the knowledge and confidence to act on any concerns.

It is also important that the process for making a referral is clear and easy for staff to understand and follow. If the correct process is not followed, this leads to delays before the prisoner is seen by the appropriate health professional, or can mean that no one assesses the prisoner.

Too often, PPO investigations have found that referrals were not made when they should have been, did not happen quickly enough, the urgency of the referral was not made clear, or despite a referral being made, the appropriate follow-up action was not taken.

In our sample of prisoners who died in prisons between 2012 and 2014, in the cases where mental health needs had been identified, our investigators considered that a mental health referral was not made when it should have been in 7% of natural cause deaths, and 29% of self-inflicted deaths. In some cases, it was found that despite clear reasons to suggest that a referral should have been made, such as a history of mental health treatment in the community or symptoms of mental health problems, the prisoner was not referred for appropriate assessment. Some investigations also found that even when a referral was made it was often not actioned or took too long to happen.

## Case study D

Mr D had been in prison for three years. During this time, he cut himself frequently and was monitored under suicide and self-harm procedures a number of times. On one occasion he cut himself so severely that he nearly died.

Mr D was transferred between prisons on a number of occasions. Various mental health assessments and interventions occurred at different prisons, including a referral to psychological services for his low mood and anxiety, being prescribed anti-depressant

medication, and being placed under the care of the mental health team.

When Mr D was transferred for the final time, a nurse conducted his reception health screen. She made a note about his mental health issues and his suicide and self-harm risk on a cell sharing risk assessment form, but she did not note these in his clinical record or make a mental health referral.

The following day, he was seen by a doctor in the Drug Dependency Unit clinic. Mr D asked the doctor if he could see the mental health team, and said that he was having thoughts of suicide and self-harm. The doctor wrote about Mr D's mental health issues in his clinical record, but he did not make a mental health referral. He said he thought that somebody else would do this and that he assumed that mental health services were already aware of him.

Later that day, a multi-disciplinary case review of Mr D's suicide and self-harm management took place. One of the attendees was a mental health trained agency nurse who was working on the primary healthcare team. The panel discussed Mr D's issues, and no mental health referral was made. The nurse assumed that a referral had already been made.

Four days later a mental health referral was made by a drugs counsellor. Mr D was then discussed at the next mental health referral meeting, but due to a mistake on the referral form and inadequate consideration of all the information provided, he was not then booked in for a mental health assessment. Another referral was made a week later, but it seems that due to staffing shortages this referral was not progressed. The following month Mr D was found hanged in his cell. He never had a mental health assessment at this prison.

The clinical reviewer found that during Mr D's first two days in the final prison, there were three occasions where a mental health referral should have been made but was not. The nurse who conducted the initial health screen, the doctor from the Drug Dependency Unit, and the nurse who attended his suicide and self-harm management case review all knew about Mr D's problems. The first nurse overlooked a referral, the doctor assumed someone else would do it, and the second nurse presumed a referral had already been made.

Even when mental health referrals were made, this did not lead to a mental health assessment for Mr D. In the first instance, a box was not ticked on the

referral form which should have been. It is important that staff take time to correctly complete referral forms so that the appropriate follow up action is taken. At the same time, when a referral is being reviewed to consider if a mental health assessment is necessary, all information provided should be considered, and a decision made based on more than just tick boxes.

In the second instance, staff shortages appear to have been the cause of the referral not progressing. This is concerning, as when a referral is made this is an indication that a staff member has concerns about a prisoner's health and thinks they might need treatment and support. The referral should act as a call to action, prompting a mental health assessment, so that appropriate care can be provided where necessary. Referral to the appropriate healthcare services can lead to provision of treatment and care to help improve the prisoner's mental health state, or at least prevent it from deteriorating. When a referral is not made or not actioned, a prisoner may not receive the care that they need.

## Lessons to be learned

### Lesson 7

Staff have a responsibility to make a mental health referral any time that they have concerns about a prisoner's mental health.

### Lesson 8

Mental health assessments should be carried out promptly after a referral is received, to ensure that necessary care and treatment can be put in place as soon as possible.

## Case study E

From the time he arrived in prison, it was evident that Mr E might try to harm himself. He had taken an overdose shortly before being remanded to prison. Once he arrived, he told various healthcare staff that he was thinking about killing himself.

A concerned mental health worker from the court where Mr E had been sentenced had phoned the prison to alert them to his risk. This information was passed onto a healthcare assistant, who requested that a nurse from the mental health in-reach team came to see Mr E in reception. A nurse from the in-reach team did come to see Mr E, but did not record her assessment on his medical record. However, the senior custody

officer on reception that evening did record that a mental health nurse had seen Mr E and had not raised any concerns about him. The same officer wrote in Mr E's prison record that he had arrived with a suicide and self-harm warning form, and had a history of depression and self-harm. No one made a mental health referral, or started suicide and self-harm monitoring procedures.

Two weeks later, Mr E was moved to a different wing, where an officer became concerned about him. She noticed that he looked unwell, said very little, and was not eating. She asked another officer to refer him to the mental health in-reach team, as that officer was making a call to the in-reach team that morning. The second officer phoned the in-reach team to make the referral, and highlighted the first officer's concerns.

As Mr E had not previously been diagnosed with a serious and enduring mental illness, the mental health in-reach team referred him to the primary mental health team for triage. This was done by sending a task on SystemOne. The next day, before anyone had considered the referral or seen Mr E, he hanged himself.

The prison's Head of Healthcare told us that the duty mental health nurse should review the SystemOne task list daily, once their immediate duties were completed. The duty mental health nurse said that she did not see the task until the evening after it was sent. She said that as there was nothing to indicate that it was an urgent referral, it would likely have been a few days before it was dealt with. The original officer who had asked for the referral, told us that she had been so concerned about Mr E that she would have liked someone to have seen him on the day of the referral.

When staff are unsure about the referral process, this can cause unnecessary delay in appropriate action being taken. It is impossible to say whether an intervention by the mental health team would have altered the outcome for Mr E, but his case highlighted the need for a clear and consistent system for making referrals. Both the person making and the person receiving the referral need to have the same understanding of the process in order to remove any ambiguity from the request. Staff need to understand the difference between a standard and an urgent referral, so that the urgency of any required action is apparent.

## Lessons to be learned

### Lesson 9

Prisons should ensure that they have a clear and consistent process for prison staff to refer prisoners directly to the mental health team, and that prison and healthcare staff have a shared understanding of this process and how to make urgent referrals when necessary.

Some prisons have implemented a process by which any member of prison or healthcare staff who has concerns about a prisoner's mental health can make what is often referred to as a 'single point referral'. When this is made, the care of the prisoner will be discussed at a meeting made up of representatives from all healthcare teams involved in the provision of mental health care. At the meeting, the prisoner's needs will be discussed, and one of the teams will be allocated to lead their care. For this to be effective, someone with sufficient expertise needs to have already met the prisoner and assessed them. When this is the case, this process can help facilitate a coordinated approach and prevent overlap or conflicting provision of care.

## Assessments

When a referral has been made, this should prompt an assessment from the appropriate healthcare professional. Depending on the nature of the prisoner's issue, and the reason for the referral, the assessment might be carried out by a GP, someone from the primary care team, or a member of a specialist mental health in-reach team.

As with reception health screenings, it is important for the health professional carrying out the assessment to review all available documentation, so that they can get as full an understanding as possible of the prisoner's mental health history. The assessor should be aware of and follow the NICE guidelines related to mental health, such as the guidance for recognising and managing depression in adults<sup>42</sup>. This guidance recommends, for example, that the assessment should consider symptoms, but also any other factors which could have affected the development of a person's potential depression. This might include social isolation, quality of interpersonal relationships, and previous experience of medication.

There are a number of standard assessment tools, commonly used in primary care, which can be used as part of the assessment process to help inform and evaluate treatment. Standard depression screening and assessment questionnaires can be used for

prisoners suffering from depression, for example, to assess and record levels of depression and response to treatment.

## Case study F

When Mr F arrived in prison, his PER noted that he had taken an overdose a few weeks before, and had made another previous suicide attempt. Healthcare staff obtained his GP records, which recorded these two suicide attempts, and entered this information in his prison medical record (SystemOne).

Mr F transferred prisons two months later. The reception nurse at the receiving prison noted that he had some family issues that were causing him distress and she referred him to the mental health team. After the referral, it took more than six weeks before a mental health nurse assessed Mr F.

In the interim, a doctor saw Mr F to prescribe insulin for diabetes. The doctor noted that Mr F was low in mood and was not sleeping well. He was worrying about his family and had not yet seen his baby who had been born after he was sentenced to prison. The doctor prescribed a course of sertraline, an anti-depressant usually prescribed for major depressive episodes, but did not use any standard tools for assessing anxiety or depression.

The nurse who subsequently conducted his mental health assessment did not notice the previous suicide attempts, which were noted in Mr F's medical record, and did not notice that he had been prescribed anti-depressants. She did not use a standard mental health assessment tool. She identified some risk factors, such as the fact he had not yet seen his new baby, but she scored his risk of harming himself as zero. Three months later Mr F was found hanged in his cell.

PPO investigations have found that standard mental health assessment tools are not always used during mental health assessments. When interviewed, the mental health nurse who conducted Mr F's assessment agreed that, at the time the assessment took place, assessment procedures were poor in that prison and assessment tools were not well used. The use of validated tools is only one element of the assessment process, but can play an important part in informing the outcome.



An assessor should make use of all the resources available to them in order to reach an accurate understanding of the existence and severity of a prisoner's mental health condition. This includes using standard assessment tools, reviewing existing records, and following NICE guidelines.

In the case of Mr F, the doctor also failed to use any standard tools for assessing anxiety or depression. Doctors should use a validated tool to help diagnose depression and inform treatment, before prescribing anti-depression medication. This is particularly important when prescribing medication usually used to treat major depressive episodes, such as the medication the GP prescribed for Mr F.

## Lessons to be learned

### Lesson 10

Mental health assessments should take into account all relevant information, use standard mental health assessment tools, and be compliant with NICE guidelines.

There is a wide variety of standard assessment tools available, however, there is little guidance to support the selection of an appropriate tool for use in a prison setting. If better guidance on the use of assessment tools was available for prison healthcare staff, this might help to encourage their use as standard practice.

## Lessons to be learned

### Lesson 11

NHS England should produce guidance for prison healthcare to advise them on best practice for the selection and use of existing validated assessment tools.

## Mental health awareness

While there are specialist mental health teams in prisons to assess prisoners and coordinate care when mental health problems are identified, residential staff have to manage prisoners with mental health issues on the wings as part of their daily routine. Prison staff awareness of mental health issues can be poor and many have received no training in mental health awareness. When prison staff do not have the skills and knowledge to recognise and manage symptoms of mental health problems, unusual or difficult behaviour of a prisoner can easily be misinterpreted

as a behavioural problem or a side-effect of taking prohibited drugs, such as new psychoactive substances (NPS)<sup>43</sup>. This can lead to a prisoner being punished, perhaps by removal to the segregation unit or a reduction in their IEP level<sup>44</sup>, rather than being referred to the appropriate healthcare professional and given the care and treatment they need. Punishment can further exacerbate a prisoner's mental health state, compromising their ability to cope.

## Case study G

When Mr G was remanded to prison, he told the nurse at his initial health screen that he had previously spent time in a hospital mental health unit, and had been prescribed anti-psychotic medication by his community GP, but was not taking it. The day after he arrived at the prison, the Criminal Justice Mental Health Team for his area faxed a letter to the prison detailing that he had been admitted to a psychiatric hospital the previous month, and had been discharged with a diagnosis of mental and behavioural disorder. There is some confusion over whether this letter was passed to the nurse who conducted the initial health screen. The nurse referred Mr G to the prison mental health team, but not as a matter of urgency.

The next day an officer found Mr G collapsed in his cell and he was taken to hospital. The hospital investigated the possibility that Mr G had a perforated duodenal ulcer, but could find no evidence of this and discharged him.

The next day, Mr G did not come out of his cell. He said he felt unwell, but no member of healthcare staff saw him. That evening he behaved strangely. He set fire to his cell, then kept ringing his emergency bell and then getting back into bed beside the fire. He ignored requests to move away from the fire and got wet when officers used a hose to put the fire out. Officers had to carry him onto the landing.

When two nurses examined him, he held his breath which hindered their checks, and repeatedly said "Help me, help me". He was unable to explain why he needed help. Both nurses considered Mr G's behaviour to be odd, but neither took any further action.

Prison staff considered that starting a cell fire was an act of bad behaviour, and they prepared a disciplinary charge against Mr G. They did not consider the incident to be an act of self-harm and that Mr G might need mental health support.

The following day Mr G was due in court. In the morning he told staff he was too unwell to go to court, but staff believed he was pretending to be ill and forcibly carried him to an escort van. An escort officer was concerned by the situation and insisted that a nurse examine him. The nurse found Mr G unresponsive. He was taken to hospital, but pronounced dead on arrival. The post-mortem found that Mr G died of peritonitis caused by a perforated duodenal ulcer and gastrointestinal bleeding, which would have caused him considerable and severe pain before his death.

Mr G died from a physical cause, which could not have been prevented by better mental health support. However, the investigation into his death raised some concerns about the mental health awareness of staff.

Mr G had disclosed some information about his mental health issues on his reception into prison, and a fax with further details was received, although it is not clear who this was shared with. A nurse referred him to the prison mental health team, but not urgently.

Although there was information to suggest that Mr G might have had mental health problems, when he acted strangely on the night before he died, the staff involved assumed he was being difficult and deliberately non-compliant. They prepared a disciplinary charge against him and did not consider whether his behaviour was related to his mental health problems.

The clinical reviewer considered that starting the fire was the action of a distressed man who was desperately trying to gain attention. He commented that “unfortunately this was interpreted as attention seeking behaviour but in retrospect the distress may well have been caused by the on-going mental health issues”.

The prison officers told us that they did not receive any training in mental health awareness. Mental health awareness training should help staff to be better able to identify symptoms of mental health problems. If Mr G’s vulnerability had been recognised, this might have led to better observation and review by officers.

The Head of Healthcare at the prison reported that primary care general nursing staff do not receive any specific training in mental health, other than risk and suicide awareness training. The clinical reviewer found that, if the nurses had greater mental health awareness, they might have interpreted Mr G’s behaviour differently.

Difficult or challenging behaviour might sometimes be the only way that distressed people with mental health problems are able to communicate when they need help. Prison and healthcare staff need to be aware of the warning signs of mental distress, so that they can act accordingly and put the correct support mechanisms in place.

## Lessons to be learned

### Lesson 12

Mental health awareness training should be mandatory for all prison officers and prison healthcare staff, to provide them with necessary guidance for the identification of signs of mental illness and vulnerability.

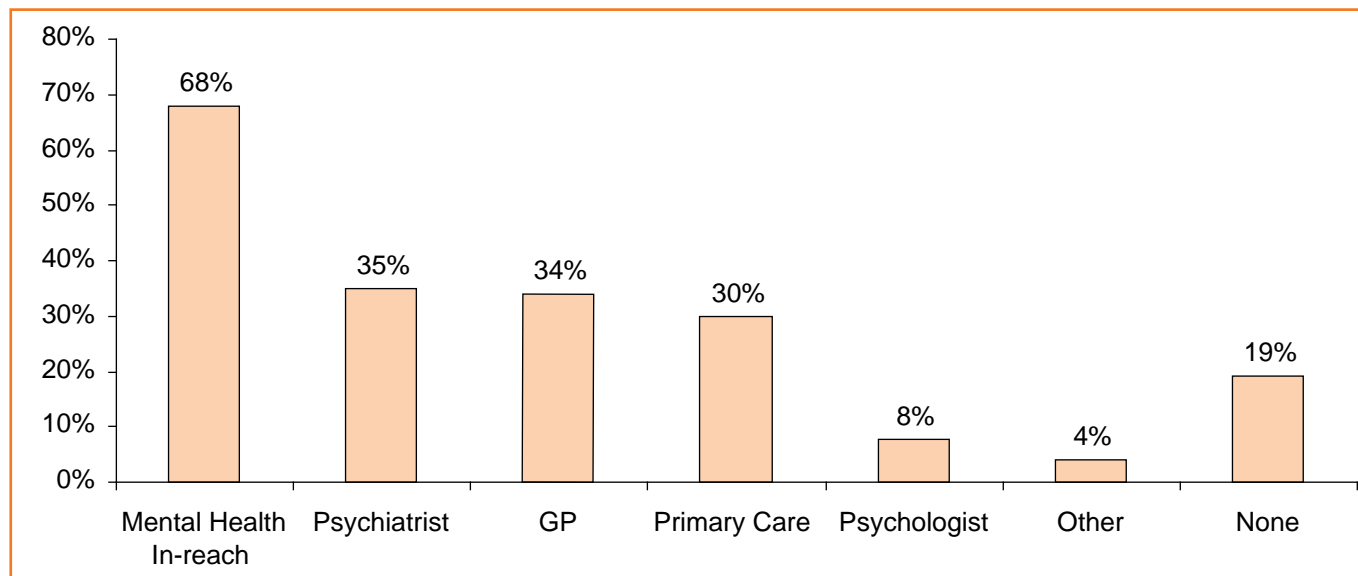
## 3.2 Provision of care

### Treatment

In the sample of prisoners who died in custody between 2012 and 2014, a large majority of the 218 prisoners who had been diagnosed with a mental health problem had received mental health care from a health professional. Around two thirds had been

seen by the mental health in-reach team, while about a third had seen a GP and the same proportion a psychiatrist. However, almost one in five had received no care from a mental health professional in prison.

**Figure 3: Mental healthcare received by those identified as having mental health needs (some will have had more than one type of treatment) (n=218)**



Talking therapies are a common form of treatment to help people overcome or deal with their mental health problems. In 2008, the government rolled out a programme called 'Improving Access to Psychological Therapies (IAPT)'. The programme was designed to develop and improve access to talking therapies services that offer treatments for depression and anxiety disorders<sup>45</sup>. IAPT was a national initiative, intended to be rolled out in prisons as well as the community, and a good practice guide was published to offer guidance on providing IAPT services to offenders<sup>46</sup>.

Talking therapies, such as counselling, cognitive behavioural therapy, or anger management courses, should now be available in prisons. However, some talking therapies are not always readily available, and long waiting lists can restrict access. In addition, prisoners often have highly complex needs, and may require therapies to be adapted to meet their specific circumstances.

### Case study H

When Mr H arrived in prison, healthcare staff noted from court psychiatric reports and his PER that he had been diagnosed with depression and a dissociative personality disorder, and had previously attempted suicide. Suicide and self-harm monitoring procedures were initiated, and he was referred to the mental health in-reach team. The prison obtained information from his GP to ensure continuity of care.

Mr H received some good support for his mental health problems and his condition improved. After a few months he was appropriately discharged from the mental health in-reach team. He was referred for cognitive behavioural therapy, which he was keen to do, and he hoped to be transferred to a 'therapeutic community'<sup>47</sup> once he had completed the course. While he was waiting for a place on the course, he reported on several

occasions that he was looking forward to it, but was frustrated about the length of time he had to wait. There was only one nurse trained to deliver the therapy, so he had to wait over a month for his first appointment.

It can take time for referrals to take place, but Mr H had a number of known risk factors. As well as his mental health problems and history of suicide and self-harm, it was his first time in prison, and, while in custody, he received a long sentence which came as a shock to him. He also had concerns over the health of his son and partner.

Given these circumstances, a more prompt response could have helped provide Mr H with additional support to help him cope.

When Mr H did begin the cognitive therapy, it soon became apparent it was not suitable for him. It was a computer-based course and Mr H did not have the necessary IT skills. After one session, a nurse agreed that Mr H should not continue with it. Staff gave him some self-help leaflets and suggested that another nurse could go through them with him.

Mr H was also referred to psychology services. More than two months after the initial referral was made, Mr H had yet to have contact with them, and he told his supervising officer he was feeling frustrated about this and wanted to engage with something. Although he reported no suicidal thoughts, a few days after this he hanged himself.

It is not always appropriate to offer just one type of course for prisoners, as every prisoner has different abilities and needs. The investigation found that the lack of appropriate services in the

prison to meet Mr H's needs meant his care was not equivalent to that he could have expected to receive in the community. The clinical reviewer concluded that, although Mr H's care was of a high standard generally, the lack of face-to-face cognitive behavioural therapy, as would have been available in the community, was poor.

Due to the high prevalence of mental health problems among the prison population, with many prisoners having multiple and complex needs, the provision of mental health care needs to at least be comparable to that in the community. The services available should be based on assessed need and sufficient to meet demand. Prisoners are also coping with life in a very different environment to the community, and services should be adapted where appropriate to take this into consideration.

## Lessons to be learned

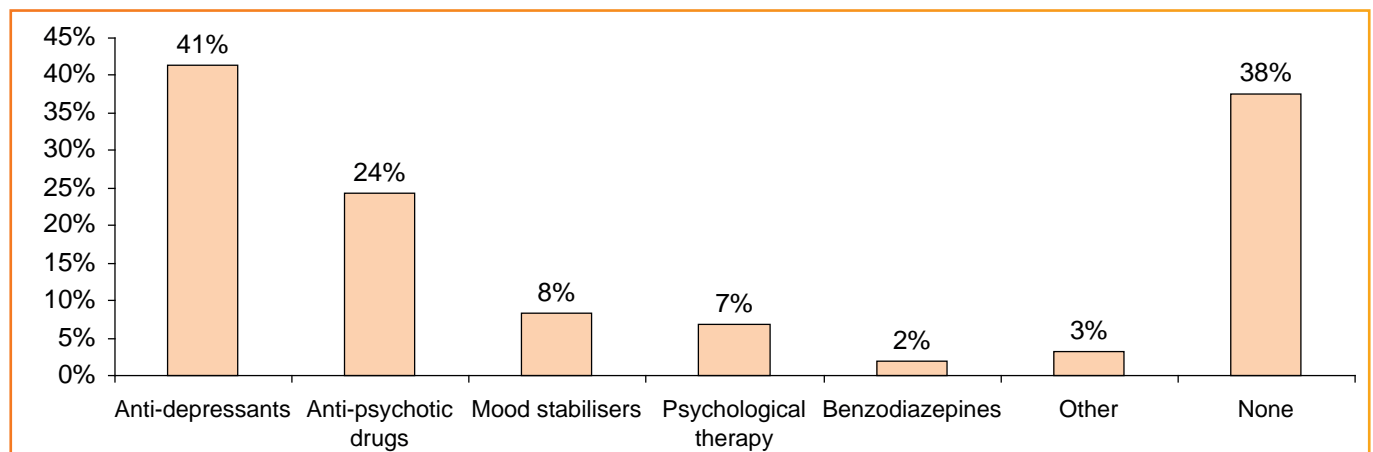
### Lesson 13

At a minimum, all prisoners should have access to the same range of psychological and talking therapies that would be available to them in the community. These services should be adapted for use in a prison environment where appropriate.

## Medication

In the sample of prison deaths from 2012 to 2014, more than half of those identified with mental health needs had been prescribed some form of medication, or were receiving psychological therapy. Anti-depressants and anti-psychotic medication were the two most common treatments.

**Figure 4: Mental health treatment received by those identified as having mental health needs (Some were prescribed more than one treatment) (n=218)**



Of those who were prescribed drug treatments, in the 121 cases where our investigators were able to determine whether the prisoner complied with their medication, just over one in four were found to be only partially compliant. A small minority (3%) were found not to have been taking any of their prescribed medication. Reasons for non-compliance included confusion and forgetfulness, difficulty swallowing, and concerns about side-effects.

When a prisoner has a diagnosed mental health condition, and is not compliant with their medication, this can have seriously detrimental effects on their ability to cope, and can lead to an increased risk of suicide.

### Case study I

Mr I was only 15 years old and was detained in a young offender institution. He had attention deficit hyperactivity disorder (ADHD) and a child psychiatrist and the mental health team reviewed him regularly. After initially appearing to settle well, Mr I began to withdraw from participation in the regime. His behaviour deteriorated and he became difficult to manage. In response, staff often imposed punishments which restricted his ability to associate with other prisoners and isolated him further.

Not long after being sentenced a consultant psychiatrist saw Mr I and prescribed a drug used to treat ADHD and an anti-psychotic also used for ADHD and to reduce impulsivity. Initially, Mr I took his prescribed medication, but he began to stop collecting it, which coincided with a deterioration in his behaviour. Over the course of a 13 day period, Mr I did not collect 14 out of 26 doses of his medication.

The establishment where Mr I was detained had an extensive policy on dealing with issues around self-harm and suicide prevention, which included a section entitled "Failure to take medication". This policy made clear that if a young person did not collect or take medication prescribed to them, staff should engage with them to try to ascertain why they were not taking their medication, and to encourage them to do so. It stated that the situation should be monitored to ensure that the young person is safe. Other than on one occasion when he talked with the psychiatrist, it does not appear that staff talked to Mr I to encourage him to take his medication. After two weeks of poor compliance with his medication, Mr I was found hanged in his cell.

It is not possible to say whether Mr I's actions were a direct consequence of not taking his medication, but it is worrying that no action was taken to encourage him to take it. Mr I had been identified as being at risk of suicide and self-harm, and had been found with ligatures made from shoelaces. He had made a number of verbal and written threats of suicide, and suicide and self-harm monitoring procedures were in place in the weeks up to his death. We were seriously concerned that so little was done to help ensure a young person, who was known to be at risk of suicide, took the medication he had been prescribed to reduce his impulsivity. Prison staff cannot force detained people to take medication, but they should encourage compliance and monitor the situation.

### Lessons to be learned

#### Lesson 14

Prison and healthcare staff have a responsibility to talk to prisoners and young people who fail to collect or take their medication, to try to ascertain why they have chosen not to comply, and to encourage them to begin taking it again.

Non-compliance with medication occurs not just with medication for mental health problems, but can also be an issue when prisoners stop taking medication to manage physical health problems. When a prisoner has mental health and physical health problems, it can be particularly problematic if their mental capacity makes it difficult for them to remember to take the medication for their physical health needs, or to understand the importance of taking it.

### Case study J

Mr J suffered from epilepsy and had some mental health problems. When examined by a psychiatrist in the community a few years before he went to prison, the psychiatrist reported that his exact diagnosis was unclear. He described Mr J as a demonstrably odd man of borderline intelligence who struggled to articulate his thoughts. He said that his problems were enduring and his prognosis poor, and he stressed the importance of Mr J taking his anti-epileptic medication as prescribed.

During his time in prison, Mr J suffered a number of epileptic seizures, but sometimes refused to be taken to hospital for further examination. Doctors



prescribed anti-epileptic drugs, but he often did not take them as prescribed. His medication was also prescribed somewhat intermittently. At one point there was a two month gap between one prescription of anti-epileptic medication ending and another one being written. Healthcare staff appeared not to notice the gap in prescriptions and there was no evidence that a GP reviewed him or of any care plan to help address his problem with medication. The prison had no local healthcare policies for managing epilepsy or for tackling non-compliance with medication.

Mr J was also prescribed anti-psychotic drugs for his mental health problems. He was sometimes volatile and often struggled with comprehension. His non-compliance with anti-epileptic medication increased the likelihood of a sudden death from epilepsy, but Mr J had difficulty in grasping the importance of taking his medication. It did not help that his anti-psychotic medication was also prescribed intermittently. Prescriptions were left to expire without any indication as to the next step, and mental health staff did not develop a care plan to address the problem.

One morning an officer went into Mr J's cell and found that he had died. The post-mortem examination found the cause of death was sudden unexpected death in epilepsy.

The clinical reviewer found that the response from healthcare staff each time Mr J had a seizure was good. Efforts to improve his compliance with medication, and therefore reduce the likelihood of seizures, were less good. This was unsurprising, as the prison had no local healthcare policy for dealing with non-compliance.

At times there were also gaps in Mr J's medication being prescribed, which worryingly seemed to go unnoticed. For non-compliance to be tackled successfully, there should be a robust system for flagging when a prisoner fails to take their medication. Once a problem is identified, clear guidance for healthcare staff about managing medication would help them to respond in a consistent and effective manner.

## Lessons to be learned

### Lesson 15

Prison healthcare leads should ensure that a robust system is in place for flagging non-compliance with medication, and that there is clear guidance for healthcare staff about the management of medication and dealing with non-compliance.

The clinical reviewer noted that Mr J's non-compliance with his anti-epileptic medication might have resulted from his ongoing mental health issues. When a mental health issue affects an individual's comprehension or memory, it can be difficult for them to remember to take their medication or understand the importance of doing so. Prisoners who have difficulties with their mental capacity cannot be forced to take medication, whether for their mental or physical health needs, but staff need to be aware of non-compliance and take steps to encourage a prisoner to take their medication. The development of a coordinated care plan for prisoners with mental health issues can help manage and tackle non-compliance with medication.

## Lessons to be learned

### Lesson 16

Compliance with all medication should be monitored and encouraged as part of an up-to-date care plan for prisoners with mental health problems.

## Sharing information with prison staff

When mental health problems are identified by healthcare staff, it is vital that relevant information is communicated to prison staff, so that they are as informed as they can be about a prisoner's needs and can play a part in providing support. When prison staff are well informed about a prisoner's mental health issues, this can help them to relate to that prisoner's behaviour, to recognise distress, and to respond in the most appropriate manner to support that prisoner.

There are some restrictions on the information that can be shared with prison staff due to medical confidentiality. A prisoner's health records are confidential, and, therefore, prison staff do not have access to them. However, consent from prisoners can be obtained to share information with prison staff. Healthcare staff can also provide certain information to prison staff to help protect that prisoner's safety without breaching confidentiality, such as an instruction to alert healthcare staff immediately if the prisoner presents a particular behaviour.

## Case study K

When Mr K was first remanded to prison there was no indication that he had a history of self-harm. At his reception health screen, he told the doctor he had previously seen a psychiatrist and had received treatment for mood swings, but the doctor found no signs of mental health problems.

After Mr K was sentenced, he had a mental health review. He agreed to see a personal support worker to help manage anxiety and also had three meetings with a counsellor. A note in his record said that he was making good use of these sessions.

Mr K was transferred to another prison and, two months after the transfer, a fellow prisoner and friend of Mr K took his own life. Two weeks later Mr K was found hanging in his cell. Staff were able to resuscitate him and he then spent six days in hospital. When he returned to prison he spent some time in the prison's healthcare centre before being gradually reintegrated into the main prison. The mental health team were in close contact with him and provided a high level of support. A care plan was drawn up in line with the NHS Care Programme Approach for people experiencing mental health problems.

Six months after Mr K returned to prison, the prison mental health team discharged him from their care. However, they drew up a crisis plan which stated that if he expressed any distress to wing staff, he should be put on constant supervision. This crisis plan was kept in his mental health record but was not noted in his primary healthcare records and was never communicated to wing staff or other healthcare staff.

For the next six months Mr K appeared to settle well, until one day security staff were conducting random telephone monitoring and overheard his partner telling him that their relationship was over.

Wing staff spoke to Mr K who said that he was alright and did not appear to be distressed. As a precaution, the wing manager decided that Mr K should be monitored under suicide and self-harm prevention procedures. The wing manager was not aware of Mr K's crisis plan, so did not know that mental health staff had recommended that he should be put on constant supervision when distressed. Early the following morning Mr K was found hanging. This time, he could not be resuscitated.

It is important that information that might affect a prisoner's safety is available to all necessary staff. Prison staff are not mental health experts, but are heavily involved in the day to day management of prisoners with mental health problems. They should have access to any information that can help them to protect the prisoners under their care.

A crisis plan was drawn up for Mr K, but the plan was not shared and so served little purpose to those outside the mental health team. Prison staff were aware of news that could have been distressing to Mr K, and acted upon this by beginning suicide and self-harm prevention procedures. Had they known about the crisis plan, they may have placed Mr K under constant observation, which could have prevented his death.

Medical confidentiality can at times prevent some information from being shared with prison staff, but we do not consider that there were any issues of medical confidentiality which would have prevented Mr K's crisis plan from being shared. No details about any medical conditions or treatments needed to be shared, but simply the instruction to place him under constant observation if he expressed distress. When healthcare staff share information with prison staff, this can help them to provide the most appropriate care when healthcare staff are not present.

## Lessons to be learned

### Lesson 17

All healthcare professionals have a responsibility to share with prison staff any information that might affect a prisoner's safety, within the boundaries of medical confidentiality.

## Coordinated care

Prisoners with multiple health problems are often treated simultaneously by different healthcare teams. A physical problem might be treated by a primary care provider, whereas mental health treatment is in some cases the responsibility of the primary care provider, but in other instances falls to specialist mental health in-reach teams. In general, specialist in-reach teams will have a fairly small caseload, with a high threshold for entry, and those who are not taken onto the in-reach team's caseload will then fall under the care of the primary healthcare provider.

When someone is suffering from mental and physical health problems at the same time, there is a danger that each is treated entirely separately by different clinicians, without any consideration of whether there is any connection between the issues. Care is delivered most effectively when there is a coordinated approach, but communication between primary physical health services and mental health services can be poor, or even non-existent. This can cause difficulties such as diagnostic overshadowing, where physical conditions are overlooked when there are prevalent mental health symptoms, or vice versa.

### Case study L

When Mr L arrived at prison, he was suffering from anxiety and low mood. He had mobility problems, and had previously suffered from pancreatitis, caused by excessive alcohol consumption. Two weeks into his sentence, Mr L said that he might kill himself. Staff began suicide and self-harm prevention procedures which continued until his death.

Mr L began to complain about abdominal pain. Over the course of a few days he saw three nurses and a GP. He said that the pain was similar to the pancreatitis he had previously had, but healthcare staff at first attributed his pain to indigestion and prescribed antacid. He continued to complain of extreme pain and said he could not cope any longer and wanted to die. The doctor prescribed him strong pain medication.

Early the following morning, Mr L intentionally cut his hand and said that he wanted to die. He had to be taken to hospital for treatment. On his return to prison later that day the prison GP saw him again. He concluded that Mr L did not have any obvious abdominal problems, and that his issues were mental rather than physical. He noted that he should see a psychiatrist.

The following day, a mental health worker and visiting psychiatrist conducted a joint assessment of Mr L. They found no evidence of any major depressive or psychotic illness, and concluded that his problems were physical. Yet, when interviewed, the psychiatrist said that Mr L was in no obvious physical pain, and he did not feel it was necessary to overrule the GP's opinion not to admit him to hospital. He also stated that as he finished the assessment after 5pm, he did not have time to discuss his findings with the GP.

There was no further investigation into the cause of Mr L's stomach pains, and the next day he hanged himself. A post-mortem examination confirmed that he had been suffering from acute chronic pancreatitis, which was likely to have caused him severe pain.

After originally considering Mr L to have a physical problem and prescribing antacid and pain medication, the prison healthcare team then seemed to consider that Mr L's issues were, for the most part, related to his mental health. The mental health team thought his problems were mostly physical. There was a lack of communication between the two teams, which meant that this contradiction was not resolved, and Mr L did not receive the treatment he needed.

A mental health diagnosis should not prevent a full investigation into physical health problems. Multiple health issues can occur simultaneously, and all symptoms should be investigated in full.

When a prisoner has multiple health needs and requires care and attention from more than one healthcare team, effective communication between teams should ensure that relevant information is shared, so that an accurate diagnosis is made, and appropriate treatment is provided.

### Lessons to be learned

#### Lesson 18

All healthcare teams involved in the care of a prisoner should communicate with each other and share information, to ensure consistency in diagnosis and a collaborative approach to treatment.



## Assessment, Care in Custody and Teamwork (ACCT)

Prisoners with poor mental health can be particularly vulnerable. Identifying their needs and providing adequate support can help prevent mental health crises, which can lead to self-harm or suicide. PSI 64/2011, Safer Custody, gives detailed guidance to staff to help manage prisoners who have been identified as at risk of harm to themselves. The instructions make clear that if a prisoner is identified as at risk, then Assessment, Care in Custody and Teamwork (ACCT) procedures need to be put in place.

ACCT is a care planning system designed to reduce the risk of suicide and self-harm. The PPO has previously published a Learning Lessons Thematic report which provides a comprehensive account of learning from our investigations of self-inflicted deaths of prisoners who were being monitored under ACCT procedures at the time of death<sup>48</sup>.

In our sample of prisoners who died by suicide in prison between 2012 and 2014, 54 of the 199 prisoners were being monitored under ACCT procedures at the time of their death. Of these 54 prisoners, 47 had been identified as having mental health problems. Active and appropriate participation in ACCT procedures by prison and healthcare staff is therefore often an integral part of a prisoner's mental health care.

When ACCT procedures are initiated, multidisciplinary action is required to assess prisoners' needs and review their progress. The multidisciplinary nature of the ACCT process is important for many reasons, including to help identify triggers for suicide and self-harm. There could be triggers which only healthcare staff are aware of, just as there could be warning signs which only a specific officer – such as their personal officer or a wing officer – know about. To address the needs of the prisoner at risk most effectively, prison staff and healthcare staff have a responsibility to work together and share information.

One of the essential tasks of prison and healthcare staff when ACCT procedures are initiated is to develop an effective Care and Management Plan (care map). The care map is a care plan which should set out how support and care is to be delivered. It should have goals and detailed time-bound actions aimed at reducing the risk posed by the prisoner, and should set out who is responsible for delivering the action to achieve the goal. The ACCT document, including the care map, should accompany the prisoner wherever he or she goes in the prison and should be updated by all staff, including healthcare staff, that the prisoner has contact with.

Once ACCT procedures have been initiated, regular case reviews should be held to monitor the prisoner's progress. In accordance with PSI 64/2011, Safer Custody, these reviews should be multidisciplinary where possible, and include all relevant people involved in a prisoner's care. It is mandatory that the first ACCT case review should include a member of healthcare staff. This case review team should complete the care map, reviewing actions and setting new ones as necessary. The team is also responsible for assessing the prisoner's level of risk and making important decisions relating to their safety, such as their location and the level of observations that they require.

PPO investigations have often found that, when a prisoner is identified as at risk of suicide and self-harm, a care map is often produced and a level of observations is initially set, but then these are not acted upon, or are not reviewed as new issues arise. There is not always a multi-disciplinary approach to making decisions, setting goals and assessing progress. Sometimes the opinions of healthcare staff appear to have been overlooked. Both prison and healthcare staff should be involved in all decisions about a prisoner's risk, including their location, level of observation, and care map goals. It is particularly important to have input from the mental health team when the prisoner has known mental health problems.

### Case study M

Ms M had a history of psychiatric problems, had made a number of previous suicide attempts, and had recently been discharged from a psychiatric hospital. Her behaviour and mood were extremely unpredictable. As soon as she arrived at prison, staff identified that she was at high risk of suicide and began ACCT procedures. They held a case review and drew up a care plan aimed at reducing her risk.

At an initial healthcare assessment a nurse recommended that Ms M should be constantly supervised. The nurse said that this was the first time that she had ever recommended constant supervision, but she was so certain that Ms M would try to kill herself that she thought this was necessary. Despite her advice, two supervising officers completed an ACCT immediate action plan and decided against constant supervision. They set checks at four an hour. Later that day Ms M tried to hang herself, and was then placed under constant supervision and moved to a 'safer cell'. This is a cell which has been specially designed to reduce the possibility of suicide, such as by reducing ligature points.

At an ACCT review three days later, a nurse advised against changing her level of observations but the case manager reduced them to four times an hour. The next day she was moved back to a normal cell. Ten days after that, Ms M made two further attempts to hang herself, and was moved back to a safer cell. Nurses again recommended constant supervision, but prison managers decided frequent checks would be adequate. The next week, prison staff moved her out of the safer cell without consulting the mental health team. This was a Saturday and, as mental health staff did not work weekends, there were no mental health staff present at ACCT reviews held that day or the next. The day after Ms M was moved out of the safer cell, she hanged herself.

Throughout Ms M's time in prison, healthcare staff made impressive efforts to support her. They identified her high risk of suicide immediately, and took steps to keep her safe. The mental health team manager held an emergency mental health assessment and quickly obtained her community clinical records and established her recent history. Further assessments by primary care staff and the mental health team were comprehensive and well documented.

In the three weeks after Ms M arrived at the prison, prison staff held 21 case reviews to help manage her care. While it is commendable that the prison held such frequent reviews, they did not always include a member of the mental health team, and prison staff took important decisions without mental health input. Nurses told us that prison managers often discounted the opinions of healthcare staff about risk and chose not to follow their advice.

While there were aspects of Ms M's care which were commendable, there should have been a more multidisciplinary and inclusive approach to making decisions. We were concerned that the views of mental health professionals were not always considered or given sufficient weight, especially as Ms M was suffering from severe mental health problems and was under the care of the mental health team. The mental health team should have been involved in all important decisions about Ms M, including any decisions to change her level of observations or to move her to a different location.

## Lessons to be learned

### Lesson 19

The mental health team should attend or contribute to all ACCT reviews for prisoners under their care, and should be fully involved in any important decisions about location, observations, and risk.

## Transfer to secure hospital

There are times when a prisoner is suffering from such a severe mental health condition, that prison is not the appropriate place for them. In such a situation, the prisoner should be transferred to a secure hospital, where their needs can be met more effectively and appropriately.

Prisoners are transferred to secure hospitals under sections 47 and 48 of the Mental Health Act (1983). The Mental Health Act states that if reports from at least two registered medical practitioners identify that the prisoner is suffering from a mental disorder, that this disorder is of such a nature that it is appropriate for them to be detained in a hospital for treatment, and that appropriate medical treatment is available for them, then the Secretary of State may warrant their transfer from prison to a secure hospital.

One of the problems associated with transfers to secure hospital is lengthy waiting times. The Mental Health Act does not specify any waiting time limit for transfers from prison to secure hospital, and it can often take a long time for the transfer to happen. Once the need for a transfer has been identified, and a request made, difficulties can arise from a number of factors, including lack of bed availability and disputes over the level of security required. This can lead to prisoners with severe and complex mental health needs having to spend significant amounts of time in prisons, sometimes in segregation units, where they do not have the level of care they need.

This problem was recognised by Lord Bradley in his 2009 Review of people with mental health needs and learning disabilities in the criminal justice system. He recommended that the Department of Health should develop a new minimum target for the NHS of 14 days to transfer a prisoner with acute, severe mental illness to an appropriate healthcare setting<sup>49</sup>. The Department of Health have since agreed with this recommendation, in 2011 publishing a good practice guide about the transfer of prisoners under the Mental Health Act<sup>50</sup>, which included a suggested timescale of 14 days. The Royal College of Psychiatrists also agreed that a maximum wait time should be set, but were concerned about feasibility, and suggested that two months might be a more realistic target<sup>51</sup>.

An additional problem is that delays are not always well recorded. The recording of the length of a waiting time does not generally begin until an assessment has taken place. This opens up the possibility of assessments being pushed back, until there is the possibility of a place opening up.

In the sample of prison deaths between 2012 and 2014, there were 139 prisoners who died from suicide and who had identified mental health problems at the time. The prison had tried to arrange a transfer to hospital for one in ten of these prisoners<sup>52</sup>. In some cases, the transfer was still being considered at the time of death and the process had not been completed. In other cases, the prisoner had been assessed and considered unsuitable. We cannot know whether an earlier transfer would have prevented any of the deaths, but where a secure hospital has been identified as the best environment to deliver appropriate care for acutely ill prisoners, we would expect all possible steps to be taken by the prison and the hospital to ensure this takes place within the 14 day target set out in the Department of Health's good practice guide of 2011.

While we encourage speedy transfers to secure hospitals, we recognise that a transfer is not something that can happen immediately. There will always be a period of time between the transfer being requested and the move taking place. During this period, prison staff have a responsibility to do all that they can to ensure that the needs of the prisoner are met as far as possible. Unfortunately, our investigations found cases where prisoners did not receive appropriate support for their mental health problems, while waiting for a transfer, or waiting to be assessed for a transfer to a secure hospital.

## Case study N

Ms N had a long history of mental health problems. Immediately before going to prison she had been an inpatient in a hospital mental health ward, but after an incident in which she damaged a pool table, she was charged with criminal damage and remanded to prison. When she arrived at the prison, she was admitted as an inpatient to the prison's healthcare centre.

Ms N had a diagnosis of emotionally unstable personality disorder. She also suffered from paranoia and at times she heard voices. Her behaviour was often impulsive and unpredictable, she often self-harmed, and she had previously threatened violence towards staff and other patients in mental health settings.

Due to Ms N's extensive mental health issues, the community mental health team in the area sent a

referral to a secure hospital about a possible hospital transfer. A meeting was being arranged to discuss the referral.

The day before the meeting was due to take place, Ms N threw a cup of boiling water at an officer. The next day, a mental health nurse assessed Ms N as fit to be segregated to face a disciplinary charge. The medical assessment before segregating a prisoner specifically aims to exclude people who are waiting for a transfer or referral to a mental health setting and those who are self-harming and potentially suicidal. All of these factors applied to Ms N, yet she was still moved to the segregation unit.

Later that day, the disciplinary hearing for the assault was held. It was adjourned and the matter referred to the police, but Ms N remained in the segregation unit. Shortly afterwards she was found collapsed on her bed with a plastic bag over her head. She was unresponsive and efforts to resuscitate her were unsuccessful.

Prisoners with complex mental health needs can be very difficult to manage. Ms N was volatile and had been violent towards staff. However, she was also very mentally unwell, required extensive care and support, and was waiting for an assessment for a possible transfer to hospital. Prison staff had an obligation to care for her, until a transfer could be arranged, if she was assessed as needing one.

Segregating a prisoner isolates them from others by removing any association. It can be difficult for some prisoners to cope with, particularly those suffering from mental health issues or at risk of suicide and self-harm. Prison Service Order 1700, Segregation, details the procedures to follow when segregating prisoners. It makes clear that a qualified doctor or nurse must complete a Segregation Safety Algorithm (safety assessment) for all segregated prisoners, to determine if it is appropriate for them. The aim is to exclude very mentally unwell, suicidal prisoners from segregation, in all but the most exceptional of circumstances.

The algorithm makes clear that if the prisoner is awaiting transfer to or being assessed for a bed in a secure hospital, then segregation is not appropriate. The nurse who completed the assessment overrode these instructions and a manager decided to segregate Ms N. There can be exceptional circumstances to segregate such a prisoner, but when this is the case all other options need to have been considered and ruled out and the reasons fully documented<sup>53</sup>. No exceptional reasons were given for Ms N's segregation.



## Lessons to be learned

### Lesson 20

Prisons need to be extra vigilant about the care of prisoners who are being considered for, or are awaiting transfer to a secure hospital. Segregation should be avoided for such prisoners, unless there are clearly recorded exceptional circumstances.

We were concerned that some transfers to hospital from prison might be delayed because prisons were regarded as a safe and appropriate environment. When interviewed, both GPs based at the prison said that prisoners waiting for transfer to a mental health hospital were given no priority as they were viewed to be in a 'place of safety'. They gave several examples of this.

Prisons do not have the same resources and specialist staff that are available in secure hospitals. When a prisoner's mental health needs are identified as being so severe that prison is not able to give them the care that they need, a secure hospital can be a much more appropriate environment. A prompt transfer can help to ensure that they get the support they require as quickly as possible, and we reiterate the calls from the Bradley report and the Royal College of Psychiatrists for the implementation of maximum wait time for transfers from prison to a secure hospital.

### Dual diagnosis

Many prisoners have drug and alcohol misuse problems. When a prisoner suffers from mental health problems as well as substance misuse issues, this is known as dual diagnosis. Difficulties in coping with mental health problems can be exacerbated when a prisoner also has to cope with the difficulties of battling drug or alcohol dependence.

A study by RAPt (the Rehabilitation for Addicted Prisoners Trust) found that drug or alcohol dependent prisoners, who engaged in their rehabilitation programmes between 2010 and 2014, presented with an average of 3.4 mental health problems each<sup>54</sup>. Based on their experience in working with dual diagnosis prisoners, they recommended that a coordinated approach between mental health and substance misuse services should be adopted when caring for and supporting prisoners who have multiple needs.

Lord Bradley's review also recommended an integrated approach to tackling mental health and dependence issues. It identified that mental health

policy and substance misuse policy were developed separately, and as a result treatments are poorly coordinated. The review even found that dual diagnosis could be a barrier to a prisoner accessing support services<sup>55</sup>.

### Case study O

Mr O was a young man with a history of mental health problems, self-harm, and drug and alcohol abuse. After being recalled into custody, he was transferred between prisons three times. He was managed frequently under ACCT procedures, due to serious self-harming behaviour. While he was in prison he was assessed as suffering from severe depression. He received frequent interventions from the mental health team.

Mr O was also dealing with drug problems and was supported by the substance misuse service. The substance misuse service maintained their own records, which were kept separately from healthcare records, and so details of his drug issues were not recorded in Mr O's SystmOne prison health record. There were no regular meetings between the substance misuse service and the mental health team to discuss and review prisoners under the care of both services. These practices prevented a shared understanding and a coordinated approach to meeting Mr O's needs.

Mr O was involved in a fight and moved wing. He had difficulties managing his anger and, a few weeks later, he assaulted another prisoner with a pool cue. The next day, he was charged with a disciplinary offence and was punished by loss of earnings, removal from association, and removal of a range of privileges, including his TV. The manager who held the hearing did not know that Mr O had been assessed as at risk of suicide and self-harm and did not take this into account when deciding on the punishment. Later that afternoon Mr O was found hanged in his cell.

The Department of Health published a 'Guide for the Management of Dual Diagnosis for Prisons' in 2009, which offered some good practice guidance for the management of dual diagnosis within a prison setting<sup>56</sup>. It recognised two different approaches to dual diagnosis, a parallel approach where care is provided by multiple treatment service at the same time, and an integrated approach involving the establishment of specialist dual diagnosis services. The guidance recognises the merits of both approaches, but emphasises the importance of coordination between all professionals involved in a prisoner's care.

The clinical reviewer in Mr O's case was concerned about the lack of interaction between the substance misuse and the mental health teams at the prison where Mr O died. There were no joint screening tools for dual diagnosis, no meetings between the substance misuse and mental health teams, and no input into prisoner health records from substance misuse teams. Better communication and information sharing between two teams might have led to a more coherent approach to Mr O's care.

## Lessons to be learned

### Lesson 21

Mental health and substance misuse teams should work together to provide a coordinated approach to prisoner care. This should involve the use of agreed dual diagnosis tools to assess prisoner needs and regular meetings to discuss and plan joint care.

### Lesson 22

Details of all interventions from substance misuse services should be recorded in a prisoner's SystemOne health record.

Even when mental health and substance misuse teams do communicate with one another, it is important that they do not just share information, but also develop a coordinated approach to simultaneously tackle a prisoner's multiple problems. Our investigations have found evidence of issues being tackled one at a time, and therefore one issue being neglected while another is treated.

## Case study P

Mr P had a history of drug and alcohol abuse and mental health problems. When remanded to prison, he was located on the substance misuse unit. A nurse conducted his initial health screen, and referred Mr P to a GP to discuss his substance misuse issues, and to the mental health team. Later that evening, a GP saw Mr P and prescribed him methadone and medication to alleviate symptoms of drug and alcohol withdrawal.

Before going to prison, Mr P had been assessed at court by a nurse. This nurse wrote a report which detailed his substance misuse and mental health history. She noted that he had periods of paranoia, sometimes heard voices, and had been self-medicating with non-prescribed anti-psychotics. She recommended in the report that

if he went to prison he should see the mental health in-reach team for monitoring while he was withdrawing from drugs and alcohol. When Mr P was sent to prison, the nurse sent this report to the prison.

On the day after his arrival, a nurse from the substance misuse team carried out an initial assessment of Mr P. When interviewed, the nurse said he thought Mr P should have been under the care of the mental health team because he was hearing voices and was self-medicating. He said he wanted him to have a mental health assessment and asked a healthcare assistant from his team to go to the daily mental health multidisciplinary meeting where Mr P was going to be discussed.

The purpose of the mental health multidisciplinary team meeting was to discuss new prisoners with mental health issues and to refer them for treatment as necessary. The meeting was attended by the healthcare assistant from the substance misuse team, as well as representatives from the primary care nursing team and the mental health in-reach team.

At the meeting, the report from the nurse who assessed Mr P at court was discussed, which included the recommendation that Mr P should see the mental health in-reach team for monitoring while he was going through withdrawal. However, a nurse from the mental health in-reach team said that her team would not see Mr P. Her justification was that the substance misuse team would monitor the effects of withdrawal on his mental health state. The following day Mr P hanged himself.

The mental health and substance misuse teams did meet to discuss Mr P's care. Instead of developing a coordinated approach however, the mental health in-reach team said that Mr P should first complete a period of detoxification, and only once this was completed would he be assessed to see if he required mental health support. This approach was not in line with local protocol for treating prisoners with a dual diagnosis, which stated:

"people whose primary issue is drug or alcohol misuse must not be automatically excluded from access to mental health services, their access or referral to another agency must be based upon the assessment of need".

There appeared to be an assumption among some healthcare staff that, as a matter of practice, a prisoner should first go through an initial period of drug and alcohol withdrawal, before being referred to the mental health team for assessment or support. When prisoners are suffering from dual diagnosis, each of their needs should be supported simultaneously and in a coordinated manner.

## Lessons to be learned

### Lesson 23

Prisoners undergoing treatment for substance misuse should not be prevented from accessing secondary mental health services.

## Personality disorder

Personality disorder is a recognised mental disorder, but differs from a mental illness. Mental illness is generally regarded as a change to an individual's usual personality, which can be treated, and their usual personality returned. Personality disorder relates to the way an individual is psychologically constructed. Their usual personality is extreme, therefore there is no illness to get rid of and no 'normal' personality to return to. Instead, treatments for personality disorder aim to help the person control and manage their abnormal personality.

In recent years, steps have been made to try to improve the recognition and treatment of personality disorder, particularly for those on the severe end of the spectrum. The Home Office launched a public consultation in 1999 on the need for better management of offenders with severe personality disorders and, in 2001, a Dangerous and Severe Personality Disorder (DSPD) Programme was launched, piloting services in three prisons<sup>57</sup>. The pilots involved the creation of dedicated units for the treatment of dangerous prisoners with severe personality disorders, providing psychological intervention within a therapeutic environment.

Further progress was made in 2007, when changes to the Mental Health Act broadened the definition of 'mental disorder' to encompass some personality disorders which were previously excluded. The treatability clause was also removed from the Act, which had previously limited provision of treatment when certain conditions were not met<sup>58</sup>. In 2009, the National Institute for Health and Care Excellence (NICE) published clinical guidance on the treatment and management of borderline and anti-social personality disorders<sup>59</sup>.

Despite movements in thinking, Lord Bradley's Report (2009) found there was not a coherent approach to the management of personality disorder and that there was need for further development of personality disorder-specific services in prisons<sup>60</sup>. Subsequent review of the DSPD Programme led to recognition of the need for a strategic plan for the treatment and management of offenders with severe personality disorders. The Department of Health and the National Offender Management Service (NOMS) jointly developed an Offender Personality Disorder Pathway Implementation Plan which went for public consultation in 2011<sup>61</sup>. Steps are now being taken to implement the plan<sup>62</sup>.

The 2014 review of the Bradley Report found some evidence of change. According to the review, while there remained little or no provision for the bulk of prisoners with personality disorders, treatment pathways for prisoners with severe disorders who pose a high risk of harm were available to a larger number of such prisoners, with Offender Personality Disorder treatment and progression services known as Psychologically Informed Planned Environments, or PIPEs, now available in a number of prisons<sup>63</sup>.

PIPEs are a key part of the Department of Health and NOMS personality disorder strategy. They are not a form of treatment, but are designed to offer a safe and facilitating environment to help prisoners develop socially and to retain any benefits they have already gained from treatment<sup>64</sup>. They were originally designed as progression units for offenders who have completed high intensity treatment, but have since developed to also provide a supportive environment for some prisoners before and during treatment<sup>65</sup>.

Any progress in supporting prisoners with personality disorder is welcome, particularly as the prevalence of personality disorders in prison is extremely high. Studies have estimated that it affects 60-70% of prisoners, compared with only 4%-11% of the general population<sup>66</sup>. Yet, personality disorders frequently go undiagnosed. In our sample of prison deaths between 2012 and 2014, personality disorder had been identified in only 10% of self-inflicted deaths, and 1% of natural cause deaths. This could be partly due to the fact that personality disorders have historically been deemed as untreatable, and therefore have been largely neglected by services in terms of both identification and support. Unusual behaviour resulting from a personality disorder can also be misinterpreted as a behavioural issue, causing the presence of a disorder to be missed.

## Case study Q

Mr Q found it difficult to manage his moods and had a history of mental health issues. He also had a history of substance misuse and self-harm.

During his time in prison Mr Q was prescribed medication to help him cope; initially he was prescribed anti-depressants and later a low dose of anti-psychotic medication. He was also referred for psychological therapies. For a time he worked with a psychologist, who helped him to learn coping strategies.

Mr Q often spoke about having suicidal thoughts and said that he thought he would die in prison. He was frequently managed under ACCT procedures and, when he was considered particularly high risk, he was moved to the inpatient unit at the prison, which had safer cells (special cells with reduced ligature points).

On one occasion, Mr Q claimed to have taken an overdose and was taken to hospital. When he returned to the prison, he was admitted to the inpatient unit. While there, he had frequent contact with psychiatrists and mental health nurses, and seemed to settle well. He was assessed by a psychiatrist who concluded that he had a persistent low mood and traits of an emotionally unstable personality disorder, but found no evidence of a major psychiatric condition, such as psychosis or schizophrenia.

The psychiatrist considered that Mr Q clearly posed a risk to himself and to others, but found that there was no clinical need for him to stay in the inpatient unit. It was decided that Mr Q should move back to a standard wing, and continue to see the psychologist and take anti-psychotic medication. A week after returning to a standard wing he hanged himself in his cell.

This case study has not been included to illustrate any failings in the treatment of a prisoner with a personality disorder, but to emphasise the difficulty in providing the appropriate treatment and support. While Mr Q seemed to cope well in the inpatient unit, he did not have a serious mental illness requiring specialist treatment. There was no identified clinical reason for him to remain there, and so he moved back to a standard prison wing. However, it appears that the smaller and structured environment of the inpatient unit was a better environment for him.

One of the psychiatrists who had assessed Mr Q told the investigator that psychological interventions are considered to be the best way to manage personality

disorders. He said that there was no medication which could cure Mr Q, but that medication could help him to control some of his symptoms.

The clinical reviewer found that the prescriptions Mr Q received were appropriate, and that he was correctly referred for counselling. He concluded that the mental health care Mr Q received was generally appropriate.

Comprehensive programmes have been developed to help manage prisoners with severe personality disorders who pose a high risk to themselves or others, but there is a lack of interventions for those with less severe disorders and those who do not present a danger to others. In the absence of a cure for personality disorders, psychological therapies can be useful to help people with personality disorders learn coping strategies to live with the condition.

There are no easy solutions to managing prisoners with personality disorders. Progress has been made to improve care for prisoners with severe disorders, and perhaps there is now need for the development of a comprehensive strategy for supporting prisoners with less severe disorders.

While specialist treatment programmes for prisoners with severe personality disorders do exist, spaces on these programmes are very limited. Some prisoners will not be eligible to start the programme for a significant length of time, and others who do receive treatment fail to engage with it, despite best efforts of staff.

## Case study R

Mr R and Mr S both had severe personality disorders. Mr R spent five years in a Dangerous and Severe Personality Disorder (DSPD) Unit, where he took part in a treatment programme. His progress was slow and he did not engage fully. Once it was felt that he had exhausted his treatment options in the DSPD unit, he moved to a medium secure psychiatric unit in the community for further treatment. Again he did not engage with the treatment. He then returned to prison, but not to a DSPD unit. Despite his history, he was not referred to the mental health team.

Mr S made two requests to move to the DSPD unit, but these requests were unsuccessful because he was at too early a stage of a long sentence. There were very limited places in the DSPD unit, and therefore there was a priority to minimise the risk to the public by dealing first with men who were likely to be released in the near future. Mr S would not have been considered



for a place in a DSPD unit until he had served a further 15 years, when he would have been approaching the end of the minimum time he was expected to serve before he could be considered for release. Mr R and Mr S subsequently ended up in neighbouring cells, in the vulnerable prisoners unit of a high security prison.

One morning, Mr R and Mr S were joined in Mr S's cell by another prisoner. They locked the door, and attacked and killed the other prisoner. Mr S then mutilated the body with weapons made from razor blades. Shortly afterwards, Mr R and Mr S both went to the wing office and confessed what they had done. Mr R later pleaded guilty to murder and Mr S to manslaughter on the grounds of diminished responsibility. Both received life sentences.

The clinical reviewer found that more than adequate efforts had been made at the DSPD unit to help Mr R, but that he had made all the progress that he was going to make and there was nothing more that could be done for him there. He had initially engaged when he transferred to the medium secure unit in the community, but then stopped cooperating. There was therefore little choice but to discharge him back to prison.

Mr R was not referred to the mental health team when he moved back to prison, apparently because he was not considered to have a mental illness and attempts to treat his personality disorders had proved futile. When interviewed, Mr R told our investigator that he became anxious after returning because he had not lived in a standard prison environment for six years.

We considered that Mr R should at least have been allocated a named mental health nurse to oversee his reintegration into prison life after his discharge from hospital. His sudden withdrawal from treatment when he returned to the prison was at odds with the previous seven years of intensive intervention, and he would have needed support to readjust. Recent developments in the strategy for dealing with prisoners with personality disorder, in particular the introduction of PIPEs, should help to ensure that there are supportive environments in place for prisoners who have previously undergone intensive therapy and need help to readjust.

## Lessons to be learned

### Lesson 24

When a prisoner is moved to a standard prison wing, from a secure mental health hospital or a specialist prison unit for those with severe personality disorder, their reintegration should be supported and their progress monitored. They should initially be allocated a healthcare practitioner with experience of personality disorder and be given appropriate care in line with an agreed care plan.

Mr S was serving a very long sentence, and was facing a very long wait before being accepted by the DSPD unit for treatment to reduce his risk. In the meantime, his risk to other prisoners and staff was not being addressed. Mr S told a nurse that because of his long sentence he felt that he had nothing to lose. Managing the long-term risk of offenders with severe personality disorder who are not in specialist units is a very difficult problem for prisons, but steps need to be taken to manage the risks they present to themselves and others.

## Lessons to be learned

### Lesson 25

The risks presented by all offenders with severe personality disorder who face long periods in prison should be identified and managed through informed sentence planning and suitably structured regimes.



# Conclusion

Prison staff, primary healthcare staff, and specialist mental health teams all have a role to play in the identification of prisoners with mental health needs, and the provision of appropriate care and support. Each has their own responsibilities, but must also work cooperatively with one another, sharing information and developing a collaborative approach, so that prisoners receive comprehensive care that addresses all of their needs in an integrated way. Our investigations found too many examples of poor communication and disjointed care. As a result, a number of the lessons included in this report relate to information sharing and a more coordinated approach to care.

The ability of staff to perform these responsibilities effectively is largely dependent on the training that they are provided with, the guidance and resources available to them, and the management and supervision they receive. Only when staff are trained in mental health awareness, have an understanding of the difficult behaviour that can be associated with mental health problems, and are informed of the processes for managing and caring for prisoners with mental health needs, will prisoners in need of health and support be identified and directed towards the appropriate services. This has prompted lessons about staff training, and the need for clear processes and guidance.

The very nature of fatal incident investigations means that PPO investigators tend to see things that have gone wrong. It is important that mistakes are identified so that lessons can be learned to prevent further deaths where possible, and to contribute to safer, fairer custody.

While the guiding principle behind this thematic review was to inform best practice and improve mental health provision in prisons, it is also important to recognise the excellent work that is carried out by many prison officers and healthcare staff. Prisoners with mental health problems can be very difficult and challenging to manage. Many of our investigations found impressive efforts by staff to do all that they could to support prisoners who were finding it difficult to cope.

There has been significant movement in policy and practice surrounding the approach to managing mental health needs of prisoners over the last two decades, and some improvement has undoubtedly been made. However, there is still a long way to go, and we hope that the lessons identified in this report can help prisons to re-evaluate and improve their practices where appropriate, amid the complex landscape of mental health provision.

# Endnotes

- <sup>1</sup> Stewart, D (2008), *The problems and needs of newly sentenced prisoners: results from a national survey*, Ministry of Justice. Available online: <http://webarchive.nationalarchives.gov.uk/20100505212400/http://www.justice.gov.uk/publications/docs/research-problems-needs-prisoners.pdf>
- <sup>2</sup> Note that this sample was designed to be representative of newly sentenced adult prisoners, sentenced to a maximum of four years, and not the total prison population. The data should not be interpreted as being representative of the prison population as a whole. It should also be noted that this study was conducted by interviewers who asked prisoners a number of questions, including questions which could indicate the presence of mental health problems. The study did not include clinical diagnosis of respondents' mental health.
- <sup>3</sup> Singleton, N., Meltzer, H. & Gatward, R. (2001) *Psychiatric morbidity among prisoners: Summary Report*. Office for National Statistics. Available online: <http://www.ons.gov.uk/ons/rel/psychiatric-morbidity/psychiatric-morbidity-among-prisoners/index.html>
- <sup>4</sup> The PPO plans to publish a learning lessons bulletin looking specifically at dementia care for prisoners in early 2016.
- <sup>5</sup> Bradley, K. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. Available online: <http://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>
- <sup>6</sup> Department of Health and Home Office (1992), *Review of health and social services for mentally disordered offenders and others requiring similar services (the Reed Report)*.
- <sup>7</sup> HM Inspectorate of Prisons (1996), *Patient or prisoner?* Available online: [http://www.justiceinspectorates.gov.uk/hmiprisoners/wp-content/uploads/sites/4/2014/08/patient\\_or\\_prisoner\\_rps.pdf](http://www.justiceinspectorates.gov.uk/hmiprisoners/wp-content/uploads/sites/4/2014/08/patient_or_prisoner_rps.pdf)
- <sup>8</sup> Department of Health (1999), *The future organisation of prison healthcare*. Available online: [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4106031.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4106031.pdf)
- <sup>9</sup> Bradley, K. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. Available online: <http://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>
- <sup>10</sup> The transfer of non-clinical substance misuse services from the Prison Services to the NHS came later in 2011.
- <sup>11</sup> The responsibility for the provision of healthcare services in prisons differs in Wales. In 2003 health services in public sector prisons in Wales were transferred from the Home Office to the Welsh Government. This responsibility has been devolved to the relevant NHS Wales Local Health Boards (LHBs). The commissioning responsibility for primary health care in the one private prison in Wales currently still rests with NOMS and is delivered via the contract with the prison operator. Secondary and tertiary care reside with NHS Wales.
- <sup>12</sup> NHS (1999), *A National Service Framework for Mental Health*. Available online: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/198051/National\\_Service\\_Framework\\_for\\_Mental\\_Health.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf)
- <sup>13</sup> Royal College of Psychiatrists (2015), *Standards for Prison Mental Health Services: Quality Network for Prison Mental Health Services*. Available online: <http://www.rcpsych.ac.uk/pdf/Standards%20for%20Prison%20Mental%20Health%20Services%20Publication2.pdf>
- <sup>14</sup> Social Exclusion Unit (2002), *Reducing re-offending by ex-prisoners: Summary of the Social Exclusion Unit report*. Available online: [http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/cabinetoffice/social\\_exclusion\\_task\\_force/assets/publications\\_1997\\_to\\_2006/reducing\\_summary.pdf](http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/reducing_summary.pdf)
- <sup>15</sup> Department of Health (2001), *Changing the Outlook: A strategy for developing and modernising mental health services in prison*. Available online: [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4034228.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034228.pdf)

- <sup>16</sup> The Care Programme Approach provides coordinated care for people experiencing severe mental illness or who have a range of complex needs. A CPA care coordinator is appointed and helps to assess the person's needs, jointly develop a care plan, review it over time and identify risks where applicable. More information can be found here: <http://www.nhs.uk/CarersDirect/guide/mental-health/Pages/care-programme-approach.aspx>
- <sup>17</sup> Department of Health (2005), *Offender Mental Health Care Pathway*. Available online: <http://www.rcpsych.ac.uk/pdf/OffenderMentalHealthCarePathway2005.pdf>
- <sup>18</sup> Royal College of Psychiatrists (2015), *Standards for Prison Mental Health*. Available online: <http://www.rcpsych.ac.uk/pdf/Standards%20for%20Prison%20Mental%20Health%20Services%20Publication.pdf>
- <sup>19</sup> Bradley, K. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. Available online: <http://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>
- <sup>20</sup> Steel, J et al. (2007), *Prison mental health inreach services*, *British Journal of Psychiatry*, 190 (5). Available online: <http://bjp.rcpsych.org/content/190/5/373.full-text.pdf+html>
- <sup>21</sup> Offender Health Research Network (2009). *A National Evaluation of Prison Mental Health In-Reach Services: A report to the National Institute of Health Research*. Available online: <http://www.ohrn.nhs.uk/resource/Research/Inreach.pdf>
- <sup>22</sup> HM Inspectorate of Prisons (2007), *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs*. Available online: <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2014/07/Mental-Health.pdf>
- <sup>23</sup> The findings from the review can be found in the Bradley Report: Bradley, K. (2009), *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. Available online: <http://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>
- <sup>24</sup> Ministry of Justice (2010), *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders*. Cm 7972. London: Stationery Office. Available online: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/185936/breaking-the-cycle.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/185936/breaking-the-cycle.pdf)
- <sup>25</sup> HM Government (2014), *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis*. Available online: [http://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353\\_Mental\\_Health\\_Crisis\\_accessible.pdf](http://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf)
- <sup>26</sup> Bradley, K. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. Available online: <http://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>
- <sup>27</sup> Ministry of Justice (2013), *Transforming Rehabilitation, A Strategy for Reform, Response to Consultation CP(R)16/2013*. Available online: <https://consult.justice.gov.uk/digital-communications/transforming-rehabilitation/results/transforming-rehabilitation-response.pdf>
- <sup>28</sup> Ministry of Justice (2014), *Target Operating Model: Version 3, Rehabilitation Programme*. Available online: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/387795/target-operating-model-3.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/387795/target-operating-model-3.pdf)
- <sup>29</sup> Centre for Mental Health (2014), *The Bradley Report five years on: An independent review of progress to date and priorities for further development*. Available online: <http://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=33874f52-53cb-4a40-b8a7-db8d34d7b583>
- <sup>30</sup> HM Inspectorate of Prisons (2007), *The mental health of prisoners: A thematic review of the care and support of prisoners with mental health needs*. Available online: <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2014/07/Mental-Health.pdf>
- <sup>31</sup> In Wales, NHS Wales Local Health Boards (LHBs) commission healthcare services in public sector prisons. In the one contracted prison the primary care commissioning responsibility rests with NOMS and is delivered via the contract with the operator, while secondary and tertiary care commissioning rests with NHS Wales.
- <sup>32</sup> NHS Commissioning Board (2013), *Securing Excellence in Commissioning for Offender Health*. Available online: <http://www.england.nhs.uk/wp-content/uploads/2013/03/offender-commissioning.pdf>
- <sup>33</sup> Royal College of Psychiatrists (2015), *Standards for Prison Mental Health*. Available online: <http://www.rcpsych.ac.uk/pdf/Standards%20for%20Prison%20Mental%20Health%20Services%20Publication.pdf>

- <sup>34</sup> More information about the upcoming NICE guidance can be found here: <https://www.nice.org.uk/news/article/improving-the-mental-health-of-prisoners>
- <sup>35</sup> While bipolar affective disorder, schizophrenia and other delusional disorders are known severe and enduring mental illnesses, other mental health problems can also be severe and enduring for some sufferers (e.g. depression). The total percentage of prisoners with severe and enduring mental illness could therefore be higher.
- <sup>36</sup> The PPO plans to publish a learning lessons bulletin looking specifically at dementia care for prisoners in early 2016.
- <sup>37</sup> Prisons and Probation Ombudsman (2014), *Learning from PPO Investigations: Self-inflicted deaths of prisoners 2013-14*. Available online: <http://www.ppo.gov.uk/wp-content/uploads/2015/03/self-inflicted-deaths-2013-14-Final-for-publication-5.pdf#view=FitH>
- <sup>38</sup> Grubin, D et al. (2002), *Report on new prison reception health screening arrangements : the results of a pilot study in 10 prisons*. Available online: <https://www.networks.nhs.uk/nhs-networks/health-and-criminal-justice-liaison-and-diversion/messageboard/implementation-plans/466291528/917135531/don-grubin-reception-screen-doc>.
- <sup>39</sup> Offender Health Research Network (2008), *An evaluation of the reception screening process used within prisons in England and Wales*. Available online: <http://www.ohrn.nhs.uk/OHRNResearch/RecepScreen.pdf>
- <sup>40</sup> Offender Health Research Network (2010), *The pathway of prisoners with mental health problems through prison health services and the effect of the prison environment on the mental health of prisoners: A report to the National Institute of Health Research*. Available online: <http://www.ohrn.nhs.uk/OHRNResearch/EnvPath.pdf>
- <sup>41</sup> Offender Health Research Network (2009), *A National Evaluation of Prison Mental Health In-Reach Services: A report to the National Institute of Health Research*. Available online: <http://www.ohrn.nhs.uk/resource/Research/Inreach.pdf>
- <sup>42</sup> This guidance can be found here: <http://www.nice.org.uk/guidance/cg90>
- <sup>43</sup> More information on NPS, and the link between NPS and difficult or erratic behaviour can be found in the PPO Learning Lessons Bulletin 'New Psychoactive Substances' (2015). Available online: [http://www.ppo.gov.uk/wp-content/uploads/2015/07/LLB\\_FII-Issue-9\\_NPS\\_Final.pdf#view=FitH](http://www.ppo.gov.uk/wp-content/uploads/2015/07/LLB_FII-Issue-9_NPS_Final.pdf#view=FitH)
- <sup>44</sup> IEP (Incentives and Earned Privileges) levels are categories applied to prisoners which determine the benefits they receive or privations imposed on them. A prisoner's behaviour is assessed over time, taking into account positive comments as well as issued warnings, and they are then assigned to one of a number of levels. Those on a higher level will be rewarded, for example having access to television, or being allowed to receive more visitors than those on a lower level.
- <sup>45</sup> Department of Health (2011), *Talking therapies: A four-year plan of action*. Available online: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213765/dh\\_123985.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213765/dh_123985.pdf)
- <sup>46</sup> NHS (2013), *IAPT – Offenders: Positive Practice Guide*. Available online: <http://www.iapt.nhs.uk/silo/files/offenders-positive-practice-guide.pdf>.
- <sup>47</sup> A therapeutic community is a dedicated residential unit which separates prisoners from the rest of the prison population and provides a programme of intensive therapy over a number of months. Prisoners are expected to participate in counselling, group work and peer support, and to live as a community in which they support one another, talk through problems and evaluate their behaviour so that they can look to learn from it and make changes.
- <sup>48</sup> Prisons and Probation Ombudsman (2014), *Learning from PPO Investigations: Self-inflicted deaths of prisoners on ACCT*. Available online: [http://www.ppo.gov.uk/wp-content/uploads/2014/07/ACCT\\_thematic\\_final\\_web.pdf](http://www.ppo.gov.uk/wp-content/uploads/2014/07/ACCT_thematic_final_web.pdf)
- <sup>49</sup> Bradley, K. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. Available online: <http://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>
- <sup>50</sup> Department of Health (2011), *Good Practice Procedure Guide: The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act*. Available online: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215648/dh\\_125768.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215648/dh_125768.pdf)
- <sup>51</sup> Royal College of Psychiatrists (2009), *Prison transfers: A survey from the Royal College of Psychiatrists*. Occasional Paper OP81. Available online: <http://www.rcpsych.ac.uk/pdf/PRISON%20TRANSFERS%20OP81.pdf>
- <sup>52</sup> This figure excludes the 12 cases where it was not established whether an attempt for a transfer had been made or not.



- <sup>53</sup> Further details about segregation and exceptional circumstances can be found in the PPO Learning Lessons Bulletin 'Segregation' (2015). Available online: <http://www.ppo.gov.uk/wp-content/uploads/2015/06/Learning-Lessons-Bulletin-Segregation-final.pdf#view=FitH>
- <sup>54</sup> RAPt (The Rehabilitation for Addicted Prisoners Trust) (2015), *RAPt Research and policy briefing series No.2: Substance misuse and mental health in prison*. Available online: <http://www.rapt.org.uk/sites/default/files/16/RAPt%20Research%20and%20Policy%20Briefing%20Number%202%20-%20FINAL%20%28Small%20for%20Email%29.pdf>
- <sup>55</sup> Bradley, K. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. Available online: <http://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>
- <sup>56</sup> Department of Health (2009), *A Guide for the Management of Dual Diagnosis for Prisons*. Available online: [http://www.nta.nhs.uk/uploads/prisons\\_dual\\_diagnosis\\_final\\_2009.pdf](http://www.nta.nhs.uk/uploads/prisons_dual_diagnosis_final_2009.pdf)
- <sup>57</sup> Benefield, N. et al. (2015), *The Offender Personality Disorder Strategy jointly delivered by NOMS and NHS England*, Prison Service Journal No 218.
- <sup>58</sup> Centre for Mental Health (2015), *The Bradley Commission: Personality disorder and complex needs*. Available online: <http://www.centreformentalhealth.org.uk/personality-disorder-and-complex-needs>
- <sup>59</sup> The guidance documents are both available online. Borderline personality disorder: <http://www.nice.org.uk/guidance/cg78> Anti-social personality disorder: <http://www.nice.org.uk/guidance/cg77>
- <sup>60</sup> Bradley, K. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health. Available online: <http://www.rcpsych.ac.uk/pdf/Bradleyreport.pdf>
- <sup>61</sup> The consultation and response are both available online. Consultation: [http://www.pn.counselling.co.uk/personality\\_disorder\\_pathway\\_feb\\_11.pdf](http://www.pn.counselling.co.uk/personality_disorder_pathway_feb_11.pdf) Response: [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_130701.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130701.pdf)
- <sup>62</sup> Lloyd, M. and Bell, R. (2015), *Editorial Comment: Personality disorder in offenders then and now*, Prison Service Journal No 218.
- <sup>63</sup> Centre for Mental Health (2014), *The Bradley Report five years on: An independent review of progress to date and priorities for further development*. Available online: <http://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=33874f52-53cb-4a40-b8a7-db8d34d7b583>
- <sup>64</sup> NatCen Social Research (2013), *Enabling features of Psychologically Informed Planned Environments*, National Offender Management Service. Available online: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/211730/enabling-pipe-research-report.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/211730/enabling-pipe-research-report.pdf)
- <sup>65</sup> Turner, K. and Bolger, L. (2015), *The provision of PIPEs — Psychologically Informed Planned Environments*. Prison Service Journal No 218.
- <sup>66</sup> Department of Health (2011). *Working with personality disordered offenders: A practitioners guide*. Available online: <https://www.justice.gov.uk/downloads/offenders/mentally-disordered-offenders/working-with-personality-disordered-offenders.pdf>



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