**Standards of Mental Health Care in Prisons in England and Wales: a qualitative study of reports from Her Majesty’s Inspectorate of Prisons**

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Running header: Mental Health Care in Prisons in England and Wales

**Abstract**

The high prevalence of mental health problems in prisons is well established and there are ongoing challenges to mental health care and service provision. The aim of this research was to identify practice that was working well and where there was scope for improvement. Forty-two independent inspectorate reports on conditions for and treatment of people across all seven categories of prison in England and Wales were analyzed thematically. Themes of *What is Working* and *Shortfalls* identified that multidisciplinary working, good communication, balancing care with security, and positive staff-prisoner relationships supported mental health, but there were numerous shortfalls in service provision across the prison estate. Conclusions support an agenda of prison reform with mental health as a key priority.

**Keywords**:

Mental health; prisons; mental health care; mental health service provision

**Introduction**

It is well established that there is a higher prevalence of mental health problems among people in prisons than in the community (e.g. Brooker, Duggan, Fox, Mills & Parsonage, 2008) and this seems to be evident internationally (e.g. Fazel, Hayes, Bartellas, Clerici & Trestman, 2016). There is not a straightforward explanation for the high prevalence of mental health problems among prisoners, but this also co-occurs with a high prevalence of childhood abuse victimization (e.g. Bodkin et al., 2019) and post-traumatic stress disorder (Baranyi, Cassidy, Fazel, Priebe & Mundt, 2018), for which there is recognized impact on mental health of male prisoners (Goddard & Pooley, 2018), including the development of persecutory symptoms of psychosis that might mediate violence risk (Green, Browne & Chou, 2019). Furthermore, the experience and pains of imprisonment (e.g. Crewe, 2011; Sykes, 1958) might trigger or exacerbate mental health problems among people who have an existing vulnerability, and this is a specific consideration for women and young people in prisons who present with greater prevalence of mental health problems than adult males (e.g. Borril et al., 2003; Chitsabesan & Hughes, 2016; Hollin & Palmer, 2006; Underwood & Washington, 2016); gender and age are relevant considerations in addressing the mental health needs of prisoners (Glorney, 2017). In the context of a rehabilitative prison culture in England and Wales, there is a compelling argument for improving the psychological well-being and mental health of prisoners not least when considering that an aim of rehabilitation is to reduce risk; psychosocial functioning and healthy forms of coping, communicating, and managing stress, are established considerations in future risk reduction and management (e.g. Douglas, Hart, Webster & Belfrage, 2013).

In England and Wales, rates of self-harm in prisons (linked to mental health problems and psychological distress; e.g. Gooding et al., 2017; Humber et al., 2011; Shaw et al., 2004) are at the highest recorded level (National Audit Office, 2017), around three times greater than in the community (Fazel et al., 2011). The peak in self-harm in prisons co-occurs with cuts to spending and staff since 2009, overcrowding, and an increase in the availability of new psychoactive substances (NPS) and violence (e.g. House of Commons Justice Committee, 2016). These are likely to be just some of the factors contributing to a high prevalence of mental health problems in prisons. Of additional concern is that in a 2017 Prison Reform Trust survey of prisoners, just 25% of people who self-reported mental health or emotional wellbeing issues in prisons received treatment. There are also well-documented lengthy delays in transferring prisoners to secure mental health beds in relevant services (e.g. Forrester, Henderson, Wilson, Cumming, Spyrou & Parrott, 2009), which add additional strain on resourcing and safety in prisons.

There remains a reduced mental health service provision and delivery in prisons in England and Wales in comparison to the community (e.g. Forrester et al., 2013; Forrester, Till, Simpson & Shaw, 2018), even though an argument might be made that increased prison provision is required due to the high prevalence of mental health problems (e.g. Fazel et al., 2016) and possibly improved outcomes on psychosocial functioning and risk-related behaviors on release from prison following mental health support. A national provider of public mental health services in the United Kingdom (UK) is the National Health Service (NHS), which is under strain and mental health care in general is poorly resourced (Mental Health Taskforce of the NHS, 2016). The NHS provides a mental health in-reach service to UK prisons, and there is some evidence that this has improved prisoner mental health care particularly through the introduction of the Care Programme Approach (CPA; Brooker and Webster, 2017).

However, there remain challenges in the delivery of mental health care in prisons. The NHS and Her Majesty’s Prison and Probation Service (HMPPS) are large, national, public sector organizations with distinct policies and procedures, including for information and data sharing and management. Even for services that appear to be integrated, such as the Mental Health In-Reach Teams (MHiRTs), sharing of information about prisoners (mental health, care planning, risk, security) might not flow to support the care of the prisoner (e.g. Samele, Urquía, Slade & Forrester, 2017). The problem of information flow and sharing might be compounded by challenges in multidisciplinary staff recruitment and retention in MHiRTs, which results in high caseloads, strain in service provision, and a lack of continuity of knowledge and care of prisoners (e.g. Bradley, 2009; Mills & Kendall, 2016). Furthermore, use of NPS means that existing mental health problems can be exacerbated and render the task of mental health care additionally challenging and demanding (Public Health England, 2015). There is demand for the integration of substance misuse and mental health services in prisons to optimize the management of dual diagnosis (e.g. Wright, Gournay, Glorney & Thornicroft, 2002).

Beyond formal mental health services in prisons, there is provision to support mental wellbeing through purposeful activities, psycho-educational programs and national peer initiatives, such as the Listener scheme provided by the charity Samaritans. However, the scope of provision is subject to local and regional commissioning and related priorities, so there is variability in the nature of and access to mental health care. There exist published standards that guide mental health care practice in prisons but these are on an opt-in basis. For example, the Standards for Prison Mental Health Service (Royal College of Psychiatrists, 2017) set out essential, expected and desirable standards for sufficient mental health provision. The Healthcare Standards for Children and Young People in Secure Settings (Royal College of Paediatrics and Child Health, 2019) offer guidance and support for service design and delivery teams for expected standards of physical and mental healthcare for this vulnerable group within forensic services. The Gender Specific Standards to Improve Health and wellbeing for Women in Prison in England (Public Health England, 2018) set out principles and standards for the good mental health and emotional wellbeing for women. There have been calls to introduce a framework for consistency and quality of care provision (e.g. Byng et al., 2012) and it might be that the implementation of the NHS England Five Year Forward View for Mental Health (NHS England, 2016) will go some way to reduce inequity in mental health service provision in prisons.

A challenge of mental health care provision in prisons is the prevalent narrative of control and punishment in comparison to care and recovery as might be common to secure mental health services (e.g. Drennan & Alred, 2012; Tronto, 2009). There are on-going debates about the role of prisons in providing care and what this means in particular for trauma-informed practice (e.g. Miller & Najavits, 2012). A critical component of mental health care of prisoners is the role of operational staff. However, the tasks and requirements of a prison officer are multiple and if training is either lacking or insufficient then sometimes officers lack confidence to work with prisoners with mental health problems (Parker, 2009; Walsh & Freshwater, 2009). Although mental health awareness is a requirement in the training of operational prison staff (House of Commons Justice Committee, 2009), they face extensive stressors in their daily work and prison officers often feel unsupported and insecure in their roles (Arnold, Liebling & Tait, 2007).

Following years of spending cuts and deterioration in prison safety, Her Majesty’s Prison and Probation Service has embarked on a period of reform and spending for mental health service provision in the criminal justice system has increased (NHS England, 2016). Tasked with reporting on conditions for and treatment of people in prison, Her Majesty’s Inspectorate of Prisons (HMIP) makes independent, unannounced assessments of prisons at least once every five years (although most are inspected every two to three years), with reference to a series of expectations framed as the Healthy Prisons Test across domains of respect, safety, purposeful activity and resettlement (HMIP, 2012). The assessment of mental health service provision is not an explicit focus of the HMIP reports but is included as a consideration of prison health in general, and can be inferred through discrete sections of reports (e.g. self-harm and safeguarding under the Safety domain, equality and diversity and health services under the Respect domain, reintegration planning in the Resettlement domain). Review of the HMIP reports, publically available through a UK Government website, could offer a cross-section of strengths and needs in mental health service provision within a whole prison context, with a view to benchmarking standards in service organization and delivery and quality of care.

In a review of systemic limitations in the delivery of mental health care in prisons in England, Patel, Harvey and Forrester (2018) analyzed all 36 HMIP reports published in 2015. Qualitative content analysis generated categories that reflected the process of mental health assessment and management, the range and quality of service provision, and issues relating to staffing. The reported frequencies indicated that delivery of mental health care was not of a standard equivalent to that provided in the community, consistent with previous research (e.g. Forrester et al., 2013), and the overall focus of the study was on what is not working in service delivery in prisons. However, due to the consecutive sampling approach of the HMIP reports, no high secure prisons and very few Category B prisons (the next most secure after high secure) were examined. Prisoners in these establishments are likely to have perpetrated very serious offences, present with disruptive behavior in prison, and/or be serving long custodial sentences. Therefore, it is likely that a consideration of these prisons is relevant to an understanding of mental health service provision in England and Wales. Furthermore, an understanding of what is working and where for mental health care in prisons would be useful in understanding the context of service delivery in England and Wales.

Through the HMIP reports, we aimed to investigate the standards of mental health care in prisons in England and Wales, with a particular focus on the identification of strengths and shortfalls in service provision across the prison estate. The HMIP does not make reference to the Standards documents published by the Royal College of Psychiatrists (2017), the Royal College of Paediatrics and Child Health (2013), nor Public Health England (2018) but where strengths and shortfalls were identified we aimed to cross-reference to Standards to gain a picture of the scope and quality of mental health service provision. Furthermore, the depth of mental-health related information in the HMIP reports does not permit quantitative analyses (see also Patel et al., 2018), so a qualitative approach that permitted a flexible approach to organizing and describing themes (e.g. Nowell, Morris, White & Moules, 2017) was adopted.

**Method**

***Design, Procedure and Materials***

Following ethical review, as required for all research at the home institution, Her Majesty’s Inspectorate of Prisons (HMIP) reports were accessed through the online, publically available repository. In order to capture breadth and currency of institutional practice, selection of reports were limited to the most recent (in July 2017) six consecutive reports for all seven categories of prison in England and Wales (n=42; see Table 1), yielding just over a two year reporting date range of January 2015 to March 2017. These 42 reports were downloaded and the secondary data were analyzed qualitatively. HMIP reports described the prison population through formal recording processes (e.g. number of prisoners at the establishment at the time of the inspection) and presented data from a standardized HMIP survey distributed to a random sample of 20-25% of the population of each establishment. The survey asked about prisoner needs and experiences of prison processes from initial reception through to release. The survey included a yes/no question on self-reported emotional and mental health problems - ‘Do you have any emotional or mental health problems?’ - responses to which generated the prevalence data on mental health problems presented in Table 1 (column three). As seen in Table 1, there was a high prevalence of self-reported mental health problems across the prisons sampled. The lowest rates were at Category D (open prisons) and the young persons estate. These figures might reflect greater mental wellbeing close to the point of release or outside of the constraints of closed conditions (Category D), or a lack of willingness to self-identify with emotional or mental health problems. The highest prevalence of self-reported emotional and mental health problems was in the women’s estate, consistent with previous research (e.g. Tyler, Miles, Karadag & Rogers, 2019). Of the 42 prisons, three were managed by private companies under HMPPS contract and governance.

[TABLE 1 ABOUT HERE]

Published standards for mental health provision in prisons provided a framework for assessment of mental health provision as described in the HMIP reports, according to the nature of the population (e.g. adults, young people, women, self-harm). The Standards for Prison Mental Health Services (Royal College of Psychiatrists, 2017) set out 99 standards across domains of: admission and assessment; case management and treatment; referral, discharge and transfer; patient experience; patient safety; environment; workforce capacity and capability; workforce training, CPD and support; governance. A rating of essential, expected, or desirable is indicated against each standard; 69 are essential, 25 expected, and five desirable. The Healthcare Standards for Children and Young People in Secure Settings (Royal College of Paediatrics and Child Health, 2019) address expected standards across domains of: entry and assessment; care planning; universal health services; physical health care and intervention; mental health and neuro-disabilities care and intervention; substance misuse care and intervention; transfer and continuity of care; healthcare environment and facilities; planning and monitoring; multiagency working; staffing and training. The Gender Specific Standards to Improve Health and wellbeing for Women in Prison in England (Public Health England, 2018) set out principles and standards for the good mental health and emotional wellbeing for women, including: prison as a trauma informed environment, continuity of care on release, provision of purposeful activities to improve overall wellbeing and self-esteem, and peer-education approaches to support health promotion. Essential standards for the management and treatment of self-harm and self-inflicted deaths were taken from the Ministry of Justice (2013) document The Management of Prisoners at Risk of Harm to Self, to Others, and from Others, a Prison Service Instruction equivalent to organizational policy and mandatory practice.

***Analytic Approach***

Thematic analysis was applied to identify and analyze reoccurring patterns and themes in the HMIP reports, to create a narrative of results that succinctly reflected the data in relation to the research question (Braun & Clarke, 2006). A deductive approach was taken to initially code data relating to one of two themes – strengths and shortfalls of service delivery. Thereafter, an inductive, semantic, data-driven approach to analysis was applied to the generation of sub-themes. Therefore, themes and sub-themes were strongly related to the data and did not fit a pre-existing coding or theoretical framework (Braun & Clarke, 2006). Thematic analysis was applied in six steps; becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and lastly producing the results (Braun & Clarke, 2006). All 42 HMIP reports were reviewed and analyzed by one author; 12 (29%) of these were independently reviewed and analyzed by another author to ensure that the codes and themes reflected the data. In a small number of cases where there were differences of interpretation across the two researchers, discussion took place until agreement was found on the best representation of the data. The two researchers regularly discussed the emergent themes and agreed on a parsimonious presentation that best reflected the data. The emergent themes were explored with reference to the four mental health service provision standards documents.

**Results**

Two superordinate themes emerged: *Mental Health Care Service Provision – What is Working?* and *Shortfalls in Mental Health Care Service Provision*. Themes are discussed in turn, with reference to relevant standards.

# *Mental Health Care Service Provision – What is Working?*

There were examples of care with positive impact on prisoners, across sub-themes of structures in care provision, identifying initial risk, integrated services and multidisciplinary work, therapeutic care, and relationships.

## Structures in Care Provision

Where there were structures and strategies in place to organize the provision of care, prisons were more able to provide a range of services such as counselling, intervention, and therapy, for a wider range of individuals, in line with standards. For example, *“mental health services in the prison consisted of a stepped care model. A five-day service adopted a psychologically-led approach covering mild to moderate problems, which included guided self-help, counselling, group work and a range of psychological therapies”* (Category C prison 1). There was evidence of the stepped care model in the Young Offenders estate also: “*the emphasis was on providing a stepped model of care with a child and adolescent mental health service (CAMHS) focus to meet the needs of this age group”* (Institution 1).

Providing structured and strategic services supported the delivery of multidisciplinary input across prisons. There was positive work where Safer Custody teams implemented prison-wide strategies for the treatment and management of self-harm incidents: *“a well-established safer custody committee monitored the overall implementation of the suicide and self-harm prevention strategy and regular meetings were well attended”* (Category B prison 3).

There was evidence in this sub-theme of support for Royal College of Psychiatrists (2017) expected standard Case Management and Treatment 15 – management of patients under the stepped care model, the Royal College of Paediatrics and Child Health (2019) Mental Health and Neurodisability Care and Intervention standard 8.2 – for the healthcare team to include a multidisciplinary CAMHS team, and Ministry of Justice (2013) specification 18 – for staff to be aware of risk identification and management procedures relating to self-harm and suicide.

## Identifying Initial Risk

Although the identification of early risk and mental health problems was not consistent across all institutional categories, there were some good examples through screening processes and early assessments: *“all new arrivals had a comprehensive health screening, including physical and mental health, substance misuse and neuro-disability, with efforts to ensure continuity of care through contact with community GPs”* (Young Offenders Institution 5). In a Category B prison (4),*“all new prisoners were offered a comprehensive mental health assessment within a few days of arrival, which was an excellent initiative”.*

There was evidence in this sub-theme of support for the Royal College of Paediatrics and Child Health (2019) Entry and Assessment standard 4.1 – prompt assessment using the Comprehensive Health Assessment Tool, and the Royal College of Psychiatrists (2017) essential standard Admission and Assessment 1 – all prisoners undergo mental health screening/assessment on induction.

## Integrated Services and Multidisciplinary Work

Where available in prisons, integrated services and multidisciplinary work appear to be at the core of good service provision, for both mental health services and self-harm incidents. Each prison category identified the valuable work of teams that had a rich skill mix, comprised of nurses, psychiatrists, psychologists, counsellors and substance misuse team members, and intellectual disability consultants: *“there was an effective weekly multidisciplinary team meeting and there were good links between the mental health and [drug and alcohol recovery] teams to support prisoners with a dual diagnosis (co- existing substance misuse and mental health problems)”* (Category D prison 2).

Issues with illegal psychoactive substances and overdosing on prescription medications were problematic across all prison categories, so where integrated services between the mental health and substance misuse teams were accessible, care was sufficient: *“joint working had improved, and there were good links with the mental health service to facilitate the care of dual diagnosis patients (with both substance misuse and mental health needs)”* (High Secure prison 1).

There was evidence in this sub-theme of support for Royal College of Psychiatrists (2017) essential standard Case Management and Treatment 17 – weekly team meetings, essential standard Workforce Capacity and Capability 68 – the multidisciplinary team has access to staff from a number of professional backgrounds, and expected standard 25 (Case Management and Treatment) that relates to joint working across substance misuse and primary care services.

## Therapeutic Care

A range of distress management interventions were available: “*therapeutic approaches included guided self-help and one-to-one supportive, brief interventions…The HCPs were beginning to support substance misuse workers, who provided group therapies for anxiety”* (Category B prison 2). Furthermore, therapeutic environments and activities were accessible in several prison categories, and were often well received by prisoners: ***“****the [day center] continued to provide a therapeutic environment for the most vulnerable women in the population. The unit was calm and offered women a well-organized enhanced and imaginative range of activities”* (Women’s prison 6). Good examples of therapeutic care extended to provision for personality disorder treatment:

*The [unit] contained a therapeutic community for prisoners with high risk behavior defined under the offender personality disorder (OPD) pathway, and a psychologically informed planned environment (PIPE), both of which were effective in providing therapy; the unit was a center of excellence.* (High secure prison 1).

There was evidence in this sub-theme of support for the Royal College of Psychiatrists (2017) essential standard Case Management and Treatment 29 – patients are offered evidence-based treatments, expected standards 62 and 63 relating to the therapeutic environment, and Public Health England (2018) standards 2.2 and 2.8 – for women to have access to a broad range of psychological therapies and that the built environment should promote recovery, health and wellbeing.

## Relationships

Across each type of prison, there were good illustrations of where positive prisoner-staff relationships had an impact on psychological wellbeing and self-harm. The HMIP reports indicate that many staff working on the prison wings and in a variety of prison categories supported people in their care with compassion and attentiveness: *“case managers (wing officers) responsible for women on [self-harm management plans, ACCTs] generally knew them well and were caring and supportive”* (Women’s prison 4).

The volunteer Listeners were valuable to prisons where the services were implemented, to meet capacity. Prisoners felt well-supported by Listeners, and Listeners felt well-supported by prison staff too, allowing their job to be straightforward and manageable: *“there was a readily accessible team of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners), who were supported by the Samaritans and well used by prisoners”* (Category D prison 4).

There was evidence in this sub-theme of support for the Royal College of Psychiatrists (2017) expected standard Patient Experience 45 – patients feel listened to and understood by staff members, and Public Health England (2018) standard 2.7 – relating to multidisciplinary staff training on the role of relationships in improving mental health and wellbeing among women prisoners.

# *Shortfalls in Mental Health Care Service Provision*

There were failures across prison categories and reference to repetition of recommendations across HMIP reports, perhaps suggesting that although there are standards, policies and procedures in place to deliver acceptable mental health care, prisons lack the resources or initiative to improve care. Key shortfalls in practice were across the following sub-themes: access to services, integrated services, staff trainings needs, transfers under the Mental Health Act, and self-harm and suicide.

## Access to Services

There was high variability of access to mental health services across prisons. Although there were good examples, some prisons had no clear provision to meet mental health needs through basic evidence-based interventions or supportive therapies: *“… the service was not sufficiently multidisciplinary and did not support prisoners with wider mental health needs such as mild learning disability … the only psychological intervention was computer-based cognitive behavioural therapy, which was useful but too limited”* (Local prison 6). Furthermore, the scope of provision varied but typically did not address the needs of people requiring access to specialist services and there was a lack of consistency of care provision:

*Staffing levels were too low to provide a satisfactory service, particularly for those with mild to moderate problems … prisoners were seen regularly but care planning was inconsistent … prisoners with primary mental health needs waited too long for services and provision was insufficient to meet need. There were 51 prisoners waiting to see the psychological wellbeing practitioner, one of whom had been waiting 38 weeks, while the counselor had a caseload of 12 patients and 46 patients waiting. No groups were running.* (Category B prison 1).

The practice context of Women’s prison 4 perhaps reflects the criticality of mental health service provision in UK prisons:

*The current staffing profile was insufficient for a complex population with particularly high expressed needs … women with clinically diagnosed mental health needs received a reasonable level of support. Some women with less serious problems did not always get sufficient support … women with learning disabilities were identified, but the pilot learning disability service no longer operated.*

There was evidence in this sub-theme that the following standards were not met: the Royal College of Psychiatrists (2017) essential standard Case Management and Treatment 18 – every patient has a written care plan that reflects their needs; essential standard Case Management and Treatment 29 – patients are offered evidence-based treatments; Workforce Capacity and Capability essential standard 68 – a range of multidisciplinary staff, and expected standard 69 – access to specialists relevant to the needs of the population; and Public Health England (2018) standard 2.2 and 2.8 – for women to have access to a broad range of psychological therapies.

## Integrated Services

There was a common need for enhanced integrated work between the substance misuse and mental health teams within prisons to identify and manage dual diagnoses (co-occurring mental health and substance use problems). There was a need for both provision -*“although there were joint reviews and care plans were shared … there was no formal dual diagnosis pathway or joint working policy”* (High secure prison 5) – and appropriate staffing: *“staffing shortages restricted service provision … mental health staff and recovery practitioners did not receive regular management supervision, and they were not up to date with mandatory training”* (Category C prison 4).

There was evidence in this sub-theme that the following standards were not met: the Royal College of Psychiatrists (2017) essential standard Case Management and Treatment 25 – written policies in place for liaising and joint working with substance misuse services and primary care; Workforce Training, CPD and Support essential standards 80 and 81 - training related to risk management, and their specific role; and expected standard 85 – monthly line management supervision.

*Staff Training Needs*

Although a standard for mental health care in forensic services, a common shortfall in mental health service provision was completion of regular mental health awareness training by prison officers: *“officers had not received any mental health awareness training over the previous three years. The team had developed a mental health awareness training package but it had not yet been delivered to custody staff”* (Women’s prison 2). There was a recognized need for more staff to be trained in the Assessment, Care in Custody & Teamwork (ACCT) process for the management of self-harm, particularly in local prisons and Categories C and D. For example, “*a quarter of staff required refresher training in ACCT procedures … it was a concern … that not all staff were aware of emergency response codes (a means of indicating the urgency of response required)”* (Category C prison 5) and:

*Arrangements to support prisoners at risk of suicide and self-harm were not yet effective. There had been two self-inflicted deaths in custody since the previous inspection. Many prisoners we spoke to said that most staff did not care for or support them through their crises … although the safer custody team had delivered refresher training in suicide and self-harm prevention to a large number of staff, we came across staff, including night staff, who told us that they had not received any refresher training”* (Local prison 4).

Failings in consistency of ACCT procedures, attributed to lack of staff training, were thought to have contributed to increases in incidents of self-harm.

There was evidence in this sub-theme that the following standards were not met: Public Health England (2018) standard 2.7 – for staff working with women to have training on improving mental health and wellbeing; the Royal College of Psychiatrists (2017) Workforce Training, CPD and Support essential standards 80 and 81 - training related to risk management, and their specific role; Royal College of Psychiatrists (2017) Patient Experience expected standard – patients feel listened to and supported by staff; Ministry of Justice (2013) specifications 18 and 25 – for staff to be aware of identification, assessment and management procedures for risk of self-harm and suicide, and for positive staff-prisoner engagement.

## Transfers Under the Mental Health Act

Transfers from prisons of prisoners in need of specialist forensic mental health care required compliance with the Mental Health Act (1983, as amended in 2007). The transfer process under the Mental Health Act requires collaboration across services and availability of limited secure mental health bed provision. Therefore, the responsibility for the meeting of the standard to transfer within 14 days is not limited to the prisons. However, there was clear evidence that transfers to secure mental health services were not in line with this requirement. For example, “*staff reported, and we observed, that some prisoners experienced long delays in assessment and transfer [under the Mental Health Act], although this was not obvious from the available data”* (Local prison 6) and *“there has been eight mental health assessments for suitability for a secure mental health bed. Three young people had waited more than two weeks for transfer, and one had waited three and a half months for transfer while unwell”* (Young Offenders Institution 5). Arguably, more consistent mental health care and provision in prisons could support the earlier identification of prisoners who require assessment for transfer, and could additionally offer support to prisoners awaiting transfer and who sometimes incur considerable and distressing delays.

There was evidence in this sub-theme that the following standards were not met: Royal College of Psychiatrists (2017) essential standard Referral, Discharge and Transfer 35 – compliance with the Mental Health Act process for transfer; Royal College of Paediatrics and Child Health (2019) Mental Health and Neurodisability Care and Intervention standard 8.7 – timely transfer of children and young people, under the Mental Health Act.

# *Self-harm and Suicide*

The ACCT process for the management and treatment of self-harm was not followed consistently and there were problems identified with the documentation of triggers for self-harm and targets to work towards, generation of care maps, and consistency of case management. For example, *“many care maps were still weak and too many ACCT reviews were not multidisciplinary”* (Young Offenders Institution 1) and *“targets in care plans were often too vague … there was little evidence that the prison considered involving prisoners’ families following self-harm. Personal officers were not specifically involved in the care of prisoners subject to ACCTs”* (High Secure prison 6).

Challenges relating to the use of segregation for the management of prisoners who self-harmed were evident across prison types and perhaps reflected a strain in the system:

M*any of the prisoners on ACCTs were housed in poor accommodation. At least two were in cells with broken windows with jagged glass … despite efforts to try to prioritise those on ACCTs for placement into activities, we found most such prisoners locked up in their cells with little to keep them purposefully occupied … over 70 prisoners on ACCTs had been held on the segregation unit in the previous six months, often in the absence of exceptional circumstances to warrant this* (Local prison 4).

Aspects of the prison environment had a detrimental impact on the utility of the Listener scheme, a valued facility for mental health support but inadequately resourced. For example, *“54% of prisoner said that they were able to speak to a Listener … if they wanted to, fewer than at the time of the previous inspection … there was a Listeners suite for mainstream prisoners but no adequate facilities for those on the vulnerable prisoner wing”* (Category B prison 6) and:

*Although Listeners said they felt well supported by the prison and the Samaritans, they did not always get access to prisoners or had to speak to them through their cell door, which was not confidential. Listener suites were generally unwelcoming and cold. There was only one Samaritans telephone, which was insufficient for the size of the population, and the signal did not reach all cells in the prison* (Local prison 2).

Lessons learned from self-inflicted deaths and trends in incidents of self-harm were thought to be critical to risk and crisis management plans but were not implemented consistently. For example, at a High Secure prison (6), *“action plans had been developed … following deaths in custody, but there were no established procedures so lessons could be learned from near-fatal acts of self-harm”* and in some prisons where self-harm and self-inflicted death rates were high, *“serious, life-threatening acts of self-harm had not been investigated sufficiently to identify lessons learned”* (Category B prison 4), even though this had been recommended at a previous inspection. Across all types of prison, the need to improve consistency of prisoner safety and care was evident.

There was evidence in this sub-theme that the following standards were not met: Royal College of Paediatrics and Child Health (2019) Mental Health and Neurodisability Care and Intervention standard 8.6 – provision of care and support, to include identification of triggers to self-harm; Ministry of Justice (2013) specification 17 – identification of triggers to self-harm; specifications 28, 29 and 32 – informing relevant visitors and stakeholders of suicide and self-harm, including next of kin; specifications 30 and 31 – serious incidents are investigated properly and lessons learned; Royal College of Psychiatrists (2017) Environment expected standard 65 – spaces for confidential discussions that can not be overheard; Governance essential and expected standards 96 and 97 – lessons learned are shared with teams, organizations, and actions plans disseminated with objectives; Patient Experience essential standard 44 – patients are treated with compassion, dignity and respect.

***Summary of standards against identified themes***

In summary, most of the strengths in practice as indicated by the Royal College of Psychiatrists (2017) standards were in the Case Management and Treatment domain (n=4), Environment (n=2), Admission and Assessment (n=1), Patient Experience (n=1), and Workforce Capacity and Capability (n=1) domains. Most of the shortfalls in standards were in the Case Management and Treatment (n=5), Workforce Training, CPD and Support (n=5), Workforce Capacity and Capability (n=2), Governance (n=2), Environment (n=1), Referral, Discharge and Transfer (n=1), and Patient Experience (n=1). Against the Public Health England Standards (2018) for women’s service, there was evidence for and against the same three standards, relating to access to a range of interventions, staff training, and a purposeful and supportive environment. There were more shortfalls than strengths identified in the Healthcare Environment and Facilities domain of the Royal College of Paediatrics and Child Health (2019), and one standard met in the Physical Health Care and Intervention domain. With reference to the Ministry of Justice (2013) instruction on the management of prisoners at risk of harm to self and from others, there was evidence of compliance with one specification (staff awareness of risk), but evidence of non-compliance with six specifications relating to identification of triggers, communication with key stakeholders, and learning from previous incidents.

***Summary of service provision, strengths and shortfalls across the prison estate***

Table 2 sets out a summary of services provided in each category of prison, as stated in the HMIP report, as well as areas where practice is likely to be meeting standards, and areas where there are clear shortfalls. The standards met and not met reflect the themes and sub-themes that emerged through the thematic analysis.

TABLE 2 ABOUT HERE

# Discussion

There are examples of good practice across the prison estate but also clear shortfalls in mental health service provision in prisons in England and Wales, consistent with previous research (e.g. Forrester et al., 2013; Forrester et al., 2018; Patel et al., 2018). Based on thematic analysis of HMIP reports, the guidelines for adults, young people, and women in prison (Public Health England, 2018; Royal College of Paediatrics and Child Health, 2019; Royal College of Psychiatrists, 2016), as well as for people who are self-harming or at risk of suicide (Ministry of Justice, 2013) are not met consistently across the prison estate.

Across the prisons reviewed in this study, it emerged that well organized systems and structures, with good communication between services and multidisciplinary working, were key, particularly for dual diagnoses of mental illness and substance use disorders. Such systems and structures supported early identification of risk and needs, multidisciplinary working across the whole prison, provision of a diverse professional skill set, and delivery of a range of interventions including therapeutic and gender-sensitive environments. The importance of relationships, balancing care with security, was also evident. Where staff felt supported and competent to work with people with mental health problems, positive staff-prisoner relationships had positive benefits for prisoners (e.g. Parker, 2009; Walsh & Freshwater, 2009). Therefore, it seems that there are critical aspects of mental health service provision that depend on a workforce that feels enabled through systems and processes and practically and emotionally supported in their role.

The key themes of shortfalls in standards for addressing mental health care in prisons related to access to provision, staff training, timely transfers under the Mental Health Act, and the identification, care and management of people at risk of self-harm and suicide. Across prisons there were variations of provision, some being very limited and/or with no access to specialist services, and long waiting lists were common across prisons, in line with findings by Patel et al. (2018). There was evidence that there is still much work to be done to develop integrated services across the prison estate, to staff these resources adequately, and provide services that meet the needs of the population.

Staffing was also key in the care and management of prisoners who were awaiting transfer from prison to a forensic mental health service; in the context of lengthy delays and limited resourcing there was evidence of a lack of service to young people and adults in distress. Although compliance with transfer to a mental health bed within 14 days is not within the control of the prison service, care and management of very vulnerable prisons remains so and contingency planning could usefully be embedded within mental health service provision for this group of prisoners. Delays to prison transfers have been common for many years (e.g. Forrester et al., 2009; Isherwood & Parrott, 2002) and although there has been some improvement in recent years, there remains a need to prioritize transfers of people in need for mental health care from prison to hospital (e.g. Revolving Doors and Centre for Mental Health, 2019).

The themes of staff training and self-harm and suicide seemed to be inter-related. There was evidence of a lack of compliance with required training in mental health awareness and the assessment and management of prisoners at risk of or who present with harm to themselves. The HMIP made explicit reference to the lack of training as being fundamentally linked to the increase in self-harm and suicides in one prison. Furthermore, there was more evidence across categories of prison that the Ministry of Justice (2013) specifications for the identification, care, and management of self-harm and suicide were not met than were met, and that there was disproportionate use of segregation for these vulnerable prisoners. It was not within the scope of these data to explore reasons why staff were not receiving appropriate training. However, these findings sit in a context of cuts to spending and staff in prisons since 2009; strains in service provision and high caseloads probably impact on the prioritization of staff training (e.g. Bradley, 2009; Mills & Kendall, 2016). This is additionally concerning given that segregation and extreme isolation predict self-harm and suicide among people in prison (Kaba et al., 2014). The issues around the management of self-harm and risk of suicide seemed to be compounded by limits to multidisciplinary engagement, information sharing and flow and, therefore, formulation of risk and needs.

As identified in HMIP reports, it might be that staff training in mental health awareness and models would support provision for mental health care throughout the prison estate. Psycho-educational courses that can support the identification of mental health problems, and enable staff to be more effective in their role, might support the reduction and management of self-harm incidents (Walsh & Freshwater, 2009), and provide an improved quality of service provision for prisoners in need of mental health support (Podkova, 2014). If staff awareness training aims to contribute towards a respectful and safe prison environment through improved identification of and support for mental health problems then this seems to be a critical component in not only risk management within prisons but also risk reduction for those prisoners moving on to the community. Therefore, an appropriately resourced prison service that promotes a culture that values training in mental health awareness and the identification and management of self-harm and suicide is likely to support uptake in training among staff, and ensure that mandatory training is adhered to. This is also likely to help staff to feel supported and valued in their roles (e.g. Arnold et al., 2007), which can help to support therapeutic and recovery-oriented environments (e.g. Durcan and Zwemstra, 2014).

With regards to specific considerations of the mental health care, treatment and management of women and young people in prison, there is some evidence that age- and gender-specific standards (Public Health England, 2018; Royal College of Paediatrics and Child Health, 2019) are in place. For example, there is some evidence in support of the overarching principle that women should be provided with a wide range of purposeful activities to improve overall health, well-being and self-esteem, and evidence that young people have access in principle to specialist services, including for neuro-diverse conditions. However, critical shortfalls in service provision for women are the accessibility to services for non-acute mental health problems, and explicit engagement with trauma-informed approaches within the prison environment, as set out as an overarching principle for care (Public Health England, 2018). For young people, accessibility of Child and Adolescent Mental Health Services was particularly problematic. For both women and young people, the problems with age- and gender- specific standards described here are in addition to the themes already discussed, common to the prison estate as a whole, and are likely to render additionally vulnerable these prisoners. The high prevalence of mental health problems (Fazel et al., 2016) and trauma (Bodkin et al., 2019; Baranyi et al., 2018), the experience and pains of imprisonment (Crewe, 2011), and the poor standard of consistent mental health care and service provision across the prison estate means that many prisoners are unlikely to receive the support and intervention they need before release from prison, and women and young people might be particularly vulnerable in this regard (Chitsabesan & Hughes, 2016; Hollin & Palmer, 2006).

***Limitations***

There are clear limitations in reviewing routine reports produced by HMIP on the health of prisons to ascertain quality of service provision specifically for mental health in prisons in England and Wales. The quantity of information about mental health care and service provision was variable across reports, perhaps reflecting that mental health was just one of numerous domains of inspection under the remit of HMIP, and the variation in presenting need and service provision across prisons. All reports included reference to mental health care and service provision, and these points of data were suitable for thematic analysis. Across all prisons, the quality of care and service provision for the mental health of prisoners more commonly featured as a shortfall and as an area for service improvement (or point of serious concern) rather than commendation. This is perhaps not unexpected of a service that is not designed to treat and manage mental health problems but is found in a position of having to address a high level of (often complex) need.

There are also limitations in the application of published standards for mental health care in prisons to the HMIP reports. It was observed through these data that examples of what was working well to support and address mental health of prisoners, and where there were clear shortfalls, seemed to be in line with a few essential or expected standards. However, there were also numerous standards for which there was no evidence in support or against. Given the themes that emerged through the reports included in this study, and the consistency of the findings with previous research that used a similar approach (e.g. Patel et al., 2018), it is likely that the balance of the scales would tip in the direction of shortfalls rather than practice over and above published standards, if a more extensive and in-depth evaluation of mental health service provision, delivery and care were to take place.

There are also shortfalls in the scope of the HMIP data. For example, comparative analyses across gender, age, category of prison and level of mental health service need were not permitted but would provide further information about strengths and limitations of mental health service provision in prisons in England and Wales.

***Implications***

The challenges in providing essential or expected standards of mental health care in prisons in England and Wales are numerous and it is likely that targeting resources at discrete parts of the prison system will not be sufficient to effect change in mental health care and provision. What works well are integrated services that are appropriately resourced across multiple, well-trained professional groups, and organized to deliver interventions relevant to the needs of the population whilst working collaboratively with diverse staff groups across a prison. In order to achieve this there must be substantial investment in staffing in prisons (Piper, Forrester and Shaw, 2019) and adoption of standards for mental health care and service provision (e.g. Byng et al., 2012) that facilitate consistency of timely access to relevant services across the prison estate. Such provision must include consideration of age- and gender-specific service models (e.g. trauma-informed) and services (e.g. neurodisability).

For mental health service provision in prisons to be successful, effective leadership is required; promoting a culture of understanding about mental ill-health and value of mental health restoration in risk reduction; reducing stigma; supporting staff training and development and promoting a culture of feeling valued; effective governance and learning from serious incidents. Trauma-informed approaches and those that map on to the principles of the recovery approach (e.g. Drennan & Alred, 2012; Durcan & Zwemstra, 2014), in which hope, choice and agency are critical, as well as respectful relationships and collaborative working could also support mental health recovery in prisons. Doing so could support a whole prison approach to mental health care and service provision.

***Conclusion***

There remains much work and investment of resources within the prison system in England and Wales to improve service provision and care for prisoners with needs relating to mental health. There are some good examples of mental health practice in the prison system. However, in general, standards fall short of the minimum requirements for mental health care in prisons, as set out by the Standards for Prison Mental Health Service (Royal College of Psychiatrists, 2017), the Healthcare Standards for Children and Young People in Secure Settings (Royal College of Paediatrics and Child Health, 2019), and the Gender Specific Standards to Improve Health and Wellbeing for Women in Prison in England (Public Health England, 2018).

**Acknowledgements**

Anonymous reviewers for comments on an earlier version of this manuscript.

**Declarations of interest**

None

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**Table 1. Description of prisons reviewed, including prevalence of mental health problems as self-reported to Her Majesty’s Inspectorate of Prisons**

|  |  |  |
| --- | --- | --- |
| Prison type\* (six reports per type, n=42); report date range | Mean, range of prison populations | Self-reported mental health problem as mean % population (range) |
| High Secure  02/2015-03/2016 | 777, 580-1118 | 38% (35%-40%) |
| Category B  08/2016-03/2017 | 691, 482-938 | 53% (44%-59%) |
| Category C  10/2016-03/2017 | 657, 480-1053 | 38% (27%-49%) |
| Category D  01/2015-09/2016 | 404, 273-506 | 17% (10%-24%) |
| Local\*\*  06/2015-02/2017 | 996, 325-1258 | 42% (30%-55%) |
| Young Offender Institution\*\*  08/2016-02/2017 | 261, 47-746 | 21% (7%-35%) |
| Women\*\*  10/2015-11/2016 | 367, 98-525 | 57% (26%-79%) |

\* High Secure provides the highest level of closed security. Security levels decrease to Category B, and then to Category C. Category D provides open security. People remanded to custody or immediately after sentencing are held in a prison local to the court where the trial is held (Local prison). Local prisons also accommodate short-sentence prisoners.

\*\* Thirty-nine prisons were run publically by Her Majesty’s Prison and Probation Service (HMPPS). One prison in each of the local, young offender, and women’s services was managed by a private company under contract to and governance of HMPPS.

**Table 2. Evidence for practice consistent with and falling short of standards for prison mental health care.**

|  |  |  |  |
| --- | --- | --- | --- |
| Prison type | Mental health service provision, as stated in HMIP report | Evidence of where standards might be met | Evidence of where standards are not met |
| High Secure | Primary and secondary care; psychosocial teams; integrated substance misuse service; psychiatry; psychiatric nursing; trauma service; occupational therapy. | Treatment and management of personality disorder.  Some prisoners felt well cared for.  Joint working. | - Consistency of provision (e.g. access to counselling) and joint working.  - Timely transfers under the Mental Health Act.  - Interim care regime for men awaiting transfer to secure mental health care.  - Consistency with ACCT protocols; identification of triggers of self-harm; care plans. |
| Category B | Primary and secondary care; integrated mental health services; stepped care model; multidisciplinary provision; Listeners. | Multidisciplinary provision for good psychological care.  One example of provision of intermediate therapeutic care for prisoners awaiting transfer under the Mental Health Act.  Listener scheme. | - Alternatives to segregation for the treatment and management of acute mental illness.  - Consistency of access to primary and secondary care.  - Timely transfers under the Mental Health Act.  - Training for prison officers to identify and support people with mental health problems.  - Consistency of multidisciplinary contributions to ACCT; risk management; care maps; identify and address triggers.  - Provision for low-level mental health problems.  - Listener scheme for vulnerable prisoners. |
| Category C | Stepped care model; counselling; self-help; psychological provision for specific mental health needs. | Multidisciplinary working.  Integrated services between mental health and substance use teams. | - Addressing the impact of NPS on mental health.  - Addressing impact of the illicit economy on mental health.  - Staff-prisoner working relationships.  - Availability and accessibility of psychological services provision, including staff recruitment and retention.  - Consistency of ACCT process; identify and address triggers and targets.  - Mandatory training for mental health service staff.  - Uptake of mental health awareness training for prison officers. |
| Category D | Stepped care model; primary and secondary care; integrated services; psychological therapy; evidenced-based interventions; counselling. | - Uptake of mental health awareness training.  - Multidisciplinary working.  - Management of self-harm; ACCT care maps, individual work with at-risk prisoners.  - Listener scheme. | - Specialist service provision, e.g. autistic spectrum disorders, ADHD.  - Consistency of ACCT process; identify and address triggers and targets; quantity of staff with ACCT training. |
| Local, men | Primary and secondary care; in-reach teams; integrated services; neurodevelopmental services; CBTs; 1:1 interventions; counselling; Listeners. | Protocols followed for management of self-harm. | - Staffing (vacancies for key roles across prisons).  - Staff training in mental health awareness.  - High variability of care; lack of consistency between and within prisons.  - Action plan to address depression and suicidality.  - Lack of across-prison consistency in access to brief 1:1 interventions, counselling.  - Alternatives to segregation for the treatment and management of acute mental illness.  - Timely transfers under the Mental Health Act.  - Interim care regime for men awaiting transfer to secure mental health care.  - Multidisciplinary contributions to ACCT; meaningful objectives for prisoners.  - Input from substance misuse teams.  - Use of segregation.  - Limited provision of the Listener scheme. |
| Women | Primary and secondary care; in-reach and out-reach services; integrated substance use and mental health services; stepped care for low-level anxiety and depression; Care Programme Approach (mental illness); 1:1 and group interventions; self-help; sleep clinics; psycho-educational courses; Listeners. | - Good examples of multidisciplinary work and integrated services.  - Emphasis on therapeutic care for women, including from personal officers.  - Positive staff-prisoner relationships.  - Protocols followed for management of self-harm. | - Access to counselling.  - Timely transfers under the Mental Health Act.  - Interim care regime for women awaiting transfer to secure mental health care.  - Multidisciplinary contributions to ACCT; identification of triggers.  - Staff training. |
| Young People | Stepped-care models; Care Programme Approach; multidisciplinary provision (e.g. psychology, psychiatry, nursing, counselling); neurodevelopmental provision; speech and language therapy; support for autistic spectrum disorders and ADHD. | - Evidence of good practice in addressing critical developmental issues.  - Mental health awareness training easily accessible.  - Some good examples of ACCT documentation and good responses to multidisciplinary provision. | - Availability and accessibility of Child and Adolescent Mental Health Services.  - Consistency of provision.  - Access to psychological therapies.  - Timely transfers under the Mental Health Act.  - Uptake of staff mental health awareness training.  - Consistency of ACCT process; identify and address triggers and targets; care maps.  - Use of segregation. |