Development and Delivery of Primary Care Psychological Services
HMP Liverpool
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Setting the Context

- HMP Liverpool (originally known as Walton Gaol) is a local prison for remand and sentenced adult males mainly from the Merseyside area.
- It is the fourth largest prison in England and Wales, capacity = 1400. It has 8 wings including the hospital wing.
- It was built in 1885 and was the site of 62 judicial executions from 1887-1964.

(Pictures by Paul Middlehurst)
The development of mental health services in HMP Liverpool

- 1996 Liverpool Criminal Justice Liaison Service (CJLS) start providing service for the prisoner’s with mental health problems they were picking up in court who were not being prescribed appropriate medication in prison. This was with the support of a high secure commissioner who was committed to the mental health of prisoners and aware of the high incidence of self inflicted deaths in custody. They were cited as an example of good practice in the Modernising CPA Document 2000.
- 2002 Dual Diagnosis team set up by the North West Prison office when the DDU was being redeveloped in prisons
- 2003 The In-reach Community Mental Health Team (CMHT) commenced work in the prison when the NHS became responsible for funding health care in prisons.
- 2005-2007 The Assessment, Care in Custody and Team work (ACCT) was introduced across the prison estate.
- 2006 A dedicated Crisis Intervention ‘Team’ was set up in the prison.
- The Weekly Single Point Referral Meeting had been established for a number of years
The Single Point Referral Meeting

• A weekly referral meeting
• Comprising: Regional Forensic Services, Prison Primary Care & inpatient services, Dual Diagnosis, Prison CMHT, Regional Criminal Justice Liaison services, Regional Learning Disability services.
• A flexible & fluid approach ensuring robust communication/information systems & outcomes.
‘Mild to Moderate’ Mental Health Problems in Offenders

• 45% of prisoners have neurotic disorders, 66% personality disorders, 45% drug dependency, 8% schizophrenia (Singleton et al 1997)

• 72% of male prisoners suffer from two or more common mental health problems, compared to 5% of the general population (Rickford & Edgar, 2005)

• Prison factors exacerbating or contributing to mental health problems include unresolved past life trauma such as physical abuse, sexual abuse, torture and PTSD (Durcan, 2008).

• It has been estimated that 7.6% of prisoners in HMP Liverpool have an IQ of below 70 and 23.6% have an IQ of 70-79 (Hayes et al, 2007)
Complexity of Prisoner needs

• 67% unemployed, 51% have housing problems and 48% have literacy skills below the level of an 11 year old (Social Exclusion Unit, 2002)

• On release 42% of prisoners have no fixed abode (Williamson, 2006) and 70% have no employment (Niven & Stewart, 2005)
Primary Care Psychological Services (PCPS)

• The purpose of the Prison Primary Care Psychological Service is to ensure that people in HMP Liverpool with mild-moderate mental health needs, are able to access the same type and quality of resources and effective intervention available to people in the community.

• PCPS employed a Stepped Care model of service provision which aimed to offer the least intensive intervention at the initial stage of seeking help, with the option of ‘stepping up’ as individual need requires. Also offered a stratified model when appropriate (Pre-IAPT).
Stepped Care model - Levels of service

**Step ONE**
Watchful waiting, advice-giving

**Step TWO**
Guided self-help, psycho-education
Range of brief, focused interventions (6-8 sessions)

**Step THREE**
Counselling or cognitive-behavioural therapy groups

**Step FOUR**
Longer-term psychological therapies, CAT, CBT etc.

**Step FIVE**
Secondary care liaison with in-reach mental health service

**Multiple sources of referral, e.g.**
Admission Assessment Healthcare staff, Secondary screening, POs on wings, Primary Care staff (practice nurses), CMHT in-reach, CJS, Probation, Dual diagnosis nurses, DDU, CARAT, Forensic, Chaplaincy, Crisis nurse, Self referral
On Remand

• Commenced post in January 2007
• Had office with no phone or pc connection (no contact with outside world)
• Little knowledge of how the prison operated
Sentenced

- First two months meeting staff in prison, sharing stepped care model and requesting feedback.
- Getting to know the prison system.
- Appointed first Graduate Worker.
• Continued Recruitment, Senior Counsellor and CBT therapist
• Worked with high profile prisoner
• Strong presence on wings (given two offices on wings by prison)
• Opening of new Healthcare Building
• Operational July 2007
• Commenced Scoping Exercise
Measuring Outcome

• Clinical Outcome in Routine Evaluation – Outcome Measure (CORE-OM) and other measures when appropriate (around 66% completed). The CORE-OM was chosen as it is a well established standardised measure with proven reliability and widely used in mental health services across the NHS (Barkham et al, 2001, NICE, 2005). It also provides a global measure of psychological distress rather than being problem specific and therefore relevant to all service users.

• Client Satisfaction Forms (around 1/3-1/2 returned)

• 17.5% do not complete therapy but only 6.1% drop out. Others have been transferred or released.
Recovery Rate

• Recovery Rate = Completed Cases = 93.9%

• Recovery Rate = Caseness (CORE-OM)
  2008 N=66 Pre intervention mean = 1.83 (clinical), Post intervention mean = 1.12 (non-clinical)
  2012 N=321 Pre intervention mean = 1.95 (clinical), post intervention mean = 1.17 (non-clinical)
Client Satisfaction

• **Primary Care Graduate Mental Health Worker**
  “I would like to say cheers for helping me, and you have made me think my life is worth something.”
  “I think that M should get a pay rise cause I’m a difficult person to work with”

• **Senior Counsellor**
  “I’d like to say my Counsellor was very good and I felt comfortable with him, he helped me when I needed it badly”
  “keep doing what you do, sometimes people just need to talk”

• **Cognitive Behaviour Psychotherapist**
  “It helped me to stop and think before acting, more listening to others and trying to talk more rather than just loosing my temper”
  “understanding & showing me goals to go for, great stuff”

• **Clinical Psychologist (CAT)**
  “I was listened to so well…it was nothing short of brilliant for me personally”
  “K has helped me to understand why people hurt me and explained how to go about it the right way instead of hurting people”.
Strengths of Service

• Use self reported psychological distress as criteria to be seen. Therefore the only inclusion criteria is that prisoners are able to engage in time limited psychological interventions.
• Offer a choice of psychological interventions
• Provide Step 4 interventions. Will see prisoners with trauma, anger and those who meet criteria for Personality Disorder
• Will conduct cognitive assessments in order to adapt interventions to meet the needs of those with Learning Difficulties and/or literacy problems
• Biggest referral source are self referrals
• Work systemically with prison, attend prison meetings e.g. safer custody, violence reduction, equality and diversity, service users etc.
Barriers to Service

Prison operational issues i.e call ups etc

• Limited time to see prisoners
• Difficulty obtaining outcome measures when prisoners transferred, released without warning
• Limited rooms to see prisoners on wings
• Implications re confidentiality and privacy when seeing prisoners on wings
• The impact of prison environment on the wellbeing of prisoners
Service Evaluation

- Scoping Exercise analysed data for first 6 months of service provision and in 2008 to determine the range of the needs of prisoners with mild to moderate mental health problems and tailor services according to the information obtained e.g. low level of BME clients accessing service

- Report on the review of mental health services in HMP Liverpool (Durcan 2008) stated that ‘HMP Liverpool’s PCPS is a unique development and one that should be replicated elsewhere in English and Welsh prison estates’. The service was cited as an example of good practice in the Sainsbury Centre Document ‘From the inside: Experiences of prison mental health care’.

- Evaluation of Service by University of Liverpool (2010) concluded that there was evidence of positive benefits to prisoners from the service, evaluated in terms of psychometric change and that positive feedback from participants and staff, and qualitative data indicate that PCPS is perceived as making a valuable contribution to service provision in the prison setting

- NAPT 2011 placed in top 25% of services nationally for clients reporting a positive therapeutic relationship/helping alliance with their therapist, a high level of satisfaction with the service and a good recovery rate
Themes in prison

- Clinical Psychological Services vs Forensic Psychology Services
- Anger as gateway for male psychological distress
- Working with type one and type two trauma
- Role of advocate
- Managing confidentiality and risk in a prison environment and working with NOMS
Future Developments

• Developing a Stepped Care Model of delivery of mental health services incorporating both primary and secondary mental health services
• Have just commenced weekly Enhanced Case Management meetings (joint between prison and mental health services)
• Looking at ways of improving continuity of care in the community in areas that do not provide step four interventions i.e. possible outreach work
• Continue to work with prisoners with ADHD offering psychological support alongside medication.
• Continue to develop role of Mental Health Liaison Officers
• Continue to develop LD pathway in the prison