An evaluation of the reception screening process used within prisons in England and Wales

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Research Team

Professor Jenny Shaw, Consultant Forensic Psychiatrist
Dr Jane Senior, Research Network Manager
Lamiece Hassan, Research Assistant
David King, Research Assistant
Naomi Mwasambilll, Research Assistant
Charlotte Lennox, Research Associate
Dr. Matthew Sanderson, Staff Grade Psychiatrist
Jade Weston, Research Assistant

Offender Health Research Network
Offender Health Research Network
Jean McFarlane Building
University of Manchester
Oxford Road
Manchester
M13 9PL
Liverpool L31 1HW.

E-mail: jennifer.shaw@manchester.ac.uk
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Executive Summary

Introduction

Offenders often come from deprived backgrounds with histories of social exclusion and disadvantage, frequently experiencing complex and multiple health problems. Since the clinical development partnership between the NHS and HM Prison Service was instigated in 1999, much work has been undertaken to improve prison based healthcare services in an attempt to improve people’s health and life chances.

Health screening upon reception into custody provides an ideal opportunity to detect and treat previously unmet healthcare needs. Historically, the purpose and value of prison health screening procedures have been criticised (Grubin et al, 1999; Birmingham et al, 1996) with evidence, for example, that previous procedures were not effective in identifying health problems, especially serious mental illness (Birmingham et al, 1996).

As a result of such criticism, a standardised health reception screening tool (Grubin et al, 1999) was developed, piloted and subsequently introduced for use throughout the prison estate in England and Wales. However, since its introduction, anecdotal evidence has suggested that a number of prisons have modified the standard tool to meet the particular needs of their offender populations. There has been no central reporting of these changes, nor any evaluation of the effects upon improving, or diminishing, the efficacy of the screen.

This study was commissioned by Offender Health at the Department of Health to evaluate reception screening procedures in prisons in England and Wales.

Aims

This study had three aims:

- To determine the extent to which the standard reception screening tool had been modified throughout the prison estate in England and Wales, including an examination of the types of modifications made, and reasons for these;
- To determine how effective prisons viewed the screening tools to be (whether original or modified) in identifying acute health problems requiring immediate attention; and
- To present views from a range of stakeholders regarding reception screening, including challenges to practice and suggestions for improvement to the process of health screening upon reception.
Methods

The study adopted a mixed-methods approach incorporating both qualitative and quantitative data. Data collection was divided into two distinct phases:

Phase 1 - A national survey to establish practices in relation to initial reception health screening procedures involving all prison establishments in England and Wales that receive new receptions.

Phase 2 - Semi-structured interviews with a sample of stakeholders from 12 prisons to elicit perspectives on reception health screening. Stakeholders included healthcare workers and managers, discipline staff, governors, and prisoners.

Results

1. Questionnaire Survey

The key findings from this section of the results can be summarised as follows.

- Those using the original screening tool perceived it to be most effective at identifying substance misuse and physical health problems. It was perceived to be least effective at identifying suicide/ self-harm risk.

- Only one of the seven Young Offender Institutions surveyed used the screening tool in its original form. This establishment did not regard the screen to be comprehensive in the areas of substance use, suicide/ self-harm risk, mental health or physical health.

- Female prisons were less likely to rate the original screening tool as effective in comparison to adult male prisons.

- Approximately half of the establishments surveyed had modified their initial screening tool in some way. The section that was most frequently modified related to physical health.

- Overall, those that were using modified versions of the screening tool considered them to be more effective than those using the original. However, despite having made modifications, only half perceived their tools to be effective at identifying suicide/self-harm risk and mental health problems.

- Learning difficulties was the most frequently identified item to be added to the first reception health screening tool.

- The majority of establishments routinely offered a follow-up health assessment following initial reception screening.

- Prisons identified a wide range of health problems as suitable for inclusion in the follow-up screen; the most frequently selected were chronic and infectious diseases. However, priorities varied across different offender populations.
2. Semi-structured Interviews

The key findings from this section of the results can be summarised as follows.

- There was confusion over the purpose of the initial reception health screen - some staff regarded the initial screen as a comprehensive assessment of all aspects of health whilst others thought it was intended to identify only the most urgent health needs, in line with the original expressed use of the tool.

- Concern was expressed about the screen's reliance on historical factors as prompts for onward referral to mental health services, rather than an emphasis on assessing a person’s mental health and mood in the "here and now".

- Health screening was noted as being only one of many processes undertaken at reception and healthcare staff reported experiencing pressure from discipline officers to undertake screens as quickly as possible, leaving them concerned about the quality of the work they were undertaking.

- Problems with the physical environment in reception areas were noted by both staff and prisoners, including worries about potential lack of privacy, the absence of IT systems and cramped, foreboding rooms.

- The second health screen was noted as a welcome opportunity to assess people at a later time when they may be more able to engage.

- However, as the second screen was not mandatory, low rates of completion were reported. Staff expressed problems in fitting the second screen into the induction regime in the first few days after reception.

- The majority of staff interviewed were in favour of a change to the current system to encompass a very brief screen at reception, followed up by a much more holistic assessment of need within the first days of custody.

- It was acknowledged that the instigation of the proposed system would have implications for both staff training and staff profiling.

- It was also noted that any change to current procedures would need to take into account the discrete needs of different groups, for example women and young people.

Recommendations

On the basis of our study findings, we recommend the following:

1. The initial health screen conducted in reception should be re-drafted to concentrate on identifying the most urgent healthcare problems which require immediate intervention. Service users should be involved in the re-drafting of the screen.

2. The initial health screen should consider issues of serious mental illness, current active risk of suicide or self-harm, alcohol and drug detoxification, and acute/chronic physical illness requiring on-going medication, for example diabetes and cardiac disease.
3. Following the initial screen, all prisoners should be kept safe overnight, with ACCT safeguards initiated for those most at risk.

4. Staff working on first night centres should receive detailed training covering effective ways to engage with and observe prisoners and the identification of, and appropriate responses to, risk triggers in people’s behaviour.

5. A revised second screen should be designed for completion on the second day in custody. The format of the revised tool should include all aspects of health, incorporating, where possible standardised, validated assessment tools, adapted as necessary to the prison population.

6. Each prison should establish clear and appropriate pathways for onward referral and care based upon local service availability. Routine auditing of health screens should be undertaken to ensure that appropriate referrals are being made and subsequently acted upon.

7. Health screening undertaken in this way will also likely identify wider social and custodial needs. Therefore effective referral pathways and information exchange should be in place between healthcare staff and other professionals, for example personal officers, ACCT co-ordinators, chaplaincy departments.

8. Specific screening tools for young people and women should be developed to meet the specific needs of those groups. These should be developed with input from service users.

9. Training in screening procedures should be mandatory for staff undertaking this role, including updates and refresher training. Training should also be available for discipline officers and staff from other agencies to ensure they are aware of the value of effective health screening for the prison as a whole, thus increasing the likelihood of their acceptance of the need to facilitate screening.

10. Appropriate clinical supervision procedures should be in place to provide support, reduce stress and burnout and improve confidence in decision making.

11. PCTs and HM Prison Service partners should, through prison partnership health boards, formalise a comprehensive plan to ensure that both first and second screens are appropriately accommodated, both physically and philosophically, and valued within prison routines and regimes. Both parties should sign up to the plan which should contain review procedures and methods of rapidly resolving problems.

12. HM Prison Service should consider comprehensive health screening and access to appropriate healthcare services as core business and include health screening within their performance monitoring system as purposeful activity.

13. A revised PSO should be issued which requires full compliance with all aspects of the revised health screening procedures.
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1 Introduction

The health needs of the UK prison population are well-documented. Rates of homelessness, unemployment and a lack of basic level education are high amongst offenders (Prison Reform Trust, 2006), as are rates of drug and alcohol dependency and mental illness (Singleton, Meltzer, Gatward, Coid & Deasy, 1998). Thus, the prison population has a different profile of health and social care needs to the wider community.

Under UK health policy, and international human rights policies, prisoners are entitled to the same quality and range of healthcare services as those received by the general public (HMPS/NHS executive, 1999; Council of Europe, 1998; United Nations, 1990). However, historically prison healthcare has been the subject of substantial criticism, and has apparently struggled to meet prisoners’ needs. Service modernisation proposals for improving the standard healthcare in prisons have prioritised a number of key areas, including reception health screening, care planning and treatment (HMIP, 2007; DH/HMPS, 2001; HMPS/NHS executive, 1999).

Health screening in prisons is widely regarded as a key stage in identifying physical and mental health needs, determining the care that a prisoner will subsequently receive (HMPS, 2004; Birmingham, 2001; Birmingham, Gray, Mason, & Grubin, 2000). Although standardised procedures for reception health screening have been improved in recent years (HMPS, 2004), a number of key challenges still remain. This literature review aims to contextualise current prison health screening practices in terms of its historical development and with reference to the prevalence of ill health amongst those received into custody. Finally, it considers the available literature on the range of current practices and associated challenges.

The prevalence of mental and physical disorder in the prison population

A number of studies have found increased rates of mental disorder in prisons when compared with community populations, both in the UK (Singleton et al, 1998; Birmingham, Mason & Grubin, 1996; Gunn, Maden & Swinton, 1991) and in Western countries generally (Fazel & Danesh, 2002). In 1998, Singleton et al established rates of psychiatric morbidity amongst prisoners in a large scale study conducted for the Office of National Statistics (ONS). The study estimated that 90% of the prison population had a mental illness, substance use disorder or both, with the highest rates occurring amongst remand and female prisoners. Amongst remand prisoners, 17% of male and 21% of female prisoners were diagnosed with major depressive disorder, while rates of psychosis were 9% and 21% in male and female prisoners respectively. Rates of disorder were lower amongst sentenced prisoners compared to those on remand. Furthermore, 78% of male and 50% of
female remand prisoners were diagnosed as having a personality disorder, the most prevalent of which was antisocial personality disorder.

Substance dependency is also a significant problem amongst those entering custody with over half of prisoners dependent on drugs (opioids, stimulants and/or cannabis) or alcohol in the year prior to imprisonment (Singleton et al, 1998). Whilst in the past alcohol misuse estimates have tended to be assimilated, and arguably lost, within the larger category of general substance misuse, it is now attracting increasing attention as a separate policy issue (e.g. Home Office, 2007; Roberts, Hayes, Carlisle & Shaw, 2007; Prime Minister’s Strategy Unit, 2003). Indeed, Jones and Hoffman (2006) claimed that alcohol dependence was the most prevalent substance use disorder in both UK and US prisons. Such problems are often further complicated by poly-substance misuse and the co-morbidity of mental illness. Indeed, one recent study has estimated that 18% of prisoners have a dual diagnosis; that is, a mental illness and co-existing drug or alcohol problem (Shaw et al, 2008).

The evidence suggests that prison populations may also exhibit different patterns of physical health problems than those found in the wider community. Communicable diseases pose a considerable public health problem in prisons. When compared to the general population, prisoners have higher rates of hepatitis B and C, tuberculosis, human immunodeficiency virus (HIV) and sexually transmitted infections in general (Long et al, 2001; Butler, Spencer, Cui, Vickery, Zou & Kaldor, 1999; Butler & Levy, 1999, Weild, Gill, Bennett, Livingstone, Parry & Curran, 1998; Holmes, Safer, Bickell, Vermund, Hannf & Phillips, 1993; Bickell, Vermund, Holmes, Safer & Burk, 1991). Furthermore, prisoners frequently present with chronic physical illness. A large scale UK study of the physical health of male prisoners reported that 46% of a sample of sentenced prisoners had some form of longstanding illness or disability, such as asthma, diabetes or heart disease (Bridgwood & Malbon, 1995). Similar studies amongst females have found even higher chronic disease rates of over 80%, even amongst young offenders (Douglas & Plugge, 2006; Plugge Douglas & Fitzpatrick, 2006). This is perhaps not surprising given the risky lifestyle behaviours offenders frequently engage in when not in custody. In addition to substance dependency, offenders entering custody routinely report higher rates of tobacco use (Lester, Hamilton-Kirkwood & Jones, 2003), unprotected sex (Plugge Douglas & Fitzpatrick, 2006), and lower rates of physical activity (Plugge Douglas & Fitzpatrick, 2006) than community populations.

Finally, the prevalence of physical disability is also relevant to discussions on the health of the prison population. Although there is a paucity of reliable research evidence in this area, it has been reported that a quarter of prisoners have a learning difficulty, with learning disability three times as prevalent in prisons as it is in the community (Prison Reform Trust, 2006). Furthermore, a study of elderly prisoners has reported that 80% have a long-standing illness or disability and concluded that prison healthcare facilities struggled to cope with prisoners with long-standing illnesses (Howse, 2003).
**The rationale for health screening**

Health screening at reception effectively acts as an initial triage process, facilitating referral into appropriate care and treatment services for people with identified health needs. Despite having complex physical and mental healthcare needs, offenders characteristically make little use of routine NHS services outside of prison (Harty, Tighe, Leese, Parrott & Thornicroft, 2003; DH, 2002). They do however make extensive use of services whilst in prison (Marshall, Simpson & Stevens, 2001; Bridgwood & Malbon, 1995). Thus, health screening in prisons provides an invaluable opportunity:

> ‘to detect, diagnose and treat...a population often hard to engage with NHS services’

(Reed and Lyne 2000:1033).

Health screening in prison serves a number of purposes. Most importantly, in acting as an initial triage process, health screening at reception is designed to identify those with acute health needs requiring immediate attention. This should, according to *Prison Service Order (PSO) 0500: Reception* (HMPS, 2004), include the detection of acute physical and mental health problems, significant drug or alcohol abuse and risk of suicide and/or self-harm. The consequences of inadequate screening are potentially severe. It has long been established that there is an increased risk of self-harm and suicide during early custody (e.g. Dooley, 1990; Backett, 1987; Topp, 1979). More recently, using data on all 172 prison suicides in England and Wales in 1999 and 2000, Shaw, Baker, Hint, Moloney and Appleby (2004) found that 32% of suicides took place during the first week of custody, with 11% of these occurring within twenty-four hours of reception. Such findings emphasise the need for prison staff to identify, share and act on acute health needs identified during reception procedures.

Healthcare workers also have a role in detecting acute physical needs, including medication needs upon reception. As noted earlier, over half of those entering custody are dependent on drugs or alcohol (Singleton et al, 1998), and many will require detoxification. Substance withdrawal in custody has associated risks; research evidence shows that those without appropriate care may resort to self-medicating, or may even consider suicide. For example, Shaw, Appleby and Baker (2003) reported a positive association between drug withdrawal and completed suicide within the first week of prison custody. The identification of those with communicable diseases is also a priority for reception staff. For example tuberculosis, if not quickly isolated, may pose a considerable risk to public health particularly within the confines of the prison environment.

Health screening also has an important role to play in contributing to continuity of care between prisons and society. Prisoners are entitled to the same quality and range of healthcare services received by the general public (HMPS/NHS executive, 1999). Thus, those people that were in contact with healthcare services in the community are entitled to an equivalent standard of care once in prison. While some services may prove difficult to provide fully in prison (e.g. specialist therapies
required for small numbers of individuals), some aspects of care may be maintained with minimal disruption, such as the ongoing management of common chronic diseases (e.g. diabetes). Reception health screening is an important first step in this process as a gateway to more detailed and timely assessment of need to allow the continuation of care and avoidance of any negative effects upon a person’s health and well being.

With regard to the detection and treatment of mental health problems in prison, joint NHS and HM Prison Service policy guidance has been clear. The document *Changing the Outlook* (DH/HMPS, 2001) heralded the recent modernisation of prison mental health services with the introduction of mental health in-reach teams, the prison-based equivalent to community mental health teams. Whilst in-reach teams accept referrals from a range of sources through a person’s time in custody, reception screening is acknowledged as an important opportunity to identify those with mental health needs (DH/HMPS, 2001). Indeed, post-reception opportunities to engage with prisoners sufficiently to diagnose mental health problems undetected at reception may be limited. As Meiklejohn, Hodges and Capon (2004) note, whilst prisoners with less severe mental health problems may actively seek out help, those most in need may ‘keep a low profile’ and thus remain unknown to services. Furthermore, for those with the most severe needs, effective screening provides a valuable opportunity to start procedures designed to divert or transfer people away from the criminal justice system into more appropriate health and social care services (Birmingham, 2001).

**Historical context**

Prior to the introduction of the current screening tool, *Healthcare Standard 1* (the national prison standard dealing with reception procedure) required all prisoners to be screened by a healthcare officer on the day of reception into custody using the standard F2169 health questionnaire (HMPS, 1994). All prisoners were then seen by a prison medical officer on that, or the next day, for a full health review. One task of the medical officer was to ‘fit’ the prisoner as suitable for one of several grades of work within prison.

However, this process was criticised for being little more than an institutionalised procedure, with a lack of clarity regarding its aims and objectives. Consequently, the quality of information collected during screening was variable and often inadequate or ambiguous (Mason, Birmingham & Grubin, 1997). In particular, Grubin, Parsons and Hopkins (1999) highlighted the inability of the F2169 screen to distinguish between those physical and mental health problems that required immediate action at, or very soon after reception, and those that were of less urgency and could be addressed later.

Screens conducted by healthcare officers were found to be consistently more reliable and comprehensive than those performed by medical officers, with doctors picking up little that was not already identified by healthcare officers (Birmingham, Mason & Grubin, 1997). This brought into question the value of each prisoner
being assessed by a doctor (Birmingham, Mason & Grubin, 1997; Mason, Birmingham & Grubin, 1997).

In addition to being inefficient, the screen was also found to be ineffective at detecting significant health problems. In a consecutive case study of remand prisoners, Birmingham, Mason and Grubin (1996) found that prison reception screening procedures vastly underestimated drug and alcohol use: reception staff identified half as many prisoners with drug use problems using the routine F2169 screen than did researchers using standardised tools and interviews. Furthermore, the standard health screen picked up just a quarter of those identified by researchers as having a current, serious mental illness. Of the fifty prisoners judged by the researchers as requiring urgent attention, only seventeen (34%) were picked up through routine screening. Screening detection rates were found to be similarly poor in women’s prisons (Parsons, Walker & Grubin, 2001). Birmingham, Mason and Grubin (1996) concluded that the screening questionnaire demonstrated low sensitivity and specificity and concluded it was therefore of ‘doubtful validity’ (1996:1524).

Prisoners themselves also expressed concerns about the process, particularly regarding confidentiality when disclosing personal health information. In their inspections of 19 prisons, Reed and Lyne (1997) found that while the vast majority of prisoners felt able to talk about their problems with a nurse or doctor, fewer felt able to talk freely with healthcare staff at reception.

In response to such problems, reception screening procedures were reviewed by HM Prison Service Healthcare Directorate in 1999. As a consequence, the then current screening instrument was revised radically, and a new version piloted and evaluated in a series of field trials in remand prisons (Grubin, Carson & Parsons, 2002; Grubin, Parsons and Hopkins, 1999).

**Current reception health screening procedures: the F2169A**

As a result of the Healthcare Directorate’s review, a number of changes to reception screening were introduced and remain in place today. The revised reception health screening tool was formally adopted by the Prison Service and rolled out for use across the estate in 2004. The revised tool is known as the F2169A (see Appendix 1) and consists of a mandatory assessment which should be completed by a healthcare worker on the prisoner’s first night in custody. The F2169A is shorter and more focused on the detection of immediate health needs than its predecessor. Crucially, it functions as a triage tool, aiming to distinguish between higher risk and lower risk cases. Questions focus predominantly on evidence of past illness as an indicator of potential current need. For example, with regard to mental health problems, respondents are asked whether they have ever seen a psychiatrist outside of prison, have ever had medication for mental health problems, or if they have ever tried to harm themselves. If the person answers yes to any of these questions, then the screener is prompted to make a referral to mental health services for further assessment. If immediate health
needs are detected then local procedures, agreed in conjunction with the local primary care trust (PCT), should ensure the prisoner's referral to appropriate healthcare professionals who will perform a more thorough assessment of needs. Box 1 provides an overview of the sections included within the F2169A.

The second part of health screening is now a follow-up interview aimed at performing a more general, overall assessment of health. The practice of all new prisoners seeing a doctor within the first twenty-four hours of custody has been formally discontinued. Rather, the follow-up assessment is undertaken by a healthcare worker sometime in the week immediately following reception into custody. The assessment is broadly equivalent to primary care assessments routinely undertaken when patients register with GPs in the community, gathering further information, acting as an opportunity to check prisoners’ well being and providing a framework for health promotion and preventative care activities. At present, this interview is neither standardised nor mandatory. However PSO 3050 (continuity of healthcare for prisoners) states that every prisoner must be offered a general health assessment (HMPS, 2006).

### Box 1: The F2169A

The F2169A is a 12-item (14-item for women) health screening questionnaire, to be completed by the healthcare worker at reception via a structured interview with the prisoner. The F2169A comprises five major sections, each of which are outlined below:

- **Personal information** - name, DOB, address, GP details, prisoner status
- **Physical health** - current medical problems and outstanding appointments. Prescribed medication, injuries sustained, chronic diseases, allergies, observations
- **Substance misuse** - alcohol use, drug use, risk of withdrawal, urine screening results
- **Mental health** - psychiatric contact history, medication, suicide/self-harm risk, observations
- **Planned action** - referrals, interventions, fitness for work and location needs.

The two additional questions in the female version of the F2169A relate specifically to pregnancy:

- Have you any reason to believe that you may be pregnant?
- Would you like a pregnancy test?
The performance and effectiveness of the F2169A has been assessed in a series of evaluations undertaken by authors of the tool (Grubin, Carson & Parsons, 2002; Grubin, Parsons and Hopkins, 1999). Prisoners who had previously been screened by Healthcare Officers using the revised screening tool were then assessed by researchers using standardised, validated tools in order to determine the presence of physical health, mental health and substance misuse problems. This allowed the researchers to determine what of the proportion of ‘true’ cases of disorder who were missed using the new screening tool.

The initial pilot in six remand prisons reported high levels of sensitivity and specificity for the detection of mental health, physical health and substance misuse problems. In the case of serious mental illness (SMI), the sensitivity and specificity of the screen were 86% and 57% respectively. Fourteen percent (n=3) of people with SMI were missed by the tool. In the case of severe drug withdrawal sensitivity was 91% and specificity 88%. Nine percent (n=4) cases of potential withdrawal were missed at reception. According to the research evaluation, nine percent (n=8) of prisoners were deemed to be at risk of alcohol withdrawal, all of whom were picked up by the screen. Although the effectiveness of the screen in picking up physical health problems and suicide/ self-harm risk was more difficult to assess, the research team concluded that there was ‘little reason to believe that those who had immediate needs were not being identified’ (Grubin, Parsons & Hopkins, 1999:1).

Later trials undertaken in ten prisons (six adult male remand; two female remand; and two youth offender establishments) reported that overall, around two thirds of prisoners at reception ‘screened positive’ for at least one current health problem, with the highest rates occurring in female establishments (Grubin, Carson & Parsons, 2002). Once again it was reported that the screen demonstrated satisfactory levels of sensitivity and specificity.

While the trials were judged to be largely successful, the researchers did acknowledge a number of challenges. They noted that while the screen successfully identified the majority of those with SMI, there was sometimes a failure to initiate appropriate follow-up action, especially in relation to mood disorders (e.g. depression). This was identified as a further training need for those using the screen. Furthermore, the authors acknowledged that because the screen was specifically designed to be sensitive (where a high proportion of people with illness are screen positive, resulting in few true cases being missed) rather than specific (where a low number of people without the disease are screen positive), large numbers of false positives were unavoidably generated. However, there was an acceptance that this was offset by the gains resultant from the low rate of missed true cases. Finally, a number of practical challenges were noted, including initial resistance from a small proportion of staff and problems in arranging follow-up general health assessments.
**Current issues**

Since its introduction nationally, it is known anecdotally that the standardised health screen has undergone local modifications in many establishments. These changes have been undertaken by individual healthcare teams in response to the perceived needs of the specific populations of their establishment. There has to date been no central reporting of these changes, nor any evidence of their effects upon improving, or diminishing, the efficacy of the screen.

Grubin, Carson and Parsons (2002) advised against modifications to the screen to gather what might be regarded as more ‘interesting’ or helpful, rather than vital and immediate information, acknowledging that every additional item added extra time without necessarily eliciting further information of great value. The authors recognised the need for different versions of the screen for different offender populations, youth offenders in particular, but stated that new questions should only be added if ‘supported by clear evidence demonstrating that they would increase the efficacy of the screen’ (2002:27).

As part of a thematic review examining mental health provision in prisons, HM Inspectorate of Prisons (2007:6) found that reception screening was ‘failing to pick up the extent or diversity of need’, particularly with regard to the provision of interventions for those with undisclosed mental health problems or learning disabilities. They felt that the screen was reliably carried out in local prisons, with the exception of alcohol dependency levels as units of alcohol consumed were not correctly recorded. Screens completed when people were transferred from one prison to another were generally less comprehensive and not as reliably completed as the initial screens completed when people were new to custody. Under half of their sample had completed a follow-up health screen, thus they also recommended that the second health assessment be carried out within 72 hours of reception for all prisoners. Further problems were evident following initial screening, including a lack of pro-active follow-up, for example in requesting information from external sources after past psychiatric histories were disclosed and a lack of recorded actions and referrals for current thoughts of self-harm and alcohol detoxification. This lack of consistent follow-up of problems indicates a need for attention to be paid to ensuring that appropriate clinical and wider social support pathways are in place to ensure required actions are reliably completed post-reception.

Durcan (2008) in his observation of reception screening in several prisons found that screening was largely regarded a one-off brief event with minimal mental health content and reported that in only one of the study prisons were people asked any questions about their current mental health. Almost half of prisoners being transferred from one establishment to another arrived with no medical information and some of the remainder arrived with only partial information. In qualitative interviews, prisoners described screening as rushed with some healthcare staff appearing uninterested or unsympathetic to their situation. Prisoners reported being tired and hungry by the time of reception into custody and not able to disclose health problems, particularly mental health problems, due to a general lack of trust and unwillingness to reveal any vulnerability. These problems
led the author to state that there needed to be a major rethink regarding how health screening is done.

In a recent review of London prisons (Durcan & Knowles, 2006), staff reported that current screening questions were not always effective in identifying mental health or substance misuse problems. Brooker and Ulmann (2008) reported mixed views from stakeholders regarding reception screening nationally with it generally being considered as effective at identifying those with severe and enduring mental illness but not effective at identifying low-level disorders. One interviewee in Brooker and Ulmann (2008:21) reported that ‘the current reception screening is better than what preceded it but it’s not good enough’.

**Research aims**

It is known, anecdotally, that many prison establishments have made modifications to the current reception screen in response to the perceived needs of the specific populations of that establishment. However, there has been no central reporting of these changes, nor any evidence of their effects upon improving, or diminishing, the efficacy of the screen.

The study was commissioned by Offender Health at the Department of Health (DH) to evaluate current reception screening procedures in prisons in England and Wales.

The study had three aims:

1. To determine the extent to which the standard reception screening tool had been modified throughout the prison estate in England and Wales, including an examination of the types of modifications made, and reasons for these;

2. To determine how effective prisons viewed the screening tools to be (whether original or modified) in identifying acute health problems requiring immediate attention; and

3. To present views from a range of stakeholders regarding reception screening, including challenges to practice and suggestions for improvement to the process of health screening upon reception.
2 Method

The study adopted a mixed-methods approach incorporating both qualitative and quantitative data. Data collection was divided into two distinct phases:

**Phase 1** - A national survey of prisons in England and Wales which accept prisoners from directly court following remand in custody or sentencing to evaluate current practices in relation to reception health screening.

**Phase 2** - Semi-structured interviews in 12 prisons to elicit professional and service user perspectives on reception health screening procedures.

2.1 Phase 1: National Survey

A national survey of prisons in England and Wales was undertaken in order to establish the perceived effectiveness of the current health reception screening tool and to identify the type and extent of local modifications to the tool.

2.1.1 Survey Design

A twenty-six item survey was developed specifically for the study (see Appendix 2 comprising questions in the following areas:

- **Establishment information** - Prison name; job title of staff member completing the survey.
- **First reception health screen** - Local modifications to screen; staff training requirements; perceived effectiveness of screen; perceived problems; suggestions for improvement.
- **Follow-up health screen** - Content of screen; staff training requirements; scope of screen; perceived problems; suggestions for improvement.

In addition to closed and likert-scale type questions, a number of free text boxes were included for respondents to provide further details of current problems associated with reception screening and suggestions for improvement to the procedure.

2.1.2 Sample

From HM Prison Service and NHS information sources, 64 prisons in England and Wales were identified as receiving people directly from court. The prisons included establishments holding adult males, young and adult females, and young offenders (male) or a combination of these populations.
2.1.3 Procedure

NHS Research Ethics Committee (REC) approval and HM Prison Service approval under the terms of Prison Service Order 7035 were granted prior to any contact being made with individual prisons.

Invitations to participate and questionnaires were sent by post to all healthcare managers during April 2008. Instructions on how to complete and return the questionnaire were provided along with a Freepost envelope. Respondents were also given the option of completing the survey over the telephone with a researcher, through email or online via a secure survey website. A deadline for responses was given.

Healthcare managers who did not reply within seven weeks were re-sent the survey and contacted by telephone as a reminder in the following week. Further copies of the survey were sent to non-responders via post and email and follow-up reminder telephone calls were made for the third and final time four weeks later. The final responses were received in June 2008.

2.1.4 Analysis

Responses were inputted into an SPSS database (SPSS Inc., 2005). Closed questions were analysed using simple descriptive statistics including frequencies and percentages. Written qualitative responses were analysed separately alongside data from individual interviews.

Responses were analysed across the whole sample and by prison type using the following categories: adult local male prisons; adult male sentenced prisons; adult male open prisons; young offender institutions (male) and female establishments (includes both YOI and adult establishments).

2.2 Phase 2: Qualitative interviews

In order to elicit views regarding existing reception screening procedures, semi-structured interviews were completed with a sample of prison staff and prisoners. The main aim of this part of the study was to identify areas of good practice and suggestions for improvement generated through practice development.

2.2.1 Interview Schedule Design

Separate interview schedules were designed for staff and for prisoners (Appendix 3). Interview schedules comprised a series of open-ended questions and follow-up prompts for clarification. The interview schedules provided structure for the interview whilst allowing the emergence of interviewee-directed topics and themes that had not been identified a priori. Schedules for staff sought to elicit views on the purpose and value of reception health screening and follow-up screening, and the perceived barriers and facilitators associated with screening at each of their establishments. Prisoner interview schedules concentrated on individual experiences of health screening, their ability to understand and participate in screening processes and the extent to which they felt that their individual health
needs had been met. All interviewees were given the opportunity to make suggestions for further improvement of health screening processes.

2.2.2 Sample

Eleven prisons were selected to augment the findings of the questionnaire returns; six adult male local prisons (one of which housed both adult and young men); three female prisons; and two male young offender institutions. Establishments were geographically spread across the prison estate.

In response to emergent themes from the survey and on-going participant interviews, a training (all-sentenced) prison that only accepted prisoners transferred from other prisons, was also asked to participate in interviews. This was in order to allow considerations of the use of screening upon transfer between establishments, with particular reference to ways of best assuring continuity of care.

At each participating establishment efforts were made to interview, as a minimum

- The prison governor/deputy governor
- The healthcare manager and/or primary care manager
- A member of healthcare staff who regularly undertook reception screening duties
- A member of the mental health team
- A prison officer (with experience of working on reception)

Additional staff whose role did not bring them directly into contact with reception screening but who had a vested interest in screening procedures and referrals were also recruited where possible, such as GPs, psychiatrists and staff specialising in substance misuse problems. Further details of the interview participants recruited can be found in the results section (see section 3.2, p.35).

In addition, at each prison where researchers were able to visit to perform face-to-face interviews, healthcare staff were also asked to identify a sample of up to four prisoners (newly received into custody within previous month) who were willing to be interviewed.

2.2.3 Procedure

NHS research ethics and governance approval and HM Prison Service approval under Prison Service Order 7035 were obtained prior to data collection.

Healthcare managers and Governors at the 12 selected establishments all accepted our invitation to take part in phase 2 of the study. Each participating establishment was asked to identify individuals willing to be interviewed, based on the above list of professional roles. All staff and prisoner participants were provided with suitably written information sheets to allow them to make an informed choice as to whether they wanted to take part in the study. It was made clear that participation was on a purely voluntary basis and that all data would be reported in a way so as to prevent the identification of specific individuals.
Face-to-face interviews were arranged and conducted at six prison sites over the period June to November 2008, comprising three prisons for adult men, one female establishment, one prison for juvenile and young men and the training prison. Healthcare managers at these prisons were also asked to identify a number of prisoners to be interviewed that had been newly received into custody within the preceding month. At the training prison, a number of prisoners transferred within the last month were interviewed. Prisoners were approached to take part in the study by a member of healthcare staff at the participating prison at least three days prior to the interview. Telephone interviews were conducted (with staff only) at the remaining six prison sites.

Healthcare managers at the prisons where face-to-face interviews were held identified a number of prisoners to be approached for interview. Prisoners were approached to take part by a member of healthcare staff at least three days prior to the interview. On the day of the interview, all participants were given a second opportunity to read through information sheets (see Appendix 4), or they were read aloud, if needed. Participants were given the opportunity to ask questions before informed consent was requested. Participants were reminded of their rights to refuse to answer any or all questions or to withdraw from the interview and/or the study at any time. Where permitted, interviews were audio-recorded. Otherwise, notes were taken by a second researcher acting as scribe. Finally, participants were debriefed and thanked. Following interview, notes were completed or recordings were transcribed.

2.2.4 Analysis

Where audio-recordings were available, interviews were transcribed and subjected to thematic analysis. The framework developed by Miles and Huberman (1994) involving a three-stage process of data reduction, data display and conclusion drawing and verification was followed.

A constant comparative method was used to selectively reduce the data (Glaser & Strauss, 1967). This involves generating themes through comparing and contrasting responses in an iterative process. Initially, a detailed micro-analysis of interviewee transcripts and field notes is undertaken, followed by a macro-level analysis concentrating on developing and refining thematic categories.

Following this process, themes were presented visually as a thematic network in order to illustrate more clearly the emerging patterns and inter-relationships between thematic categories and to facilitate conclusion drawing (Attride-Sterling, 2001). Finally, in order to guarantee the ‘confirmability’ and validity of findings, transcripts were revisited during the final stages to verify emerging conclusions and ensure that categories were accurately reflective of the data. Several individuals were involved in the analytic process in order to confirm findings, generate new insights and to ensure the conclusions drawn were credible and defensible.
3 Results

3.1 Phase one: Questionnaire survey

This section of the report describes findings from the questionnaire survey. Table 1 shows that of the 64 prisons accepting new receptions directly from court, 57 completed and returned the questionnaire – an overall response rate of 89%. All of the identified female establishments (n=8) responded.

<table>
<thead>
<tr>
<th>Prison Type</th>
<th>No. prisons in England &amp; Wales</th>
<th>No. prisons recruited to study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>34</td>
<td>85% (29)</td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>100% (8)</td>
</tr>
<tr>
<td>YOI male</td>
<td>8</td>
<td>88% (7)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>14</td>
<td>93% (13)</td>
</tr>
<tr>
<td>All</td>
<td>64</td>
<td>89% (57)</td>
</tr>
</tbody>
</table>

Figure 1 illustrates the composition of the final sample. Adult male establishments accounted for approximately half (51%) of the sample, while almost a quarter of the sample (23%) consisted of establishments for both adult males and young male offenders. The remainder of the sample was made up of female establishments (14%) and young offender institutions (12%).

Prisons were asked whether they had made any modifications to the revised F2169A screening tool (Grubin et al, 1999). Table 2 shows the number of prisons which were using original (unmodified) or modified versions of the screening tool.
Table 2. Percentage of respondents using original and modified versions of the F2169A screening tool by prison type

<table>
<thead>
<tr>
<th>Prison Type</th>
<th>Original F2169A</th>
<th>Modified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>48% (14)</td>
<td>52% (15)</td>
</tr>
<tr>
<td>Female</td>
<td>50% (4)</td>
<td>50% (4)</td>
</tr>
<tr>
<td>YOI male</td>
<td>14% (1)</td>
<td>86% (6)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>77% (10)</td>
<td>23% (3)</td>
</tr>
<tr>
<td>All</td>
<td>51% (29)</td>
<td>49% (28)</td>
</tr>
</tbody>
</table>

Table 2 shows that approximately half of the overall sample had modified their reception screening instrument, though this figure varied across the different types of prisons surveyed. While the numbers of adult male and female prisons that had modified the screening tool (52% and 50% respectively) were similar, rates were different for prisons dealing with young offenders. The vast majority (86%) of the YOI establishments had modified the tool. However, for those prisons accepting both adult and young offenders, just 23% had modified the tool.

3.1.1 First reception healthcare screen

This section of the report focuses on findings relating to the first reception healthcare screen.

Table 3 provides details regarding the types of personnel who predominantly carry out reception screening. In the vast majority (86%) of establishments surveyed, the initial screening is performed by qualified nurses. All male YOIs reported that screening was performed by qualified staff. However, in three of the establishments surveyed (5%), reception screening was undertaken predominantly by non-qualified staff, mainly healthcare assistants. In a small proportion (7%) of cases both qualified and non-qualified staff undertook reception screening equally. In the case of the single male establishment that responded ‘other’ to this question, both the nurse and the prison GP performed initial health screening.

Table 3. Which staff predominantly carry out the first reception health screen?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Qualified</th>
<th>Non-qualified</th>
<th>Both equally</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>87% (25)</td>
<td>3% (1)</td>
<td>7% (2)</td>
<td>3% (1)</td>
</tr>
<tr>
<td>Female</td>
<td>75% (6)</td>
<td>13% (1)</td>
<td>13% (1)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>YOI male</td>
<td>100% (7)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>85% (11)</td>
<td>8% (1)</td>
<td>8% (1)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>All</td>
<td>86% (49)</td>
<td>5% (3)</td>
<td>7% (4)</td>
<td>2% (1)</td>
</tr>
</tbody>
</table>
Table 4 below shows that overall, most prisons provided specific reception screening training. However, there remains a sizeable proportion (40%) that did not report the provision of such training. When looking at the responses by prison type, it is noteworthy that only a quarter (25%) of female prison establishments reported that they provided specific training in relation to reception screening procedures.

Table 4. Do healthcare staff receive specific training on the administration of reception screening?\(^1\)

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>59% (17)</td>
<td>38% (11)</td>
</tr>
<tr>
<td>Female</td>
<td>25% (2)</td>
<td>63% (5)</td>
</tr>
<tr>
<td>YOI male</td>
<td>57% (4)</td>
<td>43% (3)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>69% (9)</td>
<td>31% (4)</td>
</tr>
<tr>
<td>All</td>
<td>56% (32)</td>
<td>40% (23)</td>
</tr>
</tbody>
</table>

Prisons were asked about the level of privacy available during reception screening. The vast majority (95%) of prisons surveyed judged privacy to be adequate (Table 5), with just three (5%) (two adult male and one female) establishments responding negatively to this question.

Table 5. Does reception screening allow for adequate privacy i.e. is it conducted on a one-to-one basis, in a private room, where the prisoner cannot be overheard?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>93% (27)</td>
<td>7% (2)</td>
</tr>
<tr>
<td>Female</td>
<td>88% (7)</td>
<td>13% (1)</td>
</tr>
<tr>
<td>YOI male</td>
<td>100% (7)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>100% (13)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>All</td>
<td>95% (54)</td>
<td>5% (3)</td>
</tr>
</tbody>
</table>

3.1.2 Prisons using the original F2169A tool

This section of the report focuses on the 27 establishments that responded to the survey and stated that they had made no modifications to the current first reception health screening tool. Henceforth, this will be referred to as the ‘original’ screening tool.

Prisons were asked to rate the screening tool for its effectiveness at identifying the following health problems: mental health, suicide and self-harm, substance misuse,

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\(^1\) Percentages do not add up to 100% due to missing data.
physical health and sexual health (for female prisons only). Ratings were made on a five point likert-scale, ranging from totally comprehensive (five) through to totally inadequate (one). Table 6 shows the number of prisons that reported their screening tool as comprehensive or totally comprehensive (i.e. point four or five on the likert scale) in response to this question in each of the five areas identified.

Table 6. How effective do you feel that the current reception screening tool is for the identification of immediate/acute health problems?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>3.1.3 Number (and %) of respondents that responded totally comprehensive/comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental health</td>
</tr>
<tr>
<td>Adult male</td>
<td>43% (6)</td>
</tr>
<tr>
<td>Female</td>
<td>25% (1)</td>
</tr>
<tr>
<td>YOI male</td>
<td>0% (0)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>50% (5)</td>
</tr>
<tr>
<td>All</td>
<td>41% (12)</td>
</tr>
</tbody>
</table>

Overall, respondents found the tool to be most effective at identifying substance misuse problems (55%) and least effective at identifying suicide and self-harm risk (34%).

Adult male and mixed male adult and young offender establishments were most positive in their ratings with the screen being most frequently rated as comprehensive in the areas of substance misuse (50% and 80% respectively) and physical health (50% and 60% respectively). In general, ratings by the female prisons and the single YOI establishment were much lower than those of adult male and HMP/YOI prisons. Notably, the single YOI establishment using the original screening tool did not report it to be comprehensive in any of the five areas identified. Within the four women’s prisons surveyed, only one (25%) prison said the screening tool was comprehensive at identifying mental health problems and none described the tool as comprehensive at identifying suicide/self-harm risk.

Female prisons were asked to rate the screen for its effectiveness at identifying health needs relating to sexual health as the female version of the screen contains an additional section covering female sexual and reproductive health. None of the four establishments using the original screening tool reported that it was comprehensive in identifying such needs.

Table 7 reports the additions that prison establishments felt should be made to the original screening tool by prison type.
Table 7. What items (if any) do you feel should be added to the initial reception screen for the detection of health problems which may require urgent attention?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Learning difficulties</th>
<th>Dental problems</th>
<th>Physical disabilities</th>
<th>Blood-borne viruses/infectious disease</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>71% (10)</td>
<td>29% (4)</td>
<td>36% (5)</td>
<td>43% (6)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>Female</td>
<td>50% (2)</td>
<td>25% (1)</td>
<td>75% (3)</td>
<td>50% (2)</td>
<td>50% (2)</td>
</tr>
<tr>
<td>YOI male</td>
<td>100% (1)</td>
<td>0% (0)</td>
<td>100% (1)</td>
<td>0% (0)</td>
<td>100% (1)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>80% (8)</td>
<td>60% (6)</td>
<td>40% (4)</td>
<td>70% (7)</td>
<td>40% (4)</td>
</tr>
<tr>
<td>All</td>
<td>72% (21)</td>
<td>38% (11)</td>
<td>45% (13)</td>
<td>52% (15)</td>
<td>28% (8)</td>
</tr>
</tbody>
</table>

Table 7 shows that overall, almost three quarters (72%) of prisons wanted additions relating to learning difficulties at the initial reception screen. This was followed in popularity by blood-borne viruses (52%), physical disabilities (45%) and dental problems (38%). Of the four female establishments surveyed, three (75%) wanted additions relating to physical disabilities and two (50%) wanted additions on both learning difficulties and blood-borne viruses.

Eight prisons identified other items to be added to the screening tool. These included sexual health, chronic diseases, next of kin details, vaccination history and smoking cessation.

1.1.3 Prisons using modified versions of the F2169A tool

This section focuses on the 28 prison establishments that had made modifications to the current first reception health screening tool (the revised F2169A).

Prisons were asked to send a copy of their modified tool along with their completed questionnaires in order to determine what modifications had been made. Of the 28 establishments using modified versions of the screening tool, 15 (54%) returned copies of their modified screening instruments.

Table 8 shows the results of a systematic analysis of the 15 screening tools received as compared to the original screening tool. Modifications were noted within each of the following categories: personal information, physical health, substance misuse, mental health, sexual health and planned action. Specifically it was noted whether items had been added to or removed from the tool within each of these six categories identified.
Table 8. Percentage of prisons using modified versions of the F2169A that made modifications in each specified health area

<table>
<thead>
<tr>
<th>Prison</th>
<th>3.1.5.1 Personal Information</th>
<th>3.1.6 Physical Health</th>
<th>3.1.7 Substance Misuse</th>
<th>Mental Health</th>
<th>Sexual Health</th>
<th>Planned Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cut</td>
<td>Added</td>
<td>Cut</td>
<td>Added</td>
<td>Cut</td>
<td>Added</td>
</tr>
<tr>
<td>All - modified</td>
<td>20% (3)</td>
<td>40% (6)</td>
<td>47% (7)</td>
<td>87% (13)</td>
<td>7% (1)</td>
<td>73% (11)</td>
</tr>
</tbody>
</table>

From Table 8 it can be seen that the physical health section of the screen had been altered most frequently. In total, 13 (87%) prisons noted that additions to this section had been made and seven (47%) had removed at least one item from this section. The types of additions made varied; five prisons had made additions in relation to heart problems, four had added a section on physical observations (height, weight, blood pressure etc.) and four had added a question relating to hepatitis immunisation status. The types of items that were removed most frequently were the items on sickle cell disease (three prisons), outstanding medical appointments (two prisons) and recent GP contact (two prisons).

Eleven (73%) establishments made additions to the substance use section of the screening tool. Additions mainly consisted of more detailed assessments of alcohol consumption and withdrawal, and additional prompts regarding specific drugs (which would have been listed as “other” in unmodified screen), such as cannabis and subutex.

Six prisons made additions to the mental health section of the screening tool, which included suicide and self-harm. Additional questions included those relating to current thoughts of suicide or self-harm. One prison including a discrete suicide risk checklist with an identified threshold score, which if met, prompted the opening of an ACCT (Assessment, Care in Custody, and Teamwork) form\(^2\). The formal scale included relevant questions to the assessment of risk in custody, including whether it was a person’s first time in custody, whether they were expecting family contact and whether they had a history of self-harm etc, however the genesis of the tool was unknown and unaccredited. It would be useful to further investigate the validity of this tool in order to establish the possible utility of rolling it out more widely. Notably one male prison returned a copy of a modified screening instrument that no longer contained any specific question(s) relating to current suicide and self-harm risk.

\(^2\) ACCT is a care-planning system to help identify and care for prisoners at risk of suicide or self-harm, which has been in place in the Prison Service since April 2007. ACCT was introduced to replace the old F2052SH system, and facilitates a more multi-disciplinary approach to supporting prisoners at risk of suicide or self-harm.
One female establishment and one YOI were noted to have made modifications to the section on sexual health. Additions included items asking about genital maturation, menstruation and sexual activity.

Two thirds (67%) of prisons had made additions to the “planned action” section, which focuses on onward referral to healthcare services and specific actions such as opening an ACCT. Additions generally included referrals for additional services such as specific clinics (e.g. diabetes), admittance to the healthcare in-patient unit and/or liaison with catering in relation to specific food allergies.

Finally, some minor additions to the personal information section were noted. This included the routine collection of data items such as ethnicity (20%) and religion (13%). Prisoners’ legal status had been removed from the health screen in three (20%) cases.

One YOI was currently piloting a very different screening tool, in conjunction with the Youth Justice Board. The tool was a much lengthier document than the current screen commonly in use, designed to facilitate a very comprehensive assessment of all aspects of health. The tool is currently subject to an independent evaluation into its efficacy, acceptability and face validity, and thus further comment here about the instrument before the outcome of that evaluation is inappropriate.

Prisons using modified versions of the original screening tool were also asked to rate the tool for its effectiveness at identifying mental health problems, suicide and self-harm risk, substance misuse, physical health and, for female establishments only, sexual health. Table 9 shows the number of prisons that reported their screening tools were comprehensive or totally comprehensive in response to this question in each of the five areas identified.

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Mental health</th>
<th>Suicide/self-harm</th>
<th>Substance misuse</th>
<th>Physical health</th>
<th>Sexual health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>53% (8)</td>
<td>60% (9)</td>
<td>67% (10)</td>
<td>80% (12)</td>
<td>n/a</td>
</tr>
<tr>
<td>Female</td>
<td>75% (3)</td>
<td>50% (2)</td>
<td>75% (3)</td>
<td>100% (4)</td>
<td>75% (3)</td>
</tr>
<tr>
<td>YOI male</td>
<td>17% (1)</td>
<td>17% (1)</td>
<td>33% (2)</td>
<td>33% (2)</td>
<td>n/a</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>67% (2)</td>
<td>67% (2)</td>
<td>67% (2)</td>
<td>67% (2)</td>
<td>n/a</td>
</tr>
<tr>
<td>All</td>
<td>50% (14)</td>
<td>50% (14)</td>
<td>61% (17)</td>
<td>71% (20)</td>
<td>75% (3)</td>
</tr>
</tbody>
</table>

Overall, prisons rated their tools as most effective at identifying physical health problems (71%) and substance use problems (61%). Half of all establishments (50%) rated the screen totally comprehensive or comprehensive in identifying
mental health problems requiring immediate attention. Overall satisfaction with acceptability for detecting suicide and self-harm risk was the same (50%).

Of all the prison types, young offender institutions were the least satisfied with current screening procedures, with at most a third of these establishments agreeing the screen was comprehensive in any of the four health areas identified. Conversely, female establishments most frequently rated their modified screens as comprehensive.

Table 10 shows which items, out of a pre-identified list provided in the questionnaire, respondents felt should be included within the initial screening tool. Learning difficulties was the most frequently identified item with 82% of establishments overall, and all YOI respondents (100%) agreeing that it should be included as a screening item. Items on blood-borne viruses/infectious diseases and physical disabilities were also selected frequently, though this varied across prison types. The need to include questions to highlight dental problems was least frequently selected by all respondents.

Table 10. What items (if any) do you feel should be included in the initial reception screen for the detection of health problems which may require urgent attention?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Learning difficulties</th>
<th>Dental problems</th>
<th>Physical disabilities</th>
<th>Blood-borne viruses/infectious disease</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>87% (13)</td>
<td>47% (7)</td>
<td>60% (9)</td>
<td>53% (8)</td>
<td>20% (3)</td>
</tr>
<tr>
<td>Female</td>
<td>50% (2)</td>
<td>25% (1)</td>
<td>50% (2)</td>
<td>50% (2)</td>
<td>25% (1)</td>
</tr>
<tr>
<td>YOI male</td>
<td>100% (6)</td>
<td>33% (2)</td>
<td>17% (1)</td>
<td>50% (3)</td>
<td>50% (3)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>67% (2)</td>
<td>0% (0)</td>
<td>33% (1)</td>
<td>33% (1)</td>
<td>33% (1)</td>
</tr>
<tr>
<td>All</td>
<td>82% (23)</td>
<td>36% (10)</td>
<td>46% (13)</td>
<td>50% (14)</td>
<td>29% (8)</td>
</tr>
</tbody>
</table>

Other additions suggested by individual establishments included: sexual health, GP details, immunisation history and further details on medical history (e.g. cancer, thyroid disease).

3.1.4 Comparison of prisons using original and modified versions of the screening tool

This section of the report compares the 29 prisons that used the original screening tool with the 28 prisons that were using a locally modified version.

Table 11 and Figure 2 compare the perceived effectiveness of the current screening tool between those establishments who have modified the first screening tool and those still using the original tool.
Table 11. How effective do you feel that the current reception screening tool is for the identification of immediate /acute health problems?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>3.1.5 Number (and %) of respondents that responded totally comprehensive/ comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental health</td>
</tr>
<tr>
<td>All – original</td>
<td>41% (12)</td>
</tr>
<tr>
<td>All – modified</td>
<td>50% (14)</td>
</tr>
</tbody>
</table>

Figure 2. How effective do you feel that the current reception screening tool is for the identification of immediate /acute health problems?

It can be seen that those prisons using modified versions of the tool more frequently rated their screening tools as being comprehensive across all five areas identified. This is perhaps unsurprising, if changes have been made in response to a local consensus of the needs of particular populations. Differences were most marked in terms of sexual health (75% vs. 0%), physical health (71% vs. 45%) and suicide/self-harm (50% vs. 31%). However, it is notable that, despite having made alterations, half of establishments (50%) using modified tools still did not feel their tools were comprehensive at detecting mental health problems and suicide/self-harm risk.

Table 12 compares responses from prisons using original and modified screening tools regarding the need for additional items on the screening tool.

31
Table 12. What items (if any) do you feel should be included in the initial reception screen for the detection of health problems which may require urgent attention?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Learning difficulties</th>
<th>Dental problems</th>
<th>Physical disabilities</th>
<th>Blood-borne viruses/infectious disease</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>All – original</td>
<td>21 (72%)</td>
<td>11 (38%)</td>
<td>13 (45%)</td>
<td>15 (52%)</td>
<td>8 (28%)</td>
</tr>
<tr>
<td>All – modified</td>
<td>23 (82%)</td>
<td>10 (36%)</td>
<td>13 (46%)</td>
<td>14 (50%)</td>
<td>8 (29%)</td>
</tr>
</tbody>
</table>

Table 12 shows that whether or not modifications had already been made to their screening tool, prisons had similar views regarding which items still needed to be added. By far the most frequently selected item to be added to the screening tool was a question to ascertain learning disabilities (82%).

3.1.5 The follow-up healthcare screen

This section of the report focuses on findings related to the follow-up screen that is intended to take place within the week following the initial assessment.

Table 13 shows that the majority of prisons routinely offered a follow-up screen.

Table 13. Following the initial health screening at reception, is a second 'well man/woman' follow-up health screen routinely undertaken?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes, routinely</th>
<th>Yes, but not routinely</th>
<th>No follow-up screen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>79% (23)</td>
<td>10% (3)</td>
<td>10% (3)</td>
</tr>
<tr>
<td>Female</td>
<td>88% (7)</td>
<td>3% (1)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>YOI male</td>
<td>86% (6)</td>
<td>0% (1)</td>
<td>14% (1)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>85% (11)</td>
<td>8% (1)</td>
<td>8% (1)</td>
</tr>
<tr>
<td>All</td>
<td>82% (47)</td>
<td>9% (5)</td>
<td>9% (5)</td>
</tr>
</tbody>
</table>

The table above shows that the majority (82%) of prison establishments sampled routinely performed a follow-up screen at some time after the first reception health screen had taken place. When asked why a second screen was not offered, the five establishments that did not perform a follow-up screen gave the following variety of reasons: everything is already done on the first night (three prisons); unavailability of staff (two prisons); time constraints (two prisons), and; no perceived value (one prison).

Table 14 shows which staff, amongst the 52 prisons that offered follow-up screening, routinely performed the screen.
Table 14. Which staff predominantly carry out the follow-up health screen?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Qualified</th>
<th>Non-qualified</th>
<th>Both equally</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>65% (17)</td>
<td>15% (4)</td>
<td>15% (4)</td>
<td>4% (1)</td>
</tr>
<tr>
<td>Female</td>
<td>75% (6)</td>
<td>0% (0)</td>
<td>13% (1)</td>
<td>13% (1)</td>
</tr>
<tr>
<td>YOI male</td>
<td>67% (4)</td>
<td>17% (1)</td>
<td>0% (0)</td>
<td>17% (1)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>83% (10)</td>
<td>0% (0)</td>
<td>17% (2)</td>
<td>0% (1)</td>
</tr>
<tr>
<td>All</td>
<td>71% (37)</td>
<td>10% (5)</td>
<td>13% (7)</td>
<td>6% (3)</td>
</tr>
</tbody>
</table>

Overall, the majority of the follow-up screening was conducted by qualified nursing staff. However, five (10%) establishments relied on non-qualified staff to carry out follow-up screening. The three establishments included within the ‘other’ category all reported that screening was commonly conducted by the prison GP.

Table 15 shows the proportion of prisons offering specific training on the administration of the follow-up screen.

Table 15. Do healthcare staff receive specific training on the administration of follow-up health screening?

<table>
<thead>
<tr>
<th>Prison type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>62% (16)</td>
<td>38% (10)</td>
</tr>
<tr>
<td>Female</td>
<td>38% (3)</td>
<td>63% (5)</td>
</tr>
<tr>
<td>YOI male</td>
<td>67% (4)</td>
<td>33% (2)</td>
</tr>
<tr>
<td>HMP/YOI male</td>
<td>58% (7)</td>
<td>42% (5)</td>
</tr>
<tr>
<td>All</td>
<td>58% (30)</td>
<td>42% (22)</td>
</tr>
</tbody>
</table>

The table above shows that 30 (58%) establishments reported that they provided specific training on the administration of the follow-up screen. As with training in relation to the conduct of the initial health screen, a lower proportion (38%) of female establishments reported that they provided such training.

Survey respondents were asked to identify which were the most important health problems to be included within the follow-up screen. Table 16 displays the range and frequency of responses given for each of the 10 pre-identified categories (including ‘other’) listed on the survey.
Table 16. What do you feel are the most important health problems that should be included within the follow-up reception screen?

<table>
<thead>
<tr>
<th>Prison Type</th>
<th>Mental health</th>
<th>Suicide/self-harm</th>
<th>Substance misuse</th>
<th>Chronic disease</th>
<th>Acute physical</th>
<th>Learning difficulties</th>
<th>Dental</th>
<th>Physical disability</th>
<th>Infectious diseases</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult male</td>
<td>72% (21)</td>
<td>76% (22)</td>
<td>59% (17)</td>
<td>93% (27)</td>
<td>72% (21)</td>
<td>69% (20)</td>
<td>76% (22)</td>
<td>66% (19)</td>
<td>86% (25)</td>
<td>38% (11)</td>
</tr>
<tr>
<td>Female</td>
<td>63% (5)</td>
<td>63% (5)</td>
<td>50% (4)</td>
<td>88% (7)</td>
<td>75% (6)</td>
<td>50% (4)</td>
<td>63% (5)</td>
<td>88% (7)</td>
<td>100% (8)</td>
<td>38% (3)</td>
</tr>
<tr>
<td>YOI male</td>
<td>86% (6)</td>
<td>86% (6)</td>
<td>57% (4)</td>
<td>71% (5)</td>
<td>57% (4)</td>
<td>57% (4)</td>
<td>43% (3)</td>
<td>43% (3)</td>
<td>71% (5)</td>
<td>43% (3)</td>
</tr>
<tr>
<td>HMP/YOI</td>
<td>85% (11)</td>
<td>77% (10)</td>
<td>77% (10)</td>
<td>85% (11)</td>
<td>69% (9)</td>
<td>77% (10)</td>
<td>54% (7)</td>
<td>46% (6)</td>
<td>69% (9)</td>
<td>31% (4)</td>
</tr>
<tr>
<td>All</td>
<td>75% (43)</td>
<td>75% (43)</td>
<td>61% (35)</td>
<td>88% (50)</td>
<td>70% (40)</td>
<td>67% (38)</td>
<td>65% (37)</td>
<td>61% (35)</td>
<td>82% (47)</td>
<td>37% (21)</td>
</tr>
</tbody>
</table>

Overall, chronic disease (88%) and infectious diseases (82%) were the health problems most frequently identified for inclusion within the follow-up screen. Although frequencies were generally high across all categories, substance misuse (61%) and physical disability (61%) were identified less frequently for inclusion at this stage of the screening process.

Female prisons, in line with other establishments, identified infectious diseases (100%) more frequently than all other health problems. However, physical disability was more often selected by female prisons (88%) for inclusion within the second screen than by adult male establishments (66%). The findings for young offender institutions also appeared to differ somewhat from prisons serving adult prisoners. Whilst chronic disease and infectious disease were selected frequently (both 71%), the highest percentages within this group were recorded for mental health and suicide/self-harm (86% each). Notably, mental health was the most frequently selected category (85%, joint with chronic disease) for establishments accepting both adult males and young offenders.

Finally, by providing an ‘other’ category, establishments were given the opportunity to put forward health issues that had not already been identified within the survey. Of the 21 prisons that used this category to identify further issues not already listed, 57% (12) said sexual health issues and 24% (5) said immunisation status. The remainder or responses were identified by one or two prisons only: family history, lifestyle behaviour questions (e.g. on smoking, diet) and emotional health.
3.1.6 Summary of questionnaire survey findings

The key findings from the questionnaire can be summarised as follows:

- Those using the original screening tool perceived it to be most effective at identifying substance misuse and physical health problems. It was perceived to be least effective at identifying suicide/self-harm risk.

- Only one of the seven YOIs surveyed was using the original screening tool in an unmodified form. This establishment did not find the screen to be comprehensive in the areas of substance use, suicide/self-harm risk, mental health or physical health.

- Female prisons were less likely to rate the original screening tool as effective in comparison to adult male prisons.

- Approximately half of the establishments surveyed had modified their initial screening tool in some way. The section that was most frequently modified was that relating to physical health.

- Overall, those that were using modified versions of the screening tool considered them to be more effective than those using the original. However, despite having made local modifications, only half perceived their tools to be effective at identifying suicide/self-harm risk and mental health problems.

- Learning difficulties was the most frequently identified item to be added to the first reception health screening tool.

- The vast majority of establishments routinely offered a follow-up health assessment.

- Prisons identified a wide range of health problems to be included within the follow-up screen; most frequently selected were chronic disease and infectious disease. However, priorities varied across different offender populations.
3.2 Phase 2: Semi-structured interviews

To augment the findings of the questionnaire returns, semi-structured interviews were held with a range of key informants in a number of establishments. Interviews were either conducted by researchers in person or, where that was not possible to arrange, they were conducted by telephone at a pre-arranged time convenient for the interviewee. Site selection for in-depth interviews was based upon analysis of questionnaire responses to include prisons which reported that current reception screening procedures were suitable for purpose, those who acknowledged both good and bad points of the process, and those which expressed a general dissatisfaction with the process.

In total, 92 interviews were conducted, 68 with staff and 24 with prisoners across the 12 establishments (Table 17).

Table 17. Number of interviewees recruited by discipline

<table>
<thead>
<tr>
<th>Interviewee Discipline</th>
<th>Number interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governor/director</td>
<td>6</td>
</tr>
<tr>
<td>Healthcare management</td>
<td>14</td>
</tr>
<tr>
<td>Primary care</td>
<td>11</td>
</tr>
<tr>
<td>Reception nursing</td>
<td>9</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>10</td>
</tr>
<tr>
<td>Discipline</td>
<td>7</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>4</td>
</tr>
<tr>
<td>Mental health nursing</td>
<td>7</td>
</tr>
<tr>
<td>Prisoners</td>
<td>24</td>
</tr>
<tr>
<td>Total interviews</td>
<td>92</td>
</tr>
</tbody>
</table>

The semi-structured interview schedule covered all aspects of the health screening process, including what people saw the main purpose of the process to be; the usefulness of the current screen and any perceived shortcomings; problems with the process; the utility, form and purpose of the second screen; local experiences as to ‘what works’; and interviewees’ views on a suggested alternative procedure.

3.2.1 What is the purpose of the initial health screen?

The current initial reception screen was introduced to replace an earlier tool which was seen as overly long and confused in purpose. The previous screen, again conducted during the first hours of reception into custody, did comprise of
questions designed to elicit information of immediate concern, for example mental health problems, risk of suicide or self harm, drug and alcohol issues and acute physical ill-health. However, the screen also asked questions relating to past illness, operations and family histories of ill health, unrelated to healthcare needs in the ‘here and now’. The current screen was designed solely to identify major, current, healthcare problems needing urgent attention and to signpost staff to put in place appropriate care pathways to facilitate any immediate treatment and onward referral for further, more in-depth, assessment.

In interview, staff expressed a range of views about the purpose of the initial health screen, some of which matched the original intentions of the tool, but others at variance to the true purpose. Most accurately, a number of respondents commented to the effect that

"It is an initial screen more than a full in-depth medical assessment, it is a screening tool”

(Clinical lead)

and was designed to

"Find out problems that require treatment/action in first few days of prison before they are seen again”

(Primary care manager)

Similarly, others commented that the tool

"Is needed to define what is needed on the first night and the rest could be done later”

(Primary care manager)

and should be used to identify

"Obvious life and death things that need to be gotten through straight away”

(Governor)

and

"Medical, urgent needs...immediate needs”

(Discipline officer)

The value of initial screening was noted as being

"Extremely high (importance), if we allow someone to go through who hasn’t been screened properly they could be a risk to themselves or others, e.g. TB”

(Governor)

and that

"Screening is a high priority because if you get it wrong payback is immense”

(Healthcare manager)
However, some respondents clearly viewed the tool as a much more comprehensive health assessment, rather than a screen designed solely to identify only immediate concerns.

"Full assessment"
(Substance misuse worker)

"Ensure any healthcare, mental health and medication issues are highlighted"
(Primary care manager)

"Get a full medical history as possible"
(Governor)

"a complete history of their physical and mental health."
(Clinical lead)

"Identify factors for re-offending, poor health, alcohol and drug abuse issues, mental health issues as those impact on re-offending...major healthcare issues such as Hep C and HIV"
(Governor)

A common understanding running through responses from all types of staff was that the screen was essentially a risk assessment instrument, especially in terms of mental health issues or risks of suicide or self harm.

"Identify areas of risk for the benefit of both staff and prisoners"
(Healthcare manager)

"Self harm and cell sharing risks"
(Healthcare manager)

“I think it’s to keep then safe on the first night, from mental health perspective and suicide”
(Healthcare manager)

"Risk of suicide, self-harm, provides warning signs with them coming into prison, very high priority with suicide attempts”
(Discipline officer)

“It’s mainly about risk assessment ensuring that someone is safe for their first night within our establishment whether it be physical, mental, emotional needs”
(Primary care manager)

"Maintaining safety and reducing risk during the initial period in the establishment.”
(Primary care manager)

“Identifying any health risks that might cause a prisoner to harm themselves in the first 24 hours.”
(Governor)
"Was to check there were no problems, to make sure not suicidal and have no mental health issues”  

(Prisoner)

Less frequent were references to potential risks caused by physical health problems, but when they were referred to, it was particularly in terms of the need to identify those likely to experience the physical effects of drug and alcohol misuse.

"To determine what drugs they have in their system”  

(Reception nurse)

"Looking for substance misuse issues”  

(Discipline officer)

"Ask them about self harm and detoxing”  

(Discipline officer)

A further area of concern was the need to establish what medication people were currently taking, and to ensure that a decision was made as to its continuation or otherwise.

"What medication they come in with, what medication they have had in the past from their GP”  

(Pharmacist)

"Medication issues are highlighted so that any medication can be given to individuals, any care need can be highlighted”  

(Primary care manager)

"From our point of view we need to know all medications identified and written up to ensure continuity of care”  

(Pharmacist)

"Ensure any medication prescribed outside is continued or reviewed”  

(Pharmacist)

For prisoners, the purpose of the initial screen was sometimes unclear

"Didn’t tell me why they were asking me”  

(Prisoner)

For others, some explanation was given.
“I was told I was having a quick health check, are you on any medication? No, well just have a look through these and see if they apply to you, ok great now off you go”

(Prisoner)

“Was to check there were no problems, to make sure not suicidal and have no mental health issues”

(Prisoner)

For some, the process was of doubtful utility

“Didn’t see benefit of it, seemed to me like they were just making sure I was ok, didn’t need medication, was short and sweet, brief, happy with that, couldn’t see point in hanging around”

(Prisoner)

3.2.2 The usefulness of the current screen

Respondents were asked their views of the value and efficacy of the current screen, and its perceived shortcomings. Many respondents thought that the screen was fully fit for its intended purpose of providing an initial assessment of immediate health concerns and that the screen was

“Enough to make them safe.”

(Healthcare manager)

“effective for basic stuff”

(Discipline officer)

“Was asked all the things needed to know straight away”

(Prisoner)

“Definitely couldn’t work without it, in the female estate it provides indicators to finding out if need to pay special attention to somebody”

(Discipline officer)

“It gives us the basics”

(Reception nurse)

The current screen was seen as a

“Quick process, (get a) basic history (to) address immediate needs”

(In-reach team member).

One respondent commented that the screen was
“Very useful, I am not really sure how we could improve it. We try to cover everything and have not identified any gaps”

(Reception nurse)

The "yes/no" format of many of the questions was appreciated as

“Clear, precise (yet allowing) for expansion on issues...allows to use as a guide but expand as well”

(Discipline officer)

Although it was noted that

“They just don’t ask enough questions, it literally lasts about two and a half minutes, they ask a few questions and tick a few boxes then you just walk out”

(Prisoner)

However some respondents noted perceived inadequacies in the screen. Some of these were clearly attributable to the apparent confusion about the purpose of the screen as noted earlier. For example, one respondent commented that there were

“not enough steps. Previous medical history, operations, ulcers, history of cancer are not covered”

(Reception nurse)

“In some respects it is useful and in some respects it isn’t. He doesn’t ask past history or family or disorders within the family”

(Reception nurse)

Although it could be argued that considerations of whether people would like to undertake a smoking cessation programme should not be a task at first reception, one person still noted

“it doesn’t even ask about if they smoke or not, so there are bits that are not on there”

(Reception nurse)

Suggestions for the inclusion of additional questions reflected an understanding that, in prison, health status is potentially affected by wider considerations of a person’s situation. For example it was suggested that an initial health screen should cover

“Nature of offence, whether they had been in prison before”

(Primary care manager)

and that there was a

“Need to elaborate questions on how they feel about coming into prison”

(Primary care manager)
"More about risk needs to be added concentrated on the mood and attitudes at time of reception”

(Primary care manager)

thus acknowledging the importance of custodial and environmental factors when attempting to holistically assess risk, especially of self harm or suicide.

In relation to risk assessment, several interviewees expressed a view that a lack of training in mental health issues was a hindrance for some staff to the skilled completion of the screen, as the process was judged to emphasise the need to accurately identify mental health needs

"Not being trained in mental health is a big disadvantage as there are a lot of issues around mental health”

(Governor)

"Best practice dictates having RMN involved with the screening”

(In-reach team member)

Other respondents noted that training and the different levels of competencies of practitioners was an important consideration

"The tool is only as good as person using it but nurses are trained to identify people in distress”

(Healthcare manager)

"How and the way you ask the questions is important, the person asking is just as important as the tool”

(Discipline officer)

It was also noted that the value of a standardised screen also only goes part way to informing people’s clinical decision making and that judgments are often also influenced by less tangible factors based on experience

"There are always going to be people who it doesn’t completely fit and sometimes that’s just about gut feelings and judgment regards to what is or is not being said”

(Primary care manager)

The apparent emphasise on mental health issues noted above was not to everyone’s liking

"I think it does err on the side of mental health... they used to ask questions like, have you ever had an operation...When the new tool came in, although there are some physical questions in there, it does lead towards substance issues and mental health... I would like to see a bit more a balance”

(Healthcare manager)

Conversely, another respondent felt that the tool did not cover mental health
issues as comprehensively as was needed

“The tool needs to be changed, on the mental health side. There are not enough questions on it”

(Reception nurse)

3.2.3 Problems with the reception screening process as a whole

Comments on this topic fell into several topics including the timing of reception screening, the physical environment in which screening was undertaken and the impact of elements of the prison regime itself.

Firstly, it was widely acknowledged that coming into prison was, in itself, a distressing experience and was an unlikely opportunity for people to be able to be open, honest and fully engaged with the health screening process.

"The whole day for them is horrific”

(Healthcare manager)

“Won’t disclose because they’re frightened, scared of bullying, affected by their perceptions of what will happen if they disclose”

(Healthcare manager)

“Long day, hungry and lots of questioning...hard to develop therapeutic relations”

(Cluster manager)

“Issues of them coming from court, tired and hungry; the last thing they want to endure (is a ) full health assessment”

(Healthcare manager)

“It’s too much to take in at one go.”

(Substance misuse worker)

Immediately at reception into custody, people were thought to be

“Chaotic and stressed”

(Primary care manager)

“Frightened, apprehensive”

(In-reach team member)

“Not the most trusting of individuals”

(In-reach team member)

Prisoners agreed with these sentiments, reporting that when they first arrived in prison, they often felt confused and in shock.
“(I was) in a state of disbelief, the sentence was unexpected to be honest, I’d be sentenced at 10.45am but didn’t get to prison till 5.15pm, I had to sit in the reception for two hours before I saw the nurse, I didn’t get down on the wing until 8.30pm”

(Prisoner)

“Then suddenly the nurse starts asking you questions, and you’re like what is going on, you just don’t have your conscious decision making processes in place at that point in time to answer those questions”

(Prisoner)

This inability to fully engage with the process was noted as affecting the accuracy of the information given.

“When it’s someone who is coming in the first time, they’re shocked so they could say anything at that time because all your thoughts aren’t with you”

(Prisoner)

“Information can also be misleading”

(In-reach team member)

“Prisoners can get annoyed due to repetition. Prior to recent modifications, (they were) often kept up late at night completing screen”

(Reception nurse)

“What would make it easier would be if the patients could come in and...give clear and concise information relating to their care, time, dates, admissions dates, prescriptions...that would shorten the process of trying to follow things up.”

(In-reach team member)

The whole complexity of the reception screening process, of which healthcare is just one part was outlined by more than one respondent

“Check identity, check aged 18+, check warrant...bring to number 1 desk...cell sharing risk assessment...communications compact...use phone...family details, literacy...number 2 desk, ID card, get prison number, tally cash...searched property...”

(Discipline officer)

“Everything’s happening all at the same time, you’re getting your clothes thrown at you, you’re getting given orders form all directions, you have prisoners trying to buy your gear off you”

(Prisoner)

The sheer number of tasks involved in reception into custody led one respondent to compare the process for prisoners as like
The physical environment in prison reception areas was the subject of repeated negative comment. Staff complained that rooms used for screening at reception were often cramped, not private, and generally unfit for purpose.

“The medical room in reception is awful really, it’s got no window in it, it’s right next to the servery and the room seems to suck all the hot air in, it’s like you are in a tropical storm or something”

(Healthcare manager)

“Shocking screening room for nurses, no window, no ventilation, would make me suicidal if I thought that was what prison was like”

(Reception nurse)

A number of establishments with electronic records systems noted that they had been unable to have computers installed in reception, necessitating completing screens on paper and then transferring the information over to the electronic system, thus repeating work.

The unpredictability of the numbers of people arriving at prison, and the times of their arrival also caused problems for healthcare workers. Receptions usually started arriving early afternoon, but most arrived in large groups throughout the evening. It was noted that custody escort services planned routes to their own best advantage, thus some establishments always received people very late in the day.

“The reception nurse who has been at reception from about half past one can really be doing very little then all of a sudden ten people will come and there’s frenzy”

(Healthcare manager)

“Big groups brought in at same time...practice was safe when less boys were brought through”

(Primary care manager)

“It can be very difficult depending on the time of the detainee comes into our reception. We can have receptions any time of the day, we close our doors but quite often we have receptions going on until 8pm...there is always the pressure to get people in and make sure the lads have had their basic needs (met)]”

(Primary care manager)

“Depends, varies each day, sometimes it’s a madhouse and they don’t have time to go through stages they should go through”

(Discipline officer)

“We’ve got people coming in a very short space of time and eight come in at 9 o’clock at night and we’re meant to finish at 10 o’clock and we don’t get away till

“being processed like meat on a conveyer belt”

(Healthcare manager)
midnight. We’re making it - I’m not saying they’re being neglected but some of us have been on since 7 o’clock”

(Healthcare officer)

A further problem was noted when dealing with prisoners who could not speak English well, and how that caused anxieties for staff, worrying whether they had been able to assess risks fully.

"Language barrier, no interpreters…they cannot express problems and (it is) hard or impossible to assess risk.”

(General Practitioner)

The pressure of time was something felt acutely by a number of respondents.

"(You) get 5-10 minutes if you’re lucky and there’s pressure from officers as well. Some do need more in-depth assessments“

(Reception nurse)

"Some problems not picked up because you haven’t elaborated on the original question because of time constraints.”

(Reception nurse)

"Just (because of) the normal regime of prison you can feel quite pressurised by that to get them done”

(Reception nurse)

"It feels like the officers try and hurry you along because of the amount of people that come in and the time you are allocated. If there are a lot of people, they are rushing you do it and I think that sometimes things can be missed.”

(In-reach team member)

"Some evenings the officers turn the lights out and leave“

(Primary care manager)

"Relationship with security staff, they don’t understand what we are doing and why we can’t process the lads quicker”

(Primary care manager)

The primary care manager making that observation worked in an establishment where the governor noted

"The screen is far too long with the numbers of lads we have coming in”

(Governor)
illustrating how, even between colleagues working within the same establishment, the particular goals of different staff groups appeared capable of causing fundamental conflict.

The potential for the invasion of privacy was also noted, especially by prisoners.

"Officers constantly opening the door during the screening consultations and interrupt and pressure us"  
(Primary care manager)

“You get sat there with other lads outside, so I was worried the lads would hear what I was saying”  
(Prisoner)

“you get taken into a tiny room, like a toilet cubicle, where the nurse sits, the door isn’t even shut”  
(Prisoner)

“There were prisoners outside and I couldn’t hear her properly because of all the shouting”  
(Prisoner)

“They (officers) stand outside the door chatting and staring. It’s better now they’ve changed officers. They were grumpy”  
(Reception nurse)

The damaging affects on staff well-being of working under such sustained time pressures were expressed by one reception nurse

“I don’t sleep sometimes worrying so much about decisions and I don’t relax until I come in the next day and know they’re ok”  
(Reception nurse)

3.2.4 Suggestions for changes to current reception screening procedures

In this section of the interview, participants were asked to suggest changes they thought would improve the initial screening process. Responses fell into a number of areas including changes to particular questions, the type of personnel who should undertake screening, and wider issues including IT considerations and links with external services.

Several people commented on the immediate “first aid” type purpose of the reception screening process, noting that the tool should concentrate on identifying urgent needs and to expect an initial screen to have greater coverage was unrealistic.

"There needs to be some thought as to what info is essential for the first night to protect and at a later date do the rest of it"
Comment was made about the emphasis throughout the current tool on using historical data as indicators for referral to services. For example, with regard to risk of suicide or self harm one respondent noted

“You might have somebody who is in their 40s or 50s, first or second time in prison...who may have self harmed or overdosed when they were 15 or 16 during adolescence...now 20 or 30 years later, we now have to do a mental health assessment. I think that leads to undue pressure on staff”

A similar sentiment was echoed at another establishment

“If the question is ‘have you seen a psychiatrist?’ and they put ‘yes five years ago’ they still have to be referred but there is nothing about their current mental health...I would say it should refer to 6-12 months really”

“My main recommendation would be that the mental health page deals with current issues.”

It was mentioned at more than one prison that the availability of mental health trained staff to undertake screening was important, linking back to the apparently held belief that the screen was first and foremost a mental health and suicide/self harm risk assessment tool, as discussed above. Similarly, more than one respondent thought that screening should ideally be undertaken by more than one person to provide support in decision making.

“Want a mental health worker available on reception”

“General nurses need training and a framework around identifying key things to understand triggers of usual behaviour and subtle mental illness”

“Two nurses should do the screening, one general nurse and one mental health nurse or two mental health nurses”

“We need more training on the mental health side. Either have someone mental health trained to do it or assess them after”

“Mental health nurses could be there to deal with concerns after the screen”
“More guidance on making mental health referrals...what’s urgent, what isn’t, someone who had a one off contact with GP for depression - do they need a mental health assessment?”

(In-reach team member)

This perceived emphasis on mental health issues as a primary purpose of the screen prompted one respondent to note that risk assessment could be improved by the introduction of a standardised, validated risk assessment instrument following screening.

“Currently not using evidence based risk assessment tool if referred to mental health services”

(In-reach team member)

One respondent outlined their view that the reception screen should involve contact with several workers

“Need RGN to do the physical assessment, RMN to complete mental health assessment and CARATs to do substance misuse assessment and all assessments should come together”

(Healthcare manager)

There was also a sense that undertaking reception screening was a skill honed by experience and the importance of employing regular personnel to undertake the task.

“Would like to have a dedicated reception team, where reception was done by the same people. Reception is currently done by general nurses doing overtime”

(Primary care manager)

There was also an understanding from a number of respondents that reception into prison custody was not necessarily a discrete event, rather it was one part of a broader pathway through the criminal justice system. Such thinking is very much in line with current Department of Health policy which has expanded its remit from an initial emphasis on prison based healthcare services to include considerations of healthcare across the whole criminal justice system.

This sense of people being on a journey through the criminal justice system led respondents to start considering how this could improve screening procedures, for example by improved liaison with court and police settings so that the identification of health problems started early and systems of effectively handing over information from one setting to another were in place. One healthcare manager noted that, after a visit to a central police custody suite she had been amazed by the amount of healthcare input that had been available which, at the prison, they were unaware of. She noted that many people who ended up in prison custody had already had urine screens for drug use done in police custody, but results were
never fed through to reception healthcare staff, thus tests were repeated at not inconsiderable expense of both money and time. Other respondents commented similarly.

"Ideally- identified before come into prison- the courts and the court liaison scheme. Have all the information available"

(Discipline officer)

"Commission care in (police) custody suites with (compatible IT systems) there, can get (access to) activity in custody suite"

(Healthcare manager)

"No communication, no information sent from the courts, forms we get are blank for risks, frustrating as we supply answers for other organisations but when the tables are turned we don’t know what’s stepping off that bus. Heads up from the police or court, or prison escort record completed before they come in be nice"

(Discipline officer)

The advent of computerised records systems which linked up to the wider NHS was also discussed as a way of improving the speed and quality of information exchange, especially in regard to obtaining background information in a timely manner.

"What would really make life a lot easier is people’s GP records and direct access to them...can sometimes take weeks and it slows the process"

(In-reach team member)

"Would be brilliant if we had their GP information. Want IT systems linked to NHS, meds, background etc. For past medical history need GP info"

(Reception nurse)

"Bringing our computer systems into line between GP surgeries and PCT would make sharing information easier"

(Healthcare manager)

Ways of improving the actual practical mechanics of undertaking screening in terms of the prison regime and the physical environment were also commented upon.

"More comfortable room, cleaner environment"

(Primary care manager)

"Bigger screening room with window, ventilation and more light"

(Reception nurse)

"If we had more time and prisoners came at sensible times throughout the day and we were not rushed or hurried"

(Healthcare manager)
One governor saw value in moving the health screening process from the reception area itself in prisons where dedicated first night centres, geared specifically to meeting people’s needs in early custody, were operational.

“Speed up the process; instead of a prisoner seeing a nurse in reception we could almost do that in a first night centre”

(Governor)

Tellingly, this respondent’s primary rationale for such a change was to “speed up the process”, rather than necessarily improve efficacy. Thus, in practice, a change to first night centres as the location for screening would have to be tested out to ensure that the problems currently faced by healthcare staff in reception are properly addressed by such a move, rather than the same problems merely being physically relocated.

As well as improved mental health knowledge, a number of other training needs were identified. Firstly, training in IT and computer issues was noted as a way of ensuring that screens were comprehensively completed.

“There are some IT issues. I have noticed that some nurses miss sections of the screen out. This should be prohibited on the computer system and it should be mandatory to fill them all out”

(Pharmacist)

Secondly, issues around appropriately serving a culturally diverse population were noted by one respondent

“Need culturally competent work force, trained and aware of issues”

(Healthcare manager)

Individual suggestions for change suggested by respondents including increased importance given to alcohol issues, physical disability and diabetes.

3.2.5 The utility, form and purpose of the second screen

The follow-on screen was viewed by many respondents as a second chance to gain health information from prisoners at a time when they were more settled in custody and likely to be more able to concentrate, take information in and engage with the process.

“They’re apprehensive when (they) first come in, by time of second screen settled down and open up more”

(Primary care manager)

“Generally get seen near enough the next day now. They’ve calmed down. Need to explain access to healthcare again as they get loads of information”
“Prisoners are fresher the next day”

“(It) is good in one sense because a younger person coming into custody sees everybody on that first night so they get asked a lot of questions so this makes sure they haven’t forgotten any information, or they may need to see a dentist”

After the hurried procedures on the first day, many staff agreed with the following sentiment about the second health screen.

“I think of it as a safety net.”

The second opportunity to engage with prisoners was appreciated by staff as a way of completing the assessment process, with many respondents concentrating on the use of the screen as a “well-man/woman” tool.

“It’s a general check. More physical, with a couple of mental health and self harm questions. It’s a safety net as the first is for immediate need and they’re stressed and don’t tell stuff”

“Check up on medication needs that have been missed and need further follow-up, ensure prisoners have got their medication, Hep B status checked and vaccination offered”

“Get more comprehensive health information for risk assessment and risk management, look at lifestyle, blood pressure, assess health needs, contact other agencies”

The second screen also provided healthcare staff to give information about what services were available and build relationships with individuals.

“Opportunity to spend more time and build relationships”

“...extra time on the second screen just to plan their care more effectively or just explain what their expectations should be about what their care delivery should be whilst they are here.”
"Delving...get more information, provide appropriate care for them”
(In-reach team member)

However, for at least one member of staff, the value of the second screen was dubious.

"I think it could be improved because at the moment we literally just go over much the same as what we have done in the first screen...for the majority, you don’t find out any new information...if they’re going to be referred into the diabetic clinic, they are being seen again anyway and the second screen is therefore null and void.”
(Clinical lead)

This was a sentiment agreed with by some prisoner respondents.

"They did it all again (repeated same questions)"
(Prisoner)

"Both had similar questions"
(Prisoner)

"Fine for people who never been in prison before but repeat offenders either won’t show up or just say nothing has changed from before without giving us chance to assess them"
(Reception nurse)

Whilst the second screen was felt by staff to add value to the process of gathering health-related information, problems with the practicalities of facilitating the time and opportunity for the screen were noted. As the screen was not compulsory, some establishments reported low rates of completion.

"As it’s voluntary there’s a very low attendance - 30%”
(Reception nurse)

A respondent from the same establishment agreed.

"Make compulsory. No incentives to doing screen”
(Primary care manager)

In similar vein, a prisoner described how the value of the second screen had been explained to him.

"He said that coming back for the second health assessment would give you something to do and would get you out of your pad”
(Prisoner)
"We have very poor take up rate here of secondary screening, the main reason for this is that we have a lot of revolving door prisoners here. They’ll be let out on Friday and they come back Tuesday so they actually don’t want to fill it in again.”

(Substance misuse worker)

Suggestions to overcome low attendance included instigating an appointment system, and locating the process somewhere convenient.

"If the lads were given allocated times to be screened…”

(Primary care manager)

“Do second screens somewhere where could guarantee prisoners would turn up”

(Discipline officer)

The main problem noted with completing the second screen centred around being able to fit the process into the very busy induction process which frequently lasts for several days after reception, involving staff from a number of departments within the prison, for example gym staff, chaplaincy, the education department etc.

"From a residential point of view it’s a bit of a pain because there are that many…it impacts on the induction and other areas”

(Governor)

“In theory it’s a really good idea doing it the second day but in reality they’re getting moved off the wing, its unrealistic to think that one nurse can do sixty screens in one day”

(Reception nurse)

“It’s also finding them they have exercise time, go off to CARATS, it’s finding them that’s the problem”

(Reception nurse)

“It’s not just the nurse that wants to see them, everybody wants a little bit, so prison officers need to see them, they need the induction sort of questions...other staff want to see them, so everybody is trying to get at them and that does progress through the next few days as well, everybody’s got a box to tick, and everybody’s the most important, so it is quite difficult”

(Healthcare manager)

In at least two establishments, it was reported that the first and second screens were being conducted together at the point of initial reception. Such a practice presumably reduces the perceived benefit of the second screen in terms of an opportunity to gather information from prisoners when they are more settled and receptive to engagement.
3.2.6 Local experiences of ‘what works’

We asked respondents to share examples of good practice which they felt had improved their health screening procedures locally.

As noted earlier, there was particular benefit noted by respondents of conducting the second screen some time after the initial reception. Interviewees spoke of systems in place whereby a target for the completion of second screens within three to five days had been set. One establishment reported a positive policy of actively seeking out individuals on the wings if they failed to turn up to two specific appointments for the second screen.

Conducting the second screens away from the wings, in the healthcare centre was important for some staff, making the value of the second screen more about an individual’s health and less about the routine of the establishment.

“On the second interview, they walk over to the healthcare centre so it is in a more clinical environment rather than a prison environment which makes them maybe more comfortable to speak about medical issues”

(In-reach team member)

Other staff had overcome the problem of prisoners being caught up by the induction by actively being part of that process.

“Have a slot at induction and do a talk and the second screen (then)”

(Primary care manager)

Where electronic systems were in place, staff felt that their efficiency was improving, especially with regard to overcoming problems relating to information gathering.

“Get records from other prisons - brilliant, it’s a really good system”

(General practitioner)

“You can look back on EMIS at past info. Better than paper records as they leave, but with the IT, there’s more as it’s back-dated”

(Reception nurse)

3.2.7 An alternative method?

An alternative method for reception screening procedures was offered to interviewees for their consideration. The suggested model consisted of two stages, as at present, but with a change in emphasis at each stage.

The first stage would consist of a very limited screen designed to keep people safe for the first 24-48 hours in custody. The screen would be brief and cover only issues of immediate concern, including mental health issues, suicide and self harm risk, drug and alcohol detoxification needs and acute/chronic physical health problems requiring immediate treatment. Following the screen, any immediate needs would be facilitated. Then, using first night centres all prisoners would be kept safe overnight.
The second stage of the process would be the administration of a much more comprehensive follow-up tool than those currently in use. This tool would include the standard physical observations as are recorded currently (blood pressure, height, weight etc) and other “well man/woman” considerations, for example smoking cessation, immunisation status etc. However, a major change to this part of the process would be the introduction of much more comprehensive sections about wider health concerns, including detailed histories of physical and mental health problems, a structured mental health assessment using a standardised tool, and a detailed assessment of self harm and suicide risk, again using a validated tool. The aim would be that the second health screen would thus provide a detailed basis of the person’s future healthcare needs and clearly identify the required referral and care pathways in a similar way to the full assessment undertaken following the opening of an ACCT document does. Intuitively, detailed assessment at this stage before any crisis points are reached should increase the number of timely and appropriate referrals to relevant services and contribute positively to pro-active risk reduction. Detailed knowledge of prisoners’ needs at an early stage should also decrease the need to provide ineffective, uneconomic crisis care.

Respondents expressed mixed feelings about such a model. Some commented that, in effect, the suggested model was not substantially different from their current practices. Several concerns were raised including issues around the adequacy of a shortened initial screen; the timing of the expanded second screen; the problems fitting an expanded screen into the prison regime; and staffing issues, including training and availability.

It was thought that the model would work if

"the second screen was not optional...problems of prisoners not turning up”

(Reception nurse)

The skills of the staff conducting the screens was noted as important.

“Yes, could work, but it is about having the appropriate person doing the asking and the quality of the responses”

(Primary care manager)

“Achievable if you have got the staff to do it... If you haven’t got RMNs to do it, it will be of no benefit to anybody.”

(Healthcare manager)

“Staff? Healthcare assistants wouldn’t be happy to do it if more in-depth. It depends on whether it’s simple to use and (if) there’s a guide”

(Reception nurse)

“Not achievable, all depends on who is doing the second screen. I’m an RGN not mentally health trained, but have worked here long enough to pick up certain signs but far from qualified to do mental health assessment, have to have RGN and RMN on second day, not practical to have two nurses screening, shift work problems sometimes there might not be a RMN on in the morning”
As pointed out in the preceding quote, along with the skills required, the model was thought to have implications for staffing profiles, probably requiring the rearrangement of current working routines to cover different times, and to undertake the longer second screen.

“A doctor would be more available during the day rather than at 8 or 9pm”

(In-reach team member)

“That would require a whole restructuring of the doctors’ time. You would need two doctors at once, one for doing your normal primary care surgery and...the reception doctor during the day”

(Healthcare manager)

“That would take negotiations with GPs. It would need commissioners to see what contracts we needed and everything.”

(Healthcare manager)

“It will not work for the simple reason that there is not enough staff to do it”

(Reception nurse)

“Practically primary care is overloaded...it would be very difficult to actually implement.”

(Clinical lead)

Some people thought that, for the majority of prisoners who did not present particular risks, the system would work, but for others more care was needed.

“Needs a different assessment of high risk people”

(Primary care manager)

“Someone deemed high risk on the first night would be admitted to healthcare”

(Governor)

“If you have someone vulnerable coming in, you might not have any information and 10 minutes is not long enough.”

(Healthcare manager)

“Can’t assess mental health in ten minutes”

(Substance misuse worker)

One respondent working in a women’s prison expressed particular concerns.

“Achievable and would streamline the process, (but) would not be adequate for female estate, mental health side of it important, takes time, if not done properly and staff not aware increases risk of suicide”

(Discipline officer)
The issue of risk related to considerations of the timing of the second screen. Respondents expressed the need to balance the risk-taking possibly involved in a briefer initial screen with the value of an improved, more detailed second screen which could happen some point within the initial 48 hours of custody. However, again the value of a second opportunity to see people when they had settled somewhat was seen as advantageous.

"I like the idea of that...with them coming back the next day you would get more value I'm sure."

(Healthcare manager)

Whilst some people thought that the change could be facilitated by the regime, others saw potential problems. Respondents were aware that there would need to be a widespread culture shift within prisons, placing healthcare needs and the value of the second screen much higher up the induction agenda than was presently the case.

"I know that the first few days are really busy...so if we can get the prison to recognised that the medical side of things is as important as the custody process, I think this would be realistic”

(Healthcare manager)

"The induction programme is very strict on time with things that have got to get done and taking them away from the residential wing and getting into the regime straight away on that first day is impossible.”

(Clinical lead)

"Time constraints would be there, but as an idea as a way to process info and to get the right types of info back which are going to be valuable, it certainly seems a good idea”

(Primary care manager)

"There would have to be structured time available to health care that was ring fenced”

(Healthcare manager)

One respondent reported a feeling of relative powerlessness on the part of healthcare agencies to influence the prison regime.

"The prison day is all mapped out and the PCT has little or no jurisdiction to change that and I feel it would have to be changed to achieve this”

(In-reach team member)

The potential to speed up procedures in reception was seen as advantageous.

"Would allow staff to go home on time, result in a lack of chaos at the end of the day”

(In-reach team member)

"I think it would be good in respect that in the reception they would come through quicker because obviously we are a prison which doesn’t have a cut off time”
"Young men are coming in 'til the early hours of the morning and...the information on reception takes quite a lot time and the lads need to get to sleep (so) a 10 minute screen would be great"

However, for some respondents, this would not be without risk.

“(I) See benefits of it certainly, moving prisoners right through... (but) as soon as you reduce what you’re already doing you are by its very nature increasing the slight amount of risk”

“Positives are that it would be quicker for the staff and the young lads so they could get themselves settled in. Negatives would be I would be worried that I would miss something. Ten minutes is not long for a person”

“Don’t know how younger age group would respond and if sufficient enough to expose any issues for them”

“Only fits in from time basis, I’d worry it had not gone deep enough, run risk of not asking the right questions, almost a fast track system which is a dangerous thing to do”

“Ten minutes, it’s too quick, not given time to put person at ease which allows them to express concerns”

One respondent stated

“I think its unsafe and I wouldn’t be prepared to work with it, the prison might want that because it fits in with their regime really well but its clinically unsafe”

Interesting, a healthcare colleague working in the same prison reported

“That’s what we use now”

Overall, with caveats to ensure appropriate addressing of immediate risks, respondents were broadly in favour of a re-focussed two stage process as outlined above.

It was noted that the system would require changes to staffing arrangements and the place of healthcare processes within the induction programme.
"It would be a real massive upheaval but if all that could be done then yes it would be great."

(Healthcare manager)

The need for the screening tools to be accurate and appropriate was noted.

"Really good idea, as long as well focused...first reception screen...first night safety, meds, risk of harm, self-harm. Far better approach”

(Healthcare manager)

"As long as it gets those basics, if can get those in ten minutes that’s brilliant as spending a lot longer on current system we’re using...ideally we say it would be a RMN doing reception screen, tool would have to be easy to use”

(In-reach team member)

"Is achievable, but would need evaluating on trial basis, concern over first screen that it’s too short, things could get overlooked, how it would work within the regime also need evaluating”

(Pharmacist)

“Should be quick initial assessment, speed everything up, assess their immediate needs...could still be fitted in with core day, think it would work if you have no immediate need unless come in really ill...the quicker they’re in their cell better for everybody”

(Discipline officer)

### 3.2.8 Summary of interview findings

The key findings from the questionnaire can be summarised as follows:

- There was evident confusion about the main purpose of the initial reception health screen, with some respondents believing the tool to be a comprehensive assessment of all aspects of health need, rather than designed only to capture problems requiring immediate intervention or referral onwards, in line with the original expressed use of the tool.
- It was a commonly held belief that the tool was predominantly focussed on risk assessment in relation to mental health problems or suicide/self harm rather than eliciting information about a person’s physical health.
- The absence of standardised risk assessment tools was noted as negative.
- Concern was expressed about the concentration on historical factors as indicators of onward referral to mental health services rather than an emphasis on assessing a person’s mental health and mood in the “here and now”, especially in the context of their imprisonment.
- Training deficits, especially around improved mental health knowledge were noted by a number of respondents.
- Concern was expressed by prisoners and staff about the timing of the initial screen; it was commonly felt that the first few hours of custody were an
alarming and difficult time, and people’s confusion and distress could adversely affect the quality and accuracy of the information gathered at that time.

- Problems with the physical environment in reception areas were noted, including worries about a potential lack of privacy, the absence of IT systems and cramped, foreboding rooms.

- Health screening was noted as being only one of many processes undertaken at reception and healthcare staff reported experiencing pressure from discipline officers to undertake screens as quickly as possible, leaving them concerned about the quality of the work they were undertaking. This was compounded by the unpredictable nature of people arriving at reception, often late in the evening and in large groups.

- It was noted that increasing IT capabilities in prisons could have a positive effect on healthcare workers’ ability to access background corroborative information in a timely fashion.

- It was noted that reception into prison custody is just one part of a person’s journey through the criminal justice system and that they have contact with healthcare services elsewhere, for example in police custody. It was expressed that improving links with other settings, thus facilitating better information exchange could potentially reduce the procedures required at reception and avoid the duplication of work.

- The second health screen is appreciated by staff as giving them another opportunity to assess people at a time when they may be more able to engage.

- The fact that the second screen was not mandatory adversely affected completion rates.

- Some prisoners and staff regard the typical content of second screens as, to a large extent, merely replicating the first screen.

- Staff expressed problems in fitting the second screen into the induction regime in the first few days after reception.

- The majority of staff interviewed were in favour of a change to the current system to encompass a very brief screen at reception, followed up by a much more holistic assessment of need within the first days of custody.

- Caveats to such a change included the need to be sure that risks very early in custody were clearly and adequately identified.

- It was felt that such a system could only be success if it were mandatory to accommodate the second screen adequately within the induction regime.

- The instigation of the proposed system would have implications for both staff training and staff profiling.

- Any change to current procedures would need to take into account the discrete needs of different groups, for example women and young people.
4 Discussion

This evaluation focuses on current procedures around screening for health problems upon reception into prison custody.

Presently, this is a two stage process; the first screen is conducted within the first hours of reception into custody and concentrates on identifying health issues which may require immediate intervention, for example drug and alcohol problems, mental illness, acute physical illness and risk of suicide or self-harm. A national standardised template for the initial screen was developed and piloted by researchers (Grubin, Parsons and Hopkins, 1999; Grubin, Carson & Parsons, 2002); however, since its instigation in 2004, a number of establishments have modified the tool in response to the perceived needs of their local population. The follow-up screen essentially constitutes a more general ‘well man/woman’ examination, broadly analogous to assessments undertaken in primary care when patients register with a GP. The format and precise content of these tools varies across the prison estate; from examples supplied to the research team, they generally consist of basic physical measurements (e.g. blood pressure, height, weight) and additional items commonly including smoking cessation, immunisation history, sexual health and lifestyle and further brief mental health questions. The conduct of a follow-up screen also gives staff a further opportunity to give prisoners information detailing available health services and how they can be accessed. The completion of follow-up screens is not a mandatory requirement and is not formally monitored through a national performance monitoring system.

The evaluation consisted of two main parts. Firstly, a questionnaire devised for the study was sent to the healthcare managers of all prisons in England and Wales which were identified as receiving people directly from court as new receptions (n=64). The questionnaire covered all aspects of health screening including rating of satisfaction with the current tool; training and staffing issues; logistical problems associated with providing both the first and follow-up screen; suggestions for improvement to the tool in particular or procedures in general; and identification of local modifications.

Secondly, a series of semi-structured interviews were held with staff and prisoners in twelve prisons. Sites were chosen purposively, based on questionnaire responses, to include sites which reported that the current system worked well, those which thought it to be inadequate and those which perceived a balance of good and bad points. Interviews were conducted either face-to-face, or by telephone, and content was analysed thematically to identify key issues.

Of the 64 prisons accepting people straight from court, 57 returned the questionnaire, a response rate of 89%. Of the respondents, 49% (n=28) had modified the standard initial screen. Whilst the proportion of prisons for adult men and those for women which had modified the tool were broadly similar, six of the seven (86%) Young Offender Institutions which responded had modified the tool. The YOI which had not modified the tool reported that they did not regard the tool
as comprehensive in dealing with substance use, suicide/self-harm risk, mental health or physical health.

Prisons conducting reception screening with a locally modified tool, perhaps unsurprisingly, reported higher rates of satisfaction about how comprehensively they thought their tool screened for mental health, suicide/self-harm issues, substance misuse, physical health and sexual health. However, even considering perceived improved efficacy through local modification, levels of satisfaction with the tool in either a modified or unmodified format were generally low. For example, only 41% of all respondents regarded the original tool as comprehensive for mental health problems and 34% considered it so for assessing risks of suicide/self-harm. For those operating modified tools, the figures rose slightly, but still only half (50%) reported their modified tool to be comprehensive for either mental health or suicide/self-harm risk assessment.

With regard to staff issues, the majority of prisons (89%) ensured that screens were undertaken by qualified nurses. When asked about whether staff received particular training in relation to screening procedures, only 56% of respondents said that this was the case. A lack of training was particularly evident in women’s prisons where only a quarter (25%) reported particular training in contrast to 59% and 57% in prisons for adult and young men respectively.

When asked what issues should be included in the first health screen that were not currently covered, the most frequent suggestion was learning difficulties, mentioned by 72% of respondents. Other suggestions included physical disabilities, blood-borne viruses and chronic disease.

The semi-structured interviews were illuminating in terms of adding detail and context to the questionnaire results. There was evident confusion about the main purpose of the initial reception health screen, with some respondents believing the tool to be a comprehensive assessment of all aspects of health need, rather than designed only to capture problems requiring immediate intervention or referral onwards, in line with the original authors’ expressed purpose. It was a commonly held belief that the tool predominantly focussed on risk assessment in relation to mental health problems or suicide/self-harm rather than eliciting detailed information about a person’s physical health.

Respondents reported reservations about the concentration on historical factors, especially in the context of onward referral to mental health services rather than an emphasis on assessing a person’s mental health and mood in the ‘here and now’, particularly in the context of their imprisonment. Staff reported training deficits, predominantly in terms of mental health knowledge; many felt that reception screening should be undertaken by mental health nurses.

Concern was expressed by prisoners and staff about the timing of the initial screen; it was commonly felt that the first few hours of custody were an alarming and difficult time, and confusion and distress could adversely affect the quality and accuracy of the information given. Staff worried about the quality of their work and the reliability of their decision making when these were impacted upon by having to screen large numbers of people in a short space of time, responding to pressures from the prison regime to get prisoners located on residential units as quickly as possible. To counteract this, the follow-up health screen was noted as a
welcome opportunity to assess people at a later time when they may be more able to engage; however, as the second screen was not mandatory, low rates of completion were reported.

What became clear during this evaluation of reception health screening procedures was that there were a number of inter-connected problems with current procedures. Firstly, it is clear that the current tool is not generally regarded as effective in a number of key areas. Only a third of respondents considered it comprehensive in the identification of suicide and self-harm risk, a very important consideration in the early stages of custody. Local modification increased this satisfaction rating to 50% which is still low enough to be of concern.

Secondly, there was confusion over the purpose of both the initial tool and the second screen. Some staff regarded the initial screen to be a comprehensive assessment of health needs whilst others regarded it as identifying only the most urgent issues. However, whatever staff thought the purpose of the initial screen to be, it appeared evident to researchers that the second screens generally offered little by way of an in-depth examination of health as, by and large, they were short, consisting mainly of basic physical measurements and containing at most a few brief questions about mental and physical illness.

Thirdly, staff reported problems with the actual mechanics of undertaking both the first and follow-up screens. Respondents experienced problems in dealing with large numbers of new receptions within a limited window of time and noted that the completion of follow-up screens was hard to achieve within the limitations of the prison regime where healthcare needs were often overshadowed by other priorities, especially during the induction period.

To tackle these issues, it is suggested here that reception screening be re-focused along the lines of the alternative model described to interviewees in the second part of the research.

We suggest that the initial screen be re-drafted to clearly constitute a way of identifying the most urgent healthcare problems which require immediate intervention. It is suggested that these would include serious mental illness, current active risk of suicide or self-harm, alcohol and drug detoxification, and acute/chronic physical illness requiring on-going medication, for example diabetes and cardiac disease. We acknowledge that these areas are broadly in line with the content of the current screen. A main difference is that, in contrast to the current screen which prompts staff to make ongoing referrals e.g. to mental health services etc on the basis of the first assessment, that this be omitted, to be revisited at the follow-up screen when a more measured and informed decision about referral can be made. This recommendation is made particularly in the context of the results of the national evaluation of prison mental health in-reach services which was undertaken by the current research team in collaboration with others (Shaw et al, 2008). The in-reach evaluation identified that only 23% of prisoners with current, severe mental illness (who would have scored positively on the reception screen’s question in terms of a history of contact with services or prescription of medication for mental health problems, and thus should have been referred to mental health services), went on to be assessed by in-reach services. This led to the conclusion that, at least in terms of mental health issues, systems
for the onward referral for further assessment following initial screening were dysfunctional. Given that such low rates of assessment were achieved in an area regarded as such a high priority as mental health, we have no reason to believe that onward referral systems and care pathways for physical illness would be significantly better.

There would then need to be in place robust procedures to keep all prisoners safe overnight. Those with clearly identified risks of self-harm or suicide would have ACCT safeguards implemented and heightened observation schedules appropriate to risk; all other prisoners should be routinely monitored closely overnight within first night centres where staff are specifically trained in the risks associated with early custody.

On the second day in custody, a second health screen should be undertaken. It should be mandatory to offer this screen and subject to performance monitoring in terms of the proportion of prisoners both offered and undergoing the screen. Whilst prisoners with the capacity to refuse should of course be allowed to exercise that right if desired, the value and purpose of the screen should be carefully explained to each prisoner and refusals carefully documented in clinical notes, thus allowing accurate audit to take place. A new tool should be developed to form the basis of the second screen. The aim is that the second screen will become a comprehensive, holistic, psycho-social assessment incorporating, where appropriate, validated standardised tools, if necessary adapted for use with prison populations.

When complete, second screens undertaken in such a format should identify a person’s overall healthcare needs, and allow those needs to be categorised in terms of severity, urgency and impact upon everyday life. This recommendation is again made in the context of the results of the national evaluation of mental health in-reach services which highlighted that an over-reliance on information relating to historical factors, such as previous contact with services, appeared to detract from more proactive assessment procedures which concentrated on case-finding. In terms of mental health problems, this led to a situation where people who were in a current episode of, for example, severe depression illness but had not had any previous contact with services, were likely to remain undetected whilst in custody, thus a valuable opportunity for engagement with services and health gains likely to impact positively in a number areas of a person’s life was lost.

As a result of these more considered assessment processes, each establishment would need to have clearly identified and fully functional care pathways to be followed in line with local availability of services, including referral to primary and secondary healthcare, self-help opportunities and access to non-health pastoral support for those identified with social and custodial needs best dealt with outwith the structures of formal healthcare services.

A major issue for the success of such a revised system would be the need for the change to be embraced wholeheartedly by the prison system as a whole, from the Director General, through Area Managers and Senior Governors. The need to appropriately and comprehensively identified health deficits should be publicly acknowledged as worthwhile and likely to impact positively upon wider aspects of the prison regime and culture. There would need to be an acceptance that the
process was necessary, effective, yet time-consuming if done properly. Consideration would need to be given to ways in which health screening was consistently regarded by all staff as a valid routine, possibly through classifying it as ‘purposeful activity’ within HM Prison Service’s performance monitoring system, thus contributing to prisons’ quarterly reported performance ratings.

An over-arching need to ensure overall acceptance and facilitation of both the first and second screens in the revised system as outlined above cannot be over emphasised and would be a cornerstone to its success and ability to contribute improvements in both personal and public health.
5 Recommendations

1. The initial health screen conducted in reception should be re-drafted to concentrate on identifying the most urgent healthcare problems which require immediate intervention. Service users should be involved in the re-drafting of the screen.

2. The initial health screen should consider issues of serious mental illness, current active risk of suicide or self-harm, alcohol and drug detoxification, and acute/chronic physical illness requiring on-going medication, for example diabetes and cardiac disease.

3. Following the initial screen, all prisoners should be kept safe overnight, with ACCT safeguards initiated for those most at risk.

4. Staff working on first night centres should receive detailed training covering effective ways to engage with and observe prisoners and the identification of, and appropriate responses to, risk triggers in people’s behaviour.

5. A revised second screen should be designed for completion on the second day in custody. The format of the revised tool should include all aspects of health, incorporating, where possible standardised, validated assessment tools, adapted as necessary to the prison population.

6. Each prison should establish clear and appropriate pathways for onward referral and care based upon local service availability. Routine auditing of health screens should be undertaken to ensure that appropriate referrals are being made and subsequently acted upon.

7. Health screening undertaken in this way will also likely identify wider social and custodial needs. Therefore effective referral pathways and information exchange should be in place between healthcare staff and other professionals, for example personal officers, ACCT co-ordinators, chaplaincy departments.

8. Specific screening tools for young people and women should be developed to meet the specific needs of those groups. These should be developed with input from service users.

9. Training in screening procedures should be mandatory for staff undertaking this role, including updates and refresher training. Training should also be available for discipline officers and staff from other agencies to ensure they are aware of the value of effective health screening for the prison as a whole, thus increasing the likelihood of their acceptance of the need to facilitate screening.

10. Appropriate clinical supervision procedures should be in place to provide support, reduce stress and burnout and improve confidence in decision making.

11. PCTs and HM Prison Service partners should, through prison partnership health boards, formalise a comprehensive plan to ensure that both first and second screens are appropriately accommodated, both physically and philosophically, and
valued within prison routines and regimes. Both parties should sign up to the plan which should contain review procedures and methods of rapidly resolving problems.

12. HM Prison Service should consider comprehensive health screening and access to appropriate healthcare services as core business and include health screening within their performance monitoring system as purposeful activity.

13. A revised PSO should be issued which requires full compliance with all aspects of the revised health screening procedures.
6 References


7 Appendices

7.1 Appendix 1: F2169A

a) MODIFIED FIRST RECEPTION HEALTH SCREEN TO BE USED IN ADULT MALE PRISONS

SURNAME ______________________ PRISON NUMBER _________

FIRST NAMES ____________________ DATE __________

DATE OF BIRTH _________

HOME ADDRESS ______________________

___________________________

POSTCODE ______________________

GP NAME ______________________

GP ADDRESS ______________________

CURRENT CHARGE ______________________

PRISONER STATUS: Remand ☐ until .................

Detainee ☐

Convicted - not sentenced ☐

Convicted - sentenced ☐ length .................

MEDICAL/PSYCHIATRIC REPORT REQUIRED No ☐ Yes ☐

HEALTH INFORMATION RECEIVED FROM OUTSIDE SOURCE No ☐ Yes ☐

If so, what and from who?

HAVE YOU BEEN HOMELESS IN THE LAST YEAR? No ☐ Yes ☐

HAVE YOU BEEN IN PRISON BEFORE? No ☐ Yes ☐

If yes, where and when were you last in?
7.1.1.1

7.1.1.2 IF CHARGED WITH HOMICIDE, REFER TO MENTAL HEALTH NURSE.

PHYSICAL HEALTH

1. IN THE LAST FEW MONTHS HAVE YOU SEEN A DOCTOR?  
   Yes □  No □
   If so, why?
   Do you have any outstanding hospital or doctor’s appointment?
   When?
   With whom?

2. ARE YOU RECEIVING ANY PRESCRIBED MEDICATION?  
   Yes □  No □
   What type of treatment?

3. HAVE YOU RECEIVED ANY PHYSICAL INJURIES OVER THE PAST FEW DAYS?  
   Yes □  No □
   If yes, when and what injuries, what treatment received?

4. DO YOU HAVE PROBLEMS WITH:
   ASTHMA  Yes □  No □
   DIABETES Yes □  No □
   EPILEPSY OR FITS Yes □  No □
   CHEST PAIN Yes □  No □
   TUBERCULOSIS Yes □  No □
   SICKLE CELL DISEASE Yes □  No □
   ALLERGIES Yes □  No □

5. DO YOU HAVE ANY (OTHER) CONCERNS ABOUT YOUR PHYSICAL HEALTH?  
   Yes □  No □

Record any health related observations about the prisoner’s physical appearance.  
IF NIL OF NOTE, PLEASE DOCUMENT.
IF “YES” RECORDED TO ANY OF QUESTIONS 2 - 5 REFER TO DOCTOR OR RELEVANT CLINIC.

SUBSTANCE USE

6. DO YOU DRINK ALCOHOL? No □ Yes □
   If yes, how much do you usually drink?
   In the week before coming into custody, how much were you drinking?

7. IN THE PAST MONTH HAVE YOU USED:
   None □

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DO YOU ANY OF THESE INTRAVENOUSLY? No □ Yes □

IF USING MORE THAN ONCE PER WEEK OR POSITIVE URINE TEST, REFER TO DOCTOR AND NURSE LED DRUGS SERVICE.

8. DO YOU USE ANY OTHER DRUGS? No □ Yes □
   If so, what and how much?

MENTAL HEALTH

9. HAVE YOU EVER SEEN A PSYCHIATRIST OUTSIDE PRISON? No □ Yes □
   If yes, what was the nature of the problem?

   Have you ever stayed in a psychiatric hospital?
   (Detail most recent discharge date and name of hospital/consultant)

   Do you have a psychiatric nurse or care worker in the community?
   Who, and where?

10. HAVE YOU EVER RECEIVED MEDICATION FOR ANY MENTAL HEALTH PROBLEMS? No □ Yes □
    (Answer yes if antidepressants or antipsychotics)
    If yes, when and what?

    If current, what dose?
11. **HAVE YOU EVER TRIED TO HARM YOURSELF?**
   - No
   - Yes (in prison)
   - Yes (outside prison)

   Refer to Mental Health Nurse
   Details of most serious and most recent

12. **FOR SOME PEOPLE COMING INTO PRISON CAN BE DIFFICULT, AND A FEW FIND IT SO HARD THAT THEY MAY CONSIDER HARMING THEMSELVES. DO YOU FEEL LIKE THAT?**

   - No
   - Yes

   *IF YES TO QUESTIONS 11 OR 12 CONSIDER OPENING A F2052SH.*

   RECORD YOUR IMPRESSION OF THE PRISONER’S BEHAVIOUR AND MENTAL STATE. (If nil of note, please document.)

   *IF YES TO QUESTIONS 9 - 11 REFER TO MENTAL HEALTH NURSE FOR PSYCHIATRIC ASSESSMENT*

I do not have any more specific questions. Is there anything you would like to ask me, or anything about your health that you think I should know?

*IF NO INDICATIONS FOR MEDICAL REFERRAL:*
DO YOU THINK THERE IS ANY REASON WHY YOU MIGHT NEED TO SEE A DOCTOR?

- No
- Yes
PLANNED ACTION

HEALTHCARE SERVICES INFORMATION LEAFLET GIVEN

NO IMMEDIATE ACTION REQUIRED

REFER TO DOCTOR (DR __________ )

PHYSICAL HEALTH

SUBSTANCE USE

REFER TO NURSE LED DRUGS SERVICE

REFER TO MENTAL HEALTH NURSE

OPEN F2052SH

OTHER REFERRAL ..........................

FIT FOR NORMAL LOCATION, WORK AND ANY CELL OCCUPANCY

YES

REFERRED TO DOCTOR

Health Care Worker ___________________________ Date __________

PRINT NAME ________________________________

________________________

Date __________
**b) MODIFIED FIRST RECEPTION HEALTH SCREEN TO BE USED IN FEMALE PRISONS**

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<td>Convicted - sentenced</td>
<td>length ...............</td>
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MEDICAL/PSYCHIATRIC REPORT REQUIRED  
No [ ] Yes [ ]

HEALTH INFORMATION RECEIVED FROM OUTSIDE SOURCE  
No [ ] Yes [ ]

If so, what and from who?  

HAVE YOU BEEN HOMELESS IN THE LAST YEAR?  
No [ ] Yes [ ]

HAVE YOU BEEN IN PRISON BEFORE?  
No [ ] Yes [ ]

If yes, where and when were you last in?
IF CHARGED WITH HOMICIDE, REFER TO MENTAL HEALTH NURSE

PHYSICAL HEALTH

1. IN THE LAST FEW MONTHS HAVE YOU SEEN A DOCTOR?
   No ☐ Yes ☐
   If so, why?

   Do you have any outstanding hospital or doctor’s appointment?
   When ?
   With whom?

2. ARE YOU RECEIVING ANY PRESCRIBED MEDICATION?
   No ☐ Yes ☐
   What type of treatment?

3. HAVE YOU RECEIVED ANY PHYSICAL INJURIES OVER THE PAST FEW DAYS?
   No ☐ Yes ☐
   If yes, when and what injuries, what treatment received?

4. DO YOU HAVE PROBLEMS WITH:
   ASTHMA No ☐ Yes ☐
   DIABETES No ☐ Yes ☐
   EPILEPSY OR FITS No ☐ Yes ☐
   CHEST PAIN No ☐ Yes ☐
   TUBERCULOSIS No ☐ Yes ☐
   SICKLE CELL DISEASE No ☐ Yes ☐
   ALLERGIES No ☐ Yes ☐

5. HAVE YOU ANY REASON TO BELIEVE THAT YOU MAY BE PREGNANT?
   No ☐ Yes ☐
   If yes, note details

   If reports 10 weeks + pregnant, contact local maternity unit and refer to midwife

6. WOULD YOU LIKE A PREGNANCY TEST?
   No ☐ Yes ☐
7. DO YOU HAVE ANY (OTHER) CONCERNS ABOUT YOUR PHYSICAL HEALTH?  
No □ Yes □

Record any health related observations about the prisoner’s physical appearance.  
IF NIL OF NOTE, PLEASE DOCUMENT.

8. DO YOU DRINK ALCOHOL?  
No □ Yes □  
If yes, how much do you usually drink?

In the week before coming into custody, how much were you drinking?

9. IN THE PAST MONTH HAVE YOU USED:  
None □

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DO YOU ANY OF THESE INTRAVENOUSLY?  
No □ Yes □

**IF USING MORE THAN ONCE PER WEEK OR POSITIVE URINE TEST, REFER TO DOCTOR AND NURSE LED DRUGS SERVICE.**

10. DO YOU USE ANY OTHER DRUGS?  
No □ Yes □  
If so, what and how much?
MENTAL HEALTH

11. HAVE YOU EVER SEEN A PSYCHIATRIST OUTSIDE PRISON?
   No ☐ Yes ☐
   
   If yes, what was the nature of the problem?

   Have you ever stayed in a psychiatric hospital?
   (Detail most recent discharge date and name of hospital/consultant)

   Do you have a psychiatric nurse or care worker in the community?
   Who, and where?

12. HAVE YOU EVER RECEIVED MEDICATION FOR ANY MENTAL HEALTH PROBLEMS?
    No ☐ Yes ☐
    (Answer yes if antidepressants or antipsychotics)

    If yes, when and what?

    If current, what dose?

13. HAVE YOU EVER TRIED TO HARM YOURSELF?
    No ☐ Yes (in prison) ☐ Yes (outside prison) ☐
    Refer to Mental Health Nurse
    Details of most serious and most recent

14. FOR SOME PEOPLE COMING INTO PRISON CAN BE DIFFICULT, AND A FEW FIND IT SO HARD
    THAT THEY MAY CONSIDER HARMING THEMSELVES. DO YOU FEEL LIKE THAT? No ☐ Yes ☐

    IF YES TO QUESTIONS 13 OR 14 CONSIDER OPENING A F2052SH.

    RECORD YOUR IMPRESSION OF THE PRISONER’S BEHAVIOUR AND MENTAL STATE. (If nil of note, please
document.)

    IF YES TO QUESTIONS 11 - 13 REFER TO MENTAL HEALTH NURSE FOR
    PSYCHIATRIC ASSESSMENT

I do not have any more specific questions. Is there anything you would like to ask me, or anything
about your health that you think I should know?

IF NO INDICATION FOR MEDICAL REFERRAL:
DO YOU THINK THERE IS ANY REASON WHY YOU MIGHT NEED TO SEE A DOCTOR?
   No ☐ Yes ☐
PLANNED ACTION

HEALTHCARE SERVICES INFORMATION LEAFLET GIVEN

NO IMMEDIATE ACTION REQUIRED

REFER TO DOCTOR (DR __________)

PHYSICAL HEALTH

SUBSTANCE USE

REFER TO NURSE LED DRUGS SERVICE

REFER TO MENTAL HEALTH NURSE

REFER TO MIDWIFE

OPEN F2052SH

OTHER REFERRAL ................................

FIT FOR NORMAL LOCATION, WORK AND ANY CELL OCCUPANCY

YES

REFERRED TO DOCTOR

Health Care Worker ___________________________ Date ___________

PRINT NAME ________________________________
1. **ESTABLISHMENT INFORMATION**

   * 1. Your name
   
   * 2. Your job title
   
   * 3. Establishment name
   
   * 4. Date
   
   * 5. For day to day health consultations, how are clinical notes generally recorded:
     - Nurse
     - Doctor
     - Both
     - Other (please specify)

   * 6. Please indicate which electronic records system is currently in use at your establishment:
     - EMIS
     - Other (please specify)

2. **RECEPTION HEALTH SCREENING**

   * 7. Since the current reception health screen (F2169) was introduced in your establishment, have any local modifications been made to it?
     - Yes
     - No

   * 8. Which staff predominantly carry out the reception health screen at reception? (Tick one box)
     - Qualified nursing staff
     - Non-acute qualified health care staff e.g. healthcare assistants, healthcare officers etc.
     - Both equally
     - Other (please specify)

   * 9. Do healthcare staff receive specific training on the administration of reception screening?
     - Yes
     - No

   * 10. At reception screening do staff routinely formally request consent from prisoners to obtain health information from external services? (Tick one box)
     - Yes – to safety radiation only
     - Yes – to request of information e.g. general clinical notes, mental health case plans, contacts with GP, CRF etc.
     - No

   * 11. Does reception screening allow for adequate privacy i.e. is it conducted on a one-to-one basis, in a private room, where the prisoner cannot be overheard?
     - Yes
     - No
     - Other (please specify)
17. Please use the space below to describe any problems you may have with the existing reception health screen and if possible, suggestions for improving screening processes e.g. lack of time, facilities, training etc.

3. FOLLOW UP HEALTH SCREEN

18. Following the initial health screening at reception, is a second "well man/woman" follow up health screen routinely undertaken?
   - [ ] Yes (please send follow up health screen) proceed to question 20
   - [X] No proceed to question 19

19. If answered no, why not? (Tick all that apply) THEN PROCEED TO QUESTION 25
   - [ ] No perceived need
   - [ ] Unavailability of staff
   - [ ] Time constraints
   - [ ] Other (please specify)

20. Which staff predominantly carry out the follow up health screen at your establishment? (Tick one box)
   - [ ] Qualified screening staff
   - [ ] Non-nursing qualified healthcare staff e.g. healthcare assistants, healthcare officers etc.
   - [ ] Lone workers
   - [ ] Other (please specify)

21. Do healthcare staff receive specific training on the administration of the follow up health screen?
   - [ ] Yes
   - [ ] No

22. If yes, do you have a written training policy/protocol?
   - [ ] Yes (please send the policy/protocol)
   - [ ] No

23. In January 2008 how many prisoners completed the follow up health screen at your establishment within one week of reception into prison?
   - [ ]
24. What do you feel are the most important health problems that should be included within the follow up reception screen? (Tick all that apply)

- Mental health problems
- Substance abuse
- Chronic disease e.g. diabetes, heart disease, chronic pain
- Sleep disorder
- Other (please specify)

* 25. Please use the space below to describe any problems you may have with the follow-up health screen and if possible, suggestions for improving screening processes e.g. lack of time, facilities, training etc.

* 26. Do you have written protocols for care pathways from reception for the following areas?

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<thead>
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<th>Area</th>
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8.2 Appendix 3: Interview topic guides

a) Staff

1. Introduction and greeting
   - explain interview format
   - remind of confidentiality arrangements

2. What do you think needs to be done at the initial reception screen?
   - What is the aim of your screen?
   - How long does it take?

3. How effective is the initial screening tool used within your establishment?
   - How does it cater for the needs of those received into custody?
   - Has it been modified? *If so, for what reasons*

4. What will help the reception screen process run more effectively

5. What are the challenges associated with the current reception screen process as it stands?

6. What do you think needs to be done at the second reception screen?

7. How effective is the second screening tool used within your establishment?

8. Overview
   - What works
   - What doesn’t work?
   - How can reception screening be improved?

9. We would like to get your opinion on an alternative model for the reception screening process (*describe model)*...
   - Do you think this could work in your establishment?
b) Prisoners

1. Introduction and greeting
   - explain interview format
   - remind of confidentiality arrangements

2. Did you get a reception screen?

3. How well do you remember you reception screen? *Could you describe what happened to me?*
   - Who did your reception screen with you (nurse, healthcare)?
   - Did they explain to you why they were doing the screen

4. Did you feel you were able to answer the questions asked in the reception screen? *If not, why not?*

5. Did they ask you about
   - Physical health?
   - Mental health?
   - Medication?

6. Did the questions cover all of your health needs?
   - Did they miss anything? *If so, what?*

7. What was the member of staff like that did the healthcare screen?

8. Did you feel comfortable sharing your health information with them during the screen?

9. What was the room like where the screen was done?
   - Was it private?

10. Did you get invited back for a second screen? *If so, what was that like?*

11. Recommendations for improvement
    - How do you think the process could have been improved?
8.3 Appendix 4: Participant information sheets

a) Staff

The University of Manchester

An evaluation of current procedures for reception health screening

Introduction

My name is ______I am a researcher working at the University of Manchester, Department of Psychiatry. At the moment we are working on a project to evaluate the current procedures for reception health screening.

Why is this study important?

Since the introduction of the first reception health screen it has undergone local modification in many establishments. These changes have been undertaken by healthcare teams in response to the perceived needs of the specific populations of each prison. However, there has been no central reporting of these changes, or any evidence of their effects upon improving the efficacy of the screen. We want to speak to you about your views of the efficacy and value of the current health screen.

What will I have to do if I take part?

If you agree to take part in the study, I will interview you about your experience of working with the reception health screening process, and how this could be improved. Questions will depend on your job role but may include some of the following; describe the process by which a prisoner receives the reception health screen, describe the process of referral following the initial screen for both physical and mental health problems? Have there been any delays? Since the reception health screen has been introduced in your establishment, have there been any modifications to the reception health screen? This will take around an hour of your time. I will ask to record the interview using a Dictaphone, and will ask for your permission to use anonymous direct quotes when we report the results.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part you do not have to give a reason and no pressure will be put on you to try and change your mind. You can change your mind about taking part at any time. If you decide not to take part, or withdraw at any stage, your professional role or prospects will not be affected.

If I agree to take part what happens to the information?

All the information you give us will be confidential and used for the purposes of this study only. The information will be used in a way that will not allow you to be identified individually.

What do I do now?

Think about the information on this sheet and ask me about anything that you are not sure about. If you agree to take part, we will go ahead.
b) Prisoners

The University of Manchester

An evaluation of current procedures for reception health screening

Introduction

My name is ____________, I am a researcher working at the University of Manchester, Department of Psychiatry. At the moment we are working on a project to look at how prisons identify health problems for people coming into prison, and what they do with that information.

Why is this study important?

When you first arrive at prison reception you are asked a series of questions about your health. These include questions about physical health (e.g. ‘have you seen a doctor in the last few months?’), substance use (e.g. ‘Have you used drugs in the past month?’), and mental health (e.g. ‘Have you ever received medication for a mental health problem?’). This information is recorded and is called the reception health screen. If you have any health needs these should then be assessed.

Some prisons ask different questions about prisoners’ health than others. We want to know what you think of the questions used in this prison. We hope this study will improve identification of health problems on reception to prison.

What will I have to do if I take part?

If you agree to take part in the study, you will be involved in an individual interview with me. During this interview I will ask you about the questions you were asked about your health when you came into prison, including ‘did you tell reception staff all your health problems?’, and ‘how did you feel about telling the reception staff this information?’. I will then ask how these things could be improved.

I will ask for your consent to tape the interview using a voice recorder, and will ask for your consent to use things you say during the interview in the final report your name or any identifiable information will not be used in the report. I will also ask for your consent to look at your prison medical records.

How long will this take?

This will take around 45 minutes of your time.

Do I have to take part?

No, taking part is voluntary; you do not have to do it. If you would prefer not to take part you do not have to give a reason and no pressure will be put on you to try and change your mind. You can change your mind about taking part at any time. If you decide not to take part, or withdraw at any stage, your legal and parole rights and your access to medical care will not be affected.
If I agree to take part what happens to the information?

All the information from the interview and from your medical records will be confidential and used for this study only. The information will be used in a way that will not allow you to be identified individually. The only exception to this is if, after the interview, we feel your health or safety, or that of others around you is at immediate risk because of something you have told us about how you are feeling. In that case, we will have to pass that information on to the prison healthcare staff, so that they can help you further.

What do I do now?

Think about the information on this sheet and ask me about anything that you are not sure about. You will have 3 days to decide if you want to take part. If you agree to take part, we will go ahead.

If I need to see someone about the research after I have taken part who can I contact?

If, after taking part in the research, you want further information or have any more questions about the study, tell your personal officer who will then contact me and I will come back to see you.

But if after taking part, you become upset and need help immediately to deal with your feelings without hurting yourself, it is very important that you talk to someone straight away.

Any member of staff in the prison will be able to help you; all you need to do is speak to someone.

Please do this as soon as you start feeling upset, it will help.
Offender Health Research Network
Offender Health Research Network
Jean McFarlane Building
University of Manchester
Oxford Road
Manchester
M13 9PL
Liverpool L31 1HW.

Website: www.ohrn.nhs.uk