A National Evaluation of Prison Mental Health In-Reach Services

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Executive Summary

Introduction

Recent policy developments have focussed on implementing fundamental changes in prison based mental healthcare including:

- Tailoring services to more accurately reflect clinical need;
- Improving early identification of prisoners with mental health problems;
- Broadening therapeutic approaches to reflect clinical developments in the wider NHS; and
- The development of a specific programme of work, prison mental health in-reach, to primarily benefit prisoners with severe and enduring mental illness (SMI) through improved care both in prison and upon discharge.

This report describes a study evaluating prison mental health in-reach, comprising three inter-linked, yet discrete, elements.

1. A national survey of prison in-reach teams

Module 1 consisted of a national survey of in-reach team leaders, concentrating on considerations of team size and professional composition; team functioning; barriers to successful operation; and relationships with the wider NHS.

2. Case studies of in-reach teams

Module 2 consisted of detailed case studies of the operation of in-reach services in eight prisons.

3. Longitudinal cohort study of prison in-reach services

Module 3 identified a cohort of prisoners received into custody with SMI and tracked their progress in prison, examining whether they were assessed and/or taken onto the caseloads of in-reach services.

In addition, a “snapshot” view was taken of the caseloads of the in-reach teams at each of the study sites, to establish the diagnostic breakdown of their clientele.
Findings

Module 1

Responses were received from 53 out of 73 in-reach team leaders (73%).

Resources

- There was a 20% increase in the size of in-reach teams between 2004 and 2007, however 85% of team leaders stated that teams were not sufficiently well staffed to meet the needs of prisoners;
- Referrals to in-reach teams increased by 57% and caseload size by 32% between 2004 and 2007; and
- More than half of team leaders stated that recruitment to teams was problematic.

In-reach clients

- Over two-thirds of service users on in-reach caseloads had committed either violent offences against the person (32%) or robbery, theft or burglary (35%);
- Thirty-two percent of service users had a SMI; 26% had a dual diagnosis of SMI and either personality disorder (PD) or substance misuse; and 16% had PD alone; and
- Black/Black-British people and Asian/Asian-British people were over-represented on caseloads.

The modus operandi of prison in-reach teams

- Since the survey by Brooker et al. in 2004, the overall number of in-reach teams has increased. Previously, they were mainly found in local prisons but are now also found in category B and open/training prisons;
- There has been a move to integrate in-reach with Primary Healthcare provision (PHC). Integration with PHC was more likely to have been successful in open/training prisons and young offender institutions rather than high security and local prisons;
- The majority of referrals to in-reach teams come from PHC;
- There has been a doubling of referrals by prison officers over the last three years – this may be partly due to the programme of mental health awareness training rolled out by the Care Services Improvement Partnership (CSIP);
- Team leaders indicated that triage by PHC was poor due to lack of resources and a lack of expertise;
• Triage by PHC was rated as especially poor in high security, category B establishments and local prisons;
• Most clinical activity focused on assessment and liaison/support. There was very little face-to-face intervention undertaken by in-reach teams. In addition, skills in face-to-face intervention were cited as the greatest training need;
• Only 27% of in-reach clients were on the enhanced level of the Care Programme Approach (CPA). Team leaders described significant barriers to the implementation of CPA, for example prisoners not having an address upon release; problems liaising with external agencies; geographical distance between the prison and planned area of release; the bureaucracy in the prison system itself; and difficulties with information technology;
• In-reach teams reported highly variable approaches to involvement with HM Prison Service suicide/self-harm management Assessment, Care in Custody and Teamwork procedures (ACCT). Some in-reach team members were ACCT assessors, a specific role within the management system, and others trained ACCT teams in mental health issues. Other teams believed that involvement with ACCT confused the ‘health’ and ‘security’ agenda;
• External liaison with Community Mental Health Teams, general practitioners and Social Services departments was reported as problematic. Many team leaders felt that certain categories of prisoner were viewed less sympathetically, especially those with PD.

The in-reach concept

• All team leaders thought that in-reach was an excellent idea but that it was poorly resourced and had been generally poorly implemented.

Module 2

Members of the in-reach teams interviewed indicated that their over-riding philosophy was to extend to prisoners the same quality of mental healthcare they would receive in the community.

Several respondents noted that their role had moved beyond involvement with those with SMI to encompass assessment and intervention of those who self-harmed, those with PD and additionally those with primary mental health needs. Other roles included consultancy to other staff, giving advice and information, linking prison and NHS services and providing clinical leadership and training.

Teams reported the impact of historical, organisational and physical factors upon the everyday delivery of care. Specifically there were both opportunities and problems associated with being part of a new team entering an institutional setting with well established procedures, relationships and cultural norms.
Successful capitalisation on the opportunity to challenge unhelpful barriers to mental health service delivery appeared to require clarity of function; the active development of relationships with other stakeholders; and a degree of professional self-confidence. Active management of relationships with other stakeholders was reported repeatedly as an important role for in-reach team members. Good working relationships appeared to be both a function of the length of tenure of teams, and the reported quality of leadership of those teams. Wide networks of relationships were often described as necessary for effective working, both within and outside the prison setting.

Most of the discussion in the interviews about the functions of the in-reach teams related to the processing of referrals. There was clear divergence between teams regarding the extent to which they felt they should be involved in the assessment and management of individuals who self-harmed, or had PD. One team had embraced this activity but, perhaps as a result, the members of that team reported feeling overloaded by conflicting clinical demands.

While prison healthcare and discipline staff had less to say about the aims, roles and process of in-reach services, they could clearly identify the effects of those services. Some described very dramatic improvements in the quality of mental healthcare and in the overall atmosphere within the prison.

More than one prison healthcare team member commented that the arrival of the in-reach service had led to a reduction in the stigma associated with mental illness and several respondents saw the external, independent position of the in-reach team as helpful. Improved continuity of care for prisoners on discharge was also mentioned.

Finally, the declared aims of introducing some clinical leadership and providing training in mental health issues to prison staff seems to have been met in at least some of the prisons studied.

**Module 3**

*Prevalence of SMI in the prison population*

Population prevalence rates of SMI were calculated. The analysis showed that:

- SMI was estimated to be present in 23% of the prison population, with major depression in 19% and psychosis in 4%;
- Substance misuse (drug or alcohol) problems were present in 66% of the prison population; and
- Dual diagnosis (SMI and co-existing substance misuse problem) was present in 18% of the prison population.

Overall, 71% of the prison population had a current SMI, substance misuse problem or both.
Intervention by prison mental health in-reach services

The findings of this study indicated that the vast majority of prisoners with SMI were not identified or treated by prison mental health in-reach services.

Results showed:

- Twenty-five percent of prisoners with a current SMI were assessed by in-reach services; and
- Thirteen percent of prisoners with a current SMI were accepted onto in-reach caseloads.

Furthermore:

- Prisoners with psychosis were significantly more likely to be assessed and/or accepted onto in-reach caseloads than prisoners with major depressive disorder.
- Prisoners with SMI who had prior contact with mental health services were significantly more likely to be assessed and/or accepted onto in-reach caseloads than those that had no prior contact.

Prevalence of SMI amongst prisoners receiving in-reach services

- SMI was estimated to be present in 40% of the in-reach client caseload. Twenty-two percent had a current diagnosis of psychosis and twenty percent had major depressive disorder.
- Sixty percent of prisoners on the in-reach caseload did not have a current SMI.

Of the 60% of in-reach clients with no current SMI:

- Forty-two percent had PD; 32% had a mental illness (MI) and 42% had neither.
- In-reach clients with no current diagnosis of SMI, PD or MI (42%) exhibited high rates of prior contact with mental health services (ever) (93%) and substance misuse (69%) prior to custody.
Recommendations

This report provides evidence for the following recommendations to inform the commissioning of mental health services in prisons.

1. The mental health of prisoners should be seen as an issue of concern for the whole prison, forming part of the prison’s safer custody agenda, rather than only the responsibility of specialist groups within the prison.

2. PCTs commissioning prison based mental health services need to act fully on the basis of ‘equivalence’ in their commissioning decisions for mentally ill prisoners to ensure that the treatment and care received is of the same range and quality as services provided for people with mental health problems outside prison. In addition to considerations of the range and quality of prison based services, increased prevalence rates of all types of mental health problems in prison populations requires that specific attention is given to ensuring that mental health services are adequately resourced, so as to meet clinical need.

3. In-reach teams need to agree locally clear criteria for whom they assess and treat, with discretionary powers to broaden these criteria and accept ‘exceptions’ when appropriate, whilst ensuring that the main priority groups are properly provided for. These criteria should be clearly communicated to primary care staff, prison officers and the prison’s senior management team.

4. Primary care mental health services require development and investment to ensure that prisoners with common mental health problems receive appropriate, skilled and timely care.

5. Primary care practitioners should receive specialised training about suicide risk and the detection of mental disorder, specifically in distinguishing SMI from common mental disorder.

6. Robust training about mental health problems for primary care staff and prison officers is crucial to enable the development of efficient services. Such training would enable staff to feel manage people appropriately at primary care level and refer those who need specialist attention. Training should focus on:
   a. suicide risk and behaviour;
   b. detection of mental disorder;
   c. education on PD; and
   d. reducing stigmatisation of people with mental illness.

7. Drug and alcohol issues are a major problem among the prison population and dual diagnosis (mental illness/health problems and
substance misuse problem) is common. Mental health and substance misuse services in prisons need to provide appropriate, flexible care to those dually diagnosed, rather than using dual diagnosis as a reason for exclusion from services. Dual diagnosis should be regarded as the norm, rather than the exception.

8. PD is very common in prison populations. This study identified that there were a significant number of prisoners with a sole diagnosis of PD who were under the care of in-reach teams. The skills required to successfully manage PD are very different from those required to manage SMI. In the wider NHS, PD-specific services exist. Specialist services for PD in prison would be a valuable contribution to prison mental health services.

9. Future research on the mental health of prisoners should consider:

   a. Identifying the needs of prisoners with learning disabilities, adjustment disorders and Post Traumatic Stress Disorder; and
   b. Identifying the needs of the most severely ill prisoners who lack the capacity to consent to taking part in the research process, and who thus are not represented.
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1 Introduction, literature and policy review and research programme outline

1.1 Introduction

The mental and physical health of prisoners and the development of equitable services in comparison with the community has featured in research literature and policy reviews over the past two decades. The development of in-reach services for prisoners with mental health problems has been an important aspect of this and, in view of its extensive ‘roll-out’ across England and Wales, the Department of Health commissioned this programme of evaluative research. This chapter begins by presenting this work in its policy and service context before outlining the different parts of the research programme.

1.2 Literature and policy review

The prevalence of mental disorder amongst prisoners is high and considerably higher than in the general population (Gunn et al. 1991; Davidson et al. 1995; Singleton et al. 1998; Earthrowl et al. 2003; DH, 2001). Historically, mental healthcare in prisons has been criticised for being inadequate and not tailored to clinical need. This review will consider the prevalence of mental disorder in the prison population and outline the development of prison based mental health services, including the introduction of mental health in-reach teams, setting it within the context of policy initiatives.

1.3 Prevalence of mental disorder in prison

It is commonly argued that the high prevalence of mental disorder among prisoners is a relatively new and increasingly pressing problem which emerged with the closure of long-stay psychiatric hospitals and the introduction of “care in the community” policies. However, Seddon (2007) pointed out that the presence of people with mental disorders in prison is not new, but has been of concern for several centuries. For example, in 1784, penal reformer John Howard commented upon the high number of mentally ill people in prison:
"....many of the bridewells are crowded and offensive, because the rooms which were designed for prisoners are occupied by lunatics...No care is taken of them, although it is probable that by medicines, and proper regime, some of them might be restored to their senses and some usefulness in life..."

(cited in Reed, 2003)

In a large scale study conducted for the Office for National Statistics (ONS) in 1997, Singleton et al. (1998) found that over ninety percent of prisoners had one or more of the five psychiatric disorders studied (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence), with remand prisoners having higher rates of mental disorder than sentenced prisoners. More than half (59%) of male remand and 40% of male sentenced prisoners had a neurotic disorder, with the corresponding figures for women being 76% and 63%. Rates of psychosis varied between 7% in the male sentenced population and 14% in female prisoners; and 78% of male remand prisoners and 50% of female prisoners had a personality disorder. Levels of substance misuse were also high, with 51% of male remand, 43% of male sentenced, 41% of female sentenced and 54% of female remand prisoners being drug dependent in the year before reception into prison. Over half the men in the sample screened positive for hazardous drinking in the year before coming into prison, with the figure for female prisoners being 38% (Singleton et al. 1998). This and other studies of psychiatric morbidity in prisons in England and Wales have shown that comorbidity is the norm (Gunn et al. 1991; Maden et al. 1995; Birmingham et al. 1996; Singleton et al. 1998; Birmingham, 2001). Between 12-15% of sentenced prisoners in the ONS study had four or five psychiatric disorders (Singleton et al. 1998), and many prisoners present with complex psychiatric treatment needs (Birmingham, 2001), which are often confounded by issues of dual diagnosis.

The high prevalence of mental disorder in prisons is not confined to the UK. In a large-scale systematic review of serious mental disorder in 23,000 prisoners in western countries, Fazel & Danesh (2002) found that about one in seven prisoners had either a psychotic illness or major depression with approximately half of male prisoners and a fifth of female prisoners positive for anti-social personality disorder.

Prison populations also have high levels of suicidal and deliberate self-harming behaviours, and prisoners are at far greater risk of suicide than the general population. In the ONS study, around 24% of men and 40% of women prisoners had attempted suicide at some time in their lives. Twelve percent of male remand and 23% of female remand prisoners reported having experienced suicidal thoughts in the week before interview (rates for sentenced prisoners were considerably lower); these figures rose to 35% and 50% respectively when measured over the past year (Singleton et al. 1998).

Women prisoners tend to suffer from higher rates of mental disorder than men, possibly because of their greater use of substances (Ramsay et al. 2005; Borrill et al. 2003) and the higher levels of physical and sexual abuse that they have experienced (Corston, 2007). Women are also thought to be more vulnerable to
the ‘pains of imprisonment’ (Sykes, 1958), and are likely affected more by separation from, and concerns about, their children (Royal College of Psychiatrists, 2007).

The prevalence of psychiatric disorder is highest among young offenders and juveniles, with 95% suffering from a mental disorder, substance misuse or both (Singleton et al. 1998). Similarly, older prisoners have been found to have high levels of mental health need; Fazel et al. (2001) found that although evidence suggests that prison mental healthcare tends to be targeted toward the younger, more vocal population (HMCIP, 2004) the prevalence of depressive illness amongst older prisoners was five times greater than that of either younger adult prisoners or elderly people in the community.

Prisoners have markedly higher rates of mental illness compared to the general population. Surveys in the community have found that between 3% and 7% of men, and 1% of women suffer from a personality disorder in comparison to over three quarters of male and half of women prisoners (Singleton et al. 1998). Similarly, neurotic disorders are between three and five times more common among prisoners, as only 12% of males and 20% of females in the community suffer from any neurotic disorder (Singleton et al. 1998; Marshall et al. 2000).

Approximately 0.4% of the general population could be diagnosed with functional psychosis (Meltzer et al. 1995), compared to 7-14% of the prison population (Singleton et al. 1998). One study hypothesised that the high incidence of psychosis in prison was due to sampling issues and ascertainment differences (Brugha et al. 2005). However, when random samples of prisoners and the general population were assessed using the semi-structured interview Schedule for Clinical Assessment in Neuropsychiatry (SCAN), results confirmed that the prevalence of psychosis in prisons is substantially higher than in the community. The research demonstrated that the clinical symptom profile of psychosis was identical in both settings. The authors suggest that further research is required in order to better understand these pervasive differences (ibid).

1.4 Prison mental health risk factors

The prison environment with rules and regimes governing all aspects of daily life can be seriously detrimental to mental health (Birmingham, 2003; Nurse et al. 2003). Prisons are stigmatising and demoralising and house distressed, often-aggressive individuals in close proximity, removing all possible avenues of flight. Overcrowding, dirty and depressing environments, poor food, inadequate medical care, aggression, and lack of purposeful activity have all been described by the World Health Organisation (WHO, 1998) as factors which can have a debilitating effect on mental health, and can worsen depression and anxiety (c.f. Birmingham, 2003; Smith, 2000). Long periods of isolation with little mental
stimulation may lead to feelings of anger, frustration and anxiety (Nurse et al. 2003), and the effects of poor prison conditions can be exacerbated by staff shortages as prisoners are locked in their cells for longer periods of time. This may lead to a ‘circle of stress’ (ibid), where prisoners release their frustration on staff, causing staff stress and absence through illness resulting in further regime limitations.

The prison environment and regime can be contributing factors to the high rates of self-harm and suicide in prison. Liebling (1992; 1999) and Liebling & Krarup (1993) identified three distinct groups of prisoners who are vulnerable to suicide; life sentence prisoners (estimated to make up 20% of all suicides); the psychiatrically ill (around 22% of suicides); and ‘poor copers’ (around 45% of suicides). The latter group tend to be younger and have difficulties coping with various aspects of prison life, such as isolation from family and friends, fear of other prisoners, boredom and a lack of constructive activity. Liebling (1992) found that these prisoners were less likely to have contact with the outside world, including visits, were more likely to spend most of their time locked up in their cells and to have problems with other prisoners, but were less likely to be able to generate a solution to their predicament, leaving them vulnerable to self-destructive behaviour. Such coping difficulties may be exacerbated by withdrawal from substances that prisoners previously relied upon to help them cope with their problems (Mills, 2005), or they may use illicit substances to relieve boredom and isolation (Nurse et al. 2003). In combination with a pre-existing mental illness, this can further damage their mental state, leaving the prisoner more vulnerable (Birmingham, 2004). It has therefore been argued that in order to promote positive mental health, any improvements to prison healthcare provision need to be incorporated into wider prison policy to help facilitate more integrated, healthier living conditions in prison (Hughes, 2000; Smith, 2000) as, whilst wider prison conditions and regimes go unchanged, any localised benefits from improved healthcare services may be lost.

1.5 Prison based mental health services

Ideally

“A period in prison should present an opportunity to detect, diagnose and treat mental illness in a population often hard to engage with NHS services. This could bring major benefits not only to patients but to the wider community by ensuring continuity of care and reducing the risk of re-offending on release.”

(Reed & Lyne, 2000)

However, research has shown that much mental health need goes undetected and untreated in prison. Upon reception into prison an assessment of physical and mental healthcare needs, substance misuse problems and the risk of self-harm,
undertaken by a suitably trained healthcare worker, is a statutory requirement in England and Wales (HMPS, 2004). Nevertheless, the effectiveness of this health screening has been questioned, with concerns expressed about time constraints preventing comprehensive assessment, particularly in busy local prisons; issues surrounding compromised confidentiality; and the lack of training for prison healthcare staff (Birmingham et al. 1996; 1998; 2000; Reed & Lyne, 1997; HMPS/NHS Executive, 1999). Additionally, prisoners may be wary of admitting health difficulties for fear of discrimination, stigmatisation or being forced to accept treatment (Birmingham, 2003; 2004).

Previous research has shown that screening practices routinely pick up only 25-33% of prisoners with serious mental illness and, similarly, the extent of substance misuse problems is underestimated by approximately a third (Birmingham et al. 1996; Brooker et al. 2002; Mason et al. 1997). The failure to detect mental health problems on reception means that the opportunity to treat these individuals, who often do not engage effectively with services in the community, or are regarded as unpopular ‘hard to like’ patients, may be lost or seriously delayed with further negative consequences (Birmingham, 2001).

Even where mental health needs are detected, they may still go untreated. Singleton et al. (1998) found that approximately one in seven prisoners were refused help such as medication, counselling and consultations with psychiatric staff. Only between 15% and 30% of prisoners had received any help, with the most frequently cited source being the prison doctor, followed by a psychiatrist. Prisoners with psychosis or significant neurotic symptoms, women, and those who classed themselves as ‘white’ were more likely to receive treatment (Singleton et al. 1998).

It is estimated that, at any one time, up to 500 remand or sentenced prisoners are sufficiently ill as to require transfer to NHS mental healthcare (Reed, 2003). Transfers can be delayed due to shortage of beds; disputes over the necessary level of security; the identification and availability of funding; dual diagnosis issues; and arguments centring on the perceived ‘treatability’ of an offender-patient (BMA, 2001; Mills, 2005; Gunn et al. 1991; Reed, 2003). Prisoners awaiting transfer to hospital, or those with serious mental illness but not deemed eligible for detention under mental health legislation, are often accommodated in prison healthcare centres, where they make up approximately three-quarters of admissions (Reed & Lyne, 1997). However, prison healthcare centres have been criticised for providing impoverished regimes with inadequate levels of intervention, a lack of constructive activities or even that most basic requirement of prison needs, time out of cell (Reed & Lyne, 1997; HMCIP, 2004).

Providing decent, suitable and effective mental health services to prisoners can be very difficult for a number of different reasons. Prisons are not designed as places in which to deliver care, or to comprehensively deal with the needs of mentally disordered offenders (Birmingham, 2002; 2003). Prisons provide an essentially ‘anti-therapeutic’ environment whereby the dominant discourse is one of discipline and control (Sim, 1994; Hughes, 2000). This can pose a major barrier to effective healthcare and may conflict with notions of care and
treatment, making it impossible for a healthcare ethos to thrive, or for individuals with health needs to be seen as patients and individuals rather than as prisoners (Watson et al. 2004; Norman & Parrish, 1999; HMCIP, 1996). Furthermore, it can lead to ethical dilemmas for healthcare professionals who may find it difficult to distinguish between their professional role as carer and their situational role as custodian, creating conflicts between the need for an ordered prison regime and providing best care for prisoner-patients often deemed ‘less eligible’ and deserving of a lower standard of care than that received by non-offenders (Sim, 2002; Burrows, 1995).

1.6 Service and policy developments

Historically, HM Prison Service, through the existence of the Prison Medical Service (PMS), latterly renamed the Prison Health Service, was responsible for the provision of the majority of healthcare services for prisoners. Almost all services were provided “in-house”, ranging from primary care for everyday physical complaints through to in-patient care for those with severe mental health problems. Staff, including doctors, prison healthcare officers, and qualified nursing staff were directly employed by HM Prison Service. The development of multi-disciplinary care in prisons lagged behind such initiatives in the NHS; at a time when much mental healthcare in the wider community was being delivered by multi-disciplinary community mental health teams, most care in prisons was dependent on input from visiting forensic psychiatrists with little contribution from wider clinical disciplines (HAC, 1997; Birmingham, 2003).

The most recent debate about standards of healthcare in prisons, and possible solutions to the perceived problems, can be usefully traced back to a discussion paper entitled Patient or Prisoner?, prepared by the then Chief Inspector of Prisons, Sir David Ramsbotham (HMCIP, 1996). The over-arching recommendation of the document was that the NHS should assume overall, national, responsibility for the delivery of healthcare in prisons. It was suggested that this be done through the introduction of a purchaser/provider relationship with the Prison Service, with local NHS Trusts charged with ensuring that adequate provision for prison healthcare was made when allocating resources. The driving ideal behind the paper’s recommendations was the concept of equivalence, whereby it was acknowledged that:

"prisoners are entitled to the same level of healthcare as that provided in society at large. Those who are sick, addicted, mentally ill or disabled should be treated... to the same standards demanded within the National Health Service”

(HMCIP, 1996)

The report criticised the then current provision of prison healthcare services on a number of points, for example, a lack of suitable training for medical and nursing
staff; isolation from new clinical developments; inadequate care for the mentally disordered; a lack of continuity of care between prison and community; and a lack of consideration of the care needs of specific groups e.g. women and young people. Although providing unsatisfactory standards, prison healthcare was also noted as being more than twice as expensive, per person, than that provided by the NHS for the wider community.

To address the issues raised by Patient or Prisoner?, a joint Prison Service and NHS Executive working group was established to develop practical proposals for change that would deliver equivalent care for prisoners whilst considering wider prison and NHS agendas and the views of key stakeholders. The resulting report, The Future Organisation of Prison Health Care, conceded that prison healthcare services varied considerably in terms of organisation, delivery, quality, effectiveness and links with the NHS (HMPS/NHS Executive, 1999). The report acknowledged that an extensive programme of change was required, but rejected calls that responsibility for all prison healthcare be assumed solely by the NHS on the grounds that healthcare staff working in prisons might become marginalised due to management and cultural differences, and that neither the NHS nor the Prison Service could provide healthcare for prisoners without the expertise or cooperation of the other. It therefore recommended partnership working, whereby the two organisations were to be jointly responsible for identifying the health needs of prisoners in their area, and thereafter the planning and commissioning of appropriate services.

Following the publication of The Future Organisation of Prison Healthcare which addressed all aspects of prison based healthcare, a specific strategy for mental health, Changing the Outlook, was published in 2001 (DH/HMPS, 2001). It reaffirmed that the then current approach to healthcare delivery did not meet prisoners’ needs and was ineffective and inflexible. The strategy acknowledged that most prisoners with mental health problems were not so ill as to require detention under mental health legislation and that, if they were not in prison, they would be receiving treatment in the community rather than as in-patients.

The strategy suggested a move away from the historically held assumption that prisoners with mental health problems should be located in prison healthcare centres. It concluded that supporting prisoners with mental health problems to remain on ‘normal’ prison wings required the establishment of multi-disciplinary mental health in-reach teams, funded by local Primary Care Trusts (PCTs), providing specialist mental health services to patients in the same way as Community Mental Health Teams (CMHTs) do for patients in the community. Although it was anticipated that all prisoners would eventually benefit from the introduction of such “in-reach” services, the early focus of the teams’ work would be on those with severe and enduring mental illness (SMI), utilising the principles of the Care Programme Approach (CPA) to help ensure continuity of care between prison and community upon release from custody.
1.7 Implementing the prison in-reach programme and the care programme approach (CPA)

Research examining the operation and effectiveness of in-reach teams has thus far been limited, but has indicated that the implementation of the in-reach programme has been challenging. A report by HM Inspectorate of Prisons in 2007 provided a thematic review of the care and support of prisoners with mental health needs, coming more than ten years after the publication of Patient or Prisoner? concluded:

"when mental-health in-reach teams rode to the rescue of embattled prison staff they found a scale of need which they had neither foreseen nor planned for"

(HMIP, 2007)

The initial aim of recruiting 300 extra staff to put in place the new services has been fulfilled, with over 350 mental health in-reach workers now providing services to people with severe mental illness in 102 prisons (ibid). However, in 2007, the average team size was only three members of staff (Steel et al. 2007), although the prison population, and therefore potentially the level of mental health need, had increased rapidly since initial staffing levels were planned. At the time of the publication of Changing the Outlook, the prison population was approximately 66,300; in 2006 it was over 80,000, with projections for 2007-2013 being 80,420 to 106,550 (Home Office, 2003; De Silva et al. 2006).

The original intention for in-reach services to target those with SMI has changed; national policy has been broadened to include all those in prison with any mental disorder and in some prisons, providing services which focus on prisoners with personality disorders (Brooker et al. 2005; DH, 2003). Other models of care now established in the community, for example Assertive Outreach and Crisis Resolution Teams, have not yet been introduced into prisons and, in order to provide equivalence, the development of such services should be considered by commissioners and providers. Birmingham (2003) warned that, although mental health services in prisons are starting to improve, some targets, such as after-care on release for everyone with a mental illness, are unlikely to be achieved, particularly when the vast majority of mental health need in prison continues to go unrecognised.

It has also been suggested that, to date, in-reach services have developed using limited and idiosyncratic models of care (Steel et al. 2007). Official guidance on the development and operation of in-reach services has deliberately been non-prescriptive. Whilst this supports efforts to develop services specifically designed to suit local circumstance, innovative commissioning by PCTs may be necessary to sustain the initial momentum to deliver care of an equivalent standard nationwide (ibid).
Mental health staff face multiple challenges in attempting to replicate a functional community service in a prison setting. These include difficulties around identifying SMI, particularly where in-reach teams are reliant on prison staff to refer potential patients to them. Meiklejohn et al. (2004) found that, at one local prison, the in-reach team were often referred prisoners who did not have SMI, but instead presented with complex psychosocial problems. Such prisoners were more able to communicate their problems to prison staff or presented with disciplinary issues that drew attention to them, while their counterparts with SMI more frequently kept a lower profile and remained overlooked. Similarly, Armitage et al. (2003) reported misconceptions within prisons about what in-reach teams are “supposed to do”, stressing that, although they can provide support and expertise for staff dealing with problematic behaviour, they are not a panacea for the problem of difficult prisoners (cf. Telfer, 2000). Changing the Outlook recognised a need for mental health awareness training for prison officers to enable them to identify signs of serious mental illness; however training is not mandatory and it is unclear what proportion of officers have received such training to date.

Difficulties implementing CPA in custody have also been identified, particularly in relation to the expectation that in-reach practitioners liaise with CMHTs in the community to provide a seamless, supporting, service for mentally ill prisoners upon release (Telfer, 2000; Lee, 2003; Meiklejohn et al. 2004). In-reach teams have faced difficulties getting CMHTs to engage with patients who are about to be released, particularly where there are limited community resources, highlighting a need for greater resources for generalist community mental health teams, community forensic teams and assertive outreach services (Meiklejohn et al. 2004). Furthermore, concerns have been raised about how best to liaise with prisoner-patients’ carers as part of the CPA process. It may be impractical or near impossible to involve outside carers such as family members in care planning within the prison setting; it is also unclear to what degree prison discipline staff act as de facto carers instead, and whether mental health staff are likely to be comfortable sharing potential sensitive information with them. Pyszora & Telfer (2003) stressed the advantages of introducing the CPA into prison, stating that it provided a framework through which to identify a prisoner’s health and social needs; facilitated the integration of care and sentence planning; provided a forum for information sharing between agencies; and informed risk assessment. Yet the fluidity of the prison population and problems regarding information sharing and confidentiality may make effective implementation and co-ordination of the CPA problematic, and it remains to be seen whether it will bring the anticipated benefits.
1.8 Measures of improvements in prison healthcare to date

Final transfer of the commissioning responsibility for healthcare in public prisons to Primary Care Trusts in England was completed in April 2006. This transfer meant that, in line with all other services, it was fully the responsibility of PCTs to ensure that prison based NHS services were safe, equitable and effective. Similarly, Strategic Health Authorities now had an official role in monitoring standards and prison health services came within the remit of the Health Care Commission, latterly replaced by the Care Quality Commission.

As noted above, prison based healthcare services have historically provided care of an inferior standard to that available to the wider community. In an attempt to evidence ongoing improvements in services, the department of Offender Health within the DH developed a system of prison healthcare ‘star ratings’ in 2005. However, this system was soon felt to focus on merely measuring healthcare in terms of activity, rather than offering a meaningful measure of quality improvement, thus was of limited value.

It was therefore deemed necessary to develop a more robust, quality based system that would, over time, allow a clear picture of the successes and challenges of healthcare delivery improvement within prisons to develop. This would enable each establishment to judge its own relative performance both locally and nationally would provide NHS and Prison Service managers and health partnership boards standardised information useful to both focus their activity and action service improvement.

In late 2006, a working group was established to develop a set of key performance indicators for prison based healthcare services. The group ratified a set of 31 separate indicators to be measured on a ‘traffic light’ system of green, amber and red to indicate completeness of compliance to an accepted definition for each indicator of ‘what good should look like’. The indicator areas covered safety; clinical and cost effectiveness; governance issues; accessible and responsive care; public health; and, of direct relevance to the current research, mental health.

Each indicator was comprehensively mapped to existing key NHS, HM Prison Service and HM Chief Inspectorate of Prisons policies, standards and orders and the user guide and process documents for the first annual data collection exercise were issued regionally in September 2007. Regional prison healthcare leads were asked to co-ordinate validation of data and collate responses; additionally, prior to analysis, returns were to be ‘signed off’ by the local Strategic Health Authority. Returns were received from all public sector prisons in England, and all but two private sector establishments. Data were analysed centrally, following which national and regional reports were circulated to key stakeholders in August 2008 (DH, 2008).
The resultant report acknowledges the limitations of the findings, highlighting both the current voluntary nature of participation and the variance allowed in the required evidence supporting achievement against the indicators, both issues to be addressed in future data collection exercises. However, with those accepted caveats, the data provide an interesting picture of how prison based healthcare services have developed over recent years, highlighting areas where establishments and partner PCTs appear to have made improvements and areas where further work is indicated.

Overall, few prisons reported as ‘red’ in terms of indicators relating to patient safety and safe medication management issues. In terms of indicators around clinical and cost effectiveness, routinely around 80% of establishments reported full (green) or partial (amber) compliance to standards including personal development plans for staff; chronic disease management; and continuity of care, including upon prison transfer. Lowest compliance in this category centred around the issue of discharge planning for patients with chronic diseases, with around one quarter of establishments reporting a ‘red’ indicator, indicating that less than 75% of patients suffering from a chronic disease received a discharge plan and primary care advice containing direct reference to their condition, indicating an ongoing challenge for prisons in effecting communication with external health services.

In terms of governance issues, over 90% of prisons reported full or partial compliance with clinical and corporate governance requirements; around 80% reported achieving full or partial compliance with standards around information governance, often a thorny issue in partnerships between different organisational structures. The most problematic governance indicator concerned workforce planning, with around a third of establishments reporting that joint workforce plans were not yet in place, again a vital component to the development and sustenance of healthy inter-organisational partnerships and shared goals.

Results from indicators around accessible and responsive care were mixed. Around 70-75% of establishments reported full compliance with the requirements of good practice around the conduct of general health assessments and completion of secondary health screens, both vital for the timely and accurate identification of health problems. In terms of services for particular groups, around 60% of establishments for young prisoners reported complete compliance with the requirement for age appropriate service provision; in contrast, this was only around 35% for prisons required to provide specific services for older adults, indicating an ongoing service need for this rapidly growing group of prisoners. For all age groups, around a quarter of establishments indicated marked problems with being able to provide comprehensive services; however the ongoing programme of local health needs assessments should positively facilitate the development of more responsive and appropriate ranges of services in future, better meeting local need. Particular issues were apparent around the provision of substance misuse services, especially in establishments where Integrated Drug Treatment Services (IDTS) were not present or only partially funded; the report notes that, due to ongoing developments in the overall IDTS work programme, such services will be evaluated separately in future years.
In terms of public health indicators, very few prisons reported significant issues round ensuring prisoners had access to adequate exercise, perhaps unsurprising given the traditional importance gym activities have in prisons. In contrast, around two thirds of prisons report poor or limited compliance to the indicator around health promotion action groups, prison and local community partnerships specifically addressing issues including mental health promotion, smoking cessation, healthy eating, healthy lifestyles and substance misuse. This may indicate health promotion issues currently being of secondary precedence whilst prisons continue to consolidate primary and specialist services which have, until recently, been very under-developed. There are local examples of good health promotion initiatives across the prison estate including the development of schemes whereby prisoners are supported in becoming peer health trainers and wider publicity around such developments would be useful.

With regards to the mental healthcare indicators, around 90% of prisons reported that at least three quarters of service users with SMI were subject to the CPA, which indicates that prison in-reach teams have worked hard to overcome the problems in implementing CPA identified above, and that they have emphasised the importance of putting into place a framework through which contact with community based services can be facilitated. Similar rates of compliance with Section 117 statutory after-care requirements were reported, indicating that prisoners now routinely return from detention under the Mental Health Act in outside hospitals with accompanying after-care programmes, again indicative of improved liaison between prison based and external service providers.

Highest adherence levels are noted in terms of suicide and self-harm management whereby nearly eight out of ten prisons indicated that all prisoners subject to Assessment, Care in Custody and Teamwork procedures (ACCT) deemed to require a health assessment or intervention were seen within 24 hours, and almost all the remaining prisons reported that this happened in at least 75% of cases. Compliance to operational standards within the ACCT process is part of a formally established audit and monitoring procedure which, in this case, appears to have contributed directly to achieving high levels of compliance. This indicates the value of strict audit procedures and monitoring where possible, which may be usefully extended to other areas of healthcare delivery.

More problematic for mental health providers were issues around both primary care and specialist mental health services, further examination of which will feature in later discussions of the current research. Less than four in ten of all prisons reported complete compliance to either the primary care or specialist services performance indicator. In terms of primary care, full compliance involved the existence of a primary mental healthcare service which triaged referrals to secondary services and offered a range of therapeutic interventions at primary care level, including appropriate services for young people and older adults. Around 20% of establishments reported the lowest level of compliance to this standard.
With regard to the provision of specialist mental health services, full compliance involved access, on a needs led basis, to a comprehensive range of specialist services, including dual diagnosis, personality disorder, early intervention for psychosis, gender and age specific services, learning disability and psychotherapeutic interventions. Around a quarter of all establishments reported the lowest level of compliance to this standard.

Thus, overall, results from the first national prison health indicators performance monitoring exercise indicate some apparent improvements in services as well as some areas for future emphasis. As routine service provision improves and becomes embedded, indicators on items such as health promotion and other proactive aspects of healthcare provision should hopefully improve. The high rates of compliance to strictly audited standards, illustrated above in terms of observance to prescribed ACCT requirements, warrants further attention in terms of its possible contribution to improvements in other areas of healthcare.

Mental health services appear to have made substantial efforts to implement the CPA whilst people with SMI are in prison, and the importance of ongoing care through the use of Section 117 after-care provisions has been recognised. However, it is apparent that much more work is required in terms of developing robust primary care mental health services. Similarly, there is a pressing need to extend specialist mental health provision from the current generic community mental health team in-reach model to embrace the much more comprehensive range of mental health services now available in the community, if the goal of equivalence of prison and community services is to be sustained.

1.9 The future of healthcare within prisons

This report is produced at a time of potential change. On 27th November 2007, Offender Health at the DH, in conjunction with the Ministry of Justice, Home Office, Youth Justice Board and Department for Children, Schools and Families launched a consultation entitled Improving Health, Supporting Justice, alongside that for the National Offender Management Service Strategic Plan for Reducing Re-offending 2008-11.

The recent publication of Lord Bradley’s review of people with mental health problems in the CJS and the new DH offender health strategy, Improving Health, Supporting Justice, have emphasised the need for further improvements in offender healthcare. It is clear from Lord Bradley's independent review and the accompany national delivery plan that the transformation required to respond adequately to the level of population need cannot be achieved by one organisation alone; rather, improving prison based healthcare will require a more joined up provision of services, with effective multi-agency working across the NHS and CJS. Indeed, the Government have since established a health and
criminal justice national programme board, placing a greater emphasis upon improving joined-up service development and delivery in the future.

1.10 Summary of literature

Prisons house populations with higher rates of mental illness, substance misuse and personality disorder than are found in the wider community; however, they have been historically ill equipped to provide effective care.

Recent policy developments have focussed on implementing fundamental changes in prison based healthcare services including tailoring services so as to more accurately meet need; improving the identification of prisoners with mental health problems; broadening therapeutic approaches to reflect clinical developments in the wider NHS; and developing a specific programme of work, prison mental health in-reach, to primarily benefit prisoners with SMI through improved care both in prison and upon discharge.

The chequered history of healthcare provision in prisons is likely to mean that the introduction of mental health in-reach services to prisons is apt to be a complex work programme, requiring the ongoing active engagement of both the NHS and HM Prison Service, in terms of forging effective relationships between health service commissioners and providers, prison management, and organisations representing various staff groups. This situation may well be impacted upon by current consultations regarding improvements in health and social services for the people in contact with all parts of the criminal justice system.
1.11 The prison in-reach evaluation research programme

The research programme was designed to address both the clinical impact of mental health in-reach in prisons and also the experiences of staff working within the in-reach model in terms of its introduction, development and challenges. The evaluation comprised three inter-linked, yet discrete, elements, referred to as 'modules'.

1. A national survey of prison in-reach teams

Module 1 consisted of a national survey of in-reach teams in 2007. The survey aimed to capture a variety of data relating to workforce matters, including team size and professional composition; team functioning, including funding sources, connections with primary mental healthcare services and operational remits; the role of in-reach, including information about size and clinical composition of caseload, therapies and interventions provided, barriers to successful operation; and the relationship with the wider NHS during a prisoner's time in custody and upon release, including considerations of transfer and discharge planning.

2. Case studies of in-reach teams in operation in eight prisons

Module 2 involved detailed case studies of the operation of in-reach services in eight prisons of varying types. Over an agreed period, in-reach team leaders were asked to keep diaries, recording key events. Additionally, individual interviews and focus groups with key informants were conducted, to augment researchers’ understanding of the context, operational opportunities and barriers experienced by those providing or hosting prison based mental healthcare.

3. Longitudinal cohort study of prison in-reach services

Module 3 evaluated in-reach services in six prisons, examining their efficacy against the stated aim of prison mental health in-reach, that of the provision of
assessment, care and discharge planning for all prisoners with SMI (DH/HMPS, 2001). A cohort of prisoners received into custody with SMI was identified and their progress in prison was tracked, with an examination of whether they were assessed and/or taken onto the caseloads of in-reach services. In addition, a “snapshot” view was taken of the caseloads of the in-reach teams in each of the study sites, to determine the clinical profiles of the clients, again to see if this was reflective of an emphasis on caring for those with SMI.

The report presents the findings of each Module in turn and then discusses the implications of the whole programme.
2 MODULE 1

2.1 Aims

To conduct a survey of in-reach teams nationally:

1. To establish the structure and function of the in-reach teams; and

2. To explore facilitators and barriers to successful working.

2.2 Method

The profile of participants and the recruitment strategy

A list of all in-reach team leaders and their contact details was compiled from Care Services Improvement Partnership (CSIP) regional offices.

The survey was distributed by email, improving the speed of dissemination and ensuring safe delivery to the participants. The participants were given three options for completing the questionnaires: to return the questionnaire by post; to complete it electronically and return by email; or to undertake a telephone interview. Most in-reach team leaders opted for a telephone interview.

2.2.1 Questionnaire design and data collection

The questionnaire was developed after extensive consultation with experts in the field of prison mental health, the Department of Health, five in-reach team-leaders from the Eastern Region, and the study steering group.
2.2.2 Pilot study

The questionnaire was piloted in the Eastern CSIP region. It was emailed to all in-reach team leaders in the region, along with an introductory letter detailing the background to the project and options for completion (see Appendix 1). “Non-responders” were reminded via email and telephone. This strategy proved successful and was therefore used for the main study.

2.2.3 Questionnaire content

- Workforce: team profile and composition, recruitment and retention issues, past and proposed changes to the team composition.

- The role of the in-reach team: number of referrals, caseload size, diagnostic breakdown, therapies and interventions provided, the role of in-reach in self-harm and suicide prevention, education and training provided by the in-reach team to prison staff, barriers to the successful operation of the in-reach team.

- The functioning of the team: operational policies, the funding of the team, relationship with prison primary healthcare.

- Relationship with NHS during the prisoner’s sentence and at release: Acute transfers, information exchange and discharge planning with primary care and Community Mental Health Teams (CMHTs).

2.2.4 Ethical issues and consent forms

Advice sought from local NHS Trust Research and Development office and from the National NHS Ethics Service classified Module 1 as service evaluation. It was thus exempt from the need to obtain formal ethical review and research governance approval. Participants, however, gave their full consent and were informed in an introductory letter of the option to withdraw from the study at any point.
2.2.5 Data entry

The data collected from the questionnaire was double-entered into SPSS 14.0 (SPSS Inc, 2005), and the errors in data entry were identified using Epi-Info software (CDC, 2008). The errors were corrected, thus producing a valid data set for analysis.

2.2.6 Data analysis

Descriptive analysis was initially performed on the data to formulate the framework for future inferential analysis. The distribution of the data was assessed by the One-Sample Kolmogorov-Smirnov test. We subsequently used Wilcoxon signed-rank tests, Mann Whitney tests, Kruskall Wallis tests and Chi-Square tests.
2.3 Results

The survey identified 73 in-reach teams. Team leaders from 53 teams (73%) participated in the study. There was considerable variation across CSIP regions in participation rates. Whilst three regions (Eastern, East Midlands and South West) had return rates of 100%, London and North East were 43% and 53% respectively.

The majority of the 53 teams served more than one prison. The largest number of prisons covered by a team operated across nine prisons.

2.3.1 The in-reach workforce

2.3.1.1 In-reach teams

There was wide variation in the number of staff per team, with the smallest team having only one member and the largest 14 (Figure 1). However, most of the teams had between three and six members, with a median of five.

Figure 1: Number of clinical staff per team
Figure 2 shows that the largest professional group were nurses. Most team leaders reported vacancies across all professional groups.

**Figure 2: Composition of the in-reach team by discipline in 2007**

Compared with a similar survey in 2004 (Brooker et al. 2005) the size of the teams had increased from an average of 4-5 whole time equivalent (wte) staff over the three years (Figure 3). In particular, the number of nursing posts had increased but there has been a fall in the proportion of other professional groups in teams over that period.

**Figure 3: Clinical in-reach staff in post comparing 2004 and 2007**
2.3.1.2  **Small and large teams**

For the purposes of analysis a ‘small’ team was defined as one with four team members or less, a ‘large’ team as one with five or more team members. Just under half of the teams had four members or less.

Compared with other prison types, high secure prisons had proportionally more large teams. Not surprisingly, teams operating in more than one prison were more likely to be large (Figure 4). There was no other significant association between team size and prison type.

![Figure 4: Differences in team size by prison type](image)

2.3.1.3  **Recruitment to in-reach teams**

Seventy percent of the team leaders claimed they had at least one unfilled post in the last year. Forty-six percent of these teams had two or more posts unfilled and 14% had three or more. Large teams had more vacancies than small teams (p=0.04); 83% of leaders of large teams had one or more vacancies. Sixty-five percent of under-recruited teams had nursing vacancies and 16% had not been able to recruit a team leader. Recruitment difficulties had not improved significantly since 2004 (Brooker *et al.* 2005).

The most common difficulties that in-reach team leaders had in recruitment were financial constraints around employing new staff; ignorance about the role of in-reach; preconceptions held about working in a prison; and poor quality of
applicants. The following quotes from staff in the telephone interviews highlighted these difficulties.

"[There is] general ignorance within the NHS of what actually in-reach service is about. A lot of people fear working in prisons because it feels unsafe—which to be quite honest is exactly the opposite. It is more dangerous to work in acute wards.”

"Not everyone wants to work in a prison setting, not a mass of interest in the post. Some of it reflected in uncertainty about PCT roles”

"Current CPN vacancy has been very difficult to recruit into, we advertised twice and failed to recruit second time around. I don't anticipate it being easy to recruit for [name of prison]. When we interviewed for CPN they were just not appointable. For community services easy but different kinds of people apply to prisons…”

2.3.1.4 The retention of prison in-reach staff

Thirty-five percent of team leaders stated that they had problems retaining staff. A variety of reasons were given for this problem including the challenging nature of the job and the perception that prison work was unrewarding. According to the team leaders, retention and recruitment difficulties often went hand in hand with 25% of teams experiencing both.

2.3.2 The profile of service users on in-reach caseloads

Overall, there were approximately 4,700 clients on in-reach caseloads in England at the time of the survey. This estimate was obtained by multiplying the mean number of patients on in-reach caseloads from the survey respondents (n=53) with the overall number of in-reach teams identified at the time of the survey (n=73). According to the Home Office there are over 80,000 prisoners held at any point in English prisons. Therefore, the in-reach teams were in contact with approximately seven percent of the prison population.

Around three-quarters of the in-reach service users were White (74%) with 12% Black/Black-British and six percent Asian/Asian-British. The proportion of Black/Black-British in-reach service users was significantly higher in high secure prisons, open/training prisons and Young Offender Institutions (YOI) than in other prisons (χ=146.6, p=0.01; Table 1, Figure 5). Black and Minority Ethnic groups were over-represented on in-reach team caseloads compared to the proportion in the general prison population (HMPS, 2008).
Table 1: Ethnicity of prisoners on in-reach caseloads

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of service users in in-reach teams</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>White</td>
<td>74</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>12</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>6</td>
</tr>
<tr>
<td>Mixed-White and Black</td>
<td>2</td>
</tr>
<tr>
<td>Mixed-White and Asian</td>
<td>1</td>
</tr>
<tr>
<td>Mixed-Black and Asian</td>
<td>0.1</td>
</tr>
<tr>
<td>Other ethnic background</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 5: Ethnicity by prison type

Nearly half of all in-reach patients had committed violent crimes (either sexual offences or violence against the person); a further quarter had committed robbery, burglary or theft (Table 2).
Table 2: Offences committed by in-reach team service users

<table>
<thead>
<tr>
<th>Offences</th>
<th>Number of service users in England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Violence against person</td>
<td>32</td>
</tr>
<tr>
<td>Sex offences</td>
<td>13</td>
</tr>
<tr>
<td>Robbery</td>
<td>11</td>
</tr>
<tr>
<td>Burglary</td>
<td>11</td>
</tr>
<tr>
<td>Theft</td>
<td>4</td>
</tr>
<tr>
<td>Fraud and forgery</td>
<td>1</td>
</tr>
<tr>
<td>Criminal damage</td>
<td>4</td>
</tr>
<tr>
<td>Drug offences</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Around a third of patients (32%) had severe and enduring mental illness (SMI) and just over a quarter had SMI and a co-existing personality disorder (PD) (9%) or SMI and a co-existing substance misuse problem (17%). Twenty-eight percent had PD alone (16%) or PD and substance misuse (12%) (Table 3).

Table 3: Mental illness in service users under the care of in-reach

<table>
<thead>
<tr>
<th>Mental illness</th>
<th>Number of service users in England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
</tr>
<tr>
<td>SMI</td>
<td>32</td>
</tr>
<tr>
<td>PD</td>
<td>16</td>
</tr>
<tr>
<td>SMI and PD</td>
<td>9</td>
</tr>
<tr>
<td>SMI and substance abuse</td>
<td>17</td>
</tr>
<tr>
<td>PD and substance abuse</td>
<td>12</td>
</tr>
<tr>
<td>Other form of dual diagnosis</td>
<td>3</td>
</tr>
<tr>
<td>No primary diagnosis</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 6 examined the relationship between diagnosis and prison type. Mental illness (MI) as a sole diagnosis was most common in male local prisons, with dual diagnosis (MI and substance misuse) being most prevalent in high secure establishments and in prisoners cared for by teams working to multiple prisons.
2.3.3 Aspects of team functioning

2.3.3.1 Changes in operational policy since the establishment of the team

Forty-four percent of team leaders reported that either their operational policy had changed since the team’s foundation or that it was in the process of changing. These changes were driven by the need to provide joined-up mental healthcare in prisons, particularly in relation to closer working relationships with primary mental health teams.

The quotes below from team leaders highlighted how teams’ remits had expanded from providing care for those with SMI only.

“...prioritise SMI, do accept those requiring short-term support as well...”

“...mental health issues, even someone with adjustment problems, we do health promotion and crisis intervention...”

It is also noticeable comparing data from 2004 and 2007 there has been a marked decrease in teams having specific referral exclusion criteria (Table 4). This further suggests that teams had broadened their roles.
Table 4: Aspects of prison in-reach teams operational policies

<table>
<thead>
<tr>
<th>The team has:</th>
<th>2004</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (%)</td>
<td>Yes (%)</td>
</tr>
<tr>
<td>An operational policy</td>
<td>87</td>
<td>96</td>
</tr>
<tr>
<td>Criteria to accept a referral for initial assessment</td>
<td>81</td>
<td>59</td>
</tr>
<tr>
<td>Criteria to accept a referral onto caseload</td>
<td>74</td>
<td>72</td>
</tr>
<tr>
<td>Specific exclusion criteria</td>
<td>52</td>
<td>38</td>
</tr>
</tbody>
</table>

2.3.3.2  The extent of integration with prison primary healthcare

The team leaders were asked to rate, on a scale of 1 to 10, the extent of integration of their teams with prison primary healthcare (PHC). The mean rating for integration with PHC was 6.28 (where 0 = no integration and 10 = full integration). There was no significant relationship observed between team size or type of prison.

The analysis of the quotes made by team leaders at interview revealed that there were three different ways of working with primary care:

Separate teams

"The clinical work in the 2 prisons is very different but we (us and PHC) maintain a separate work-base by choice. The team is not based in the prison and that is good – resources in the prisons are diabolical we couldn’t do our job if we were in prison. There are issues of control within prison. PHC wouldn’t like it if we took over their cases."

Joint management

"All of the outpatient clinics are jointly managed by primary care nurses and in-reach nurses, a large percentage of referrals are made by primary care."

Merged with PHC

"We are based in the same day care centre, we share advice and support, PCT system has established SystmOne¹ (for recording) all healthcare screenings, consultations so we also make comments and entries there and we collaborate on all cases."

¹ SystmOne is an electronic clinical records system.
Overall, 67% of team leaders said that triage by prison primary care was inadequate. This was more likely to be the case in high secure, category B and local prisons, although the difference between prison types was not statistically significant (Figure 7).

**Figure 7: The quality of triage undertaken by prison primary care by prison type**

![Graph showing the quality of triage by prison type]

2.3.3.3 **Reasons for inadequate triage**

Three major reasons for inadequate triage by primary healthcare were identified by in-reach team leaders, including a lack of staff in primary care (78% of respondents), inadequate funding of primary care mental health (64%) and inadequate systems of primary care mental healthcare and expertise (64%). Two-thirds of team leaders stated that, at reception, primary care staff assessed all prisoners on psychotropic medication, those with a history of mental health contact at reception and those with a history of self-harm. The illustrative quotations below, however, demonstrate that there were problems with subsequent referrals and care pathways. The main problems were that in-reach received referrals which they felt should have been dealt with by primary care and, secondly, that people with SMI were not referred to in-reach directly from reception.

“...Regarding the triage of cases by primary care, it is inadequate, [we get] a lot of inappropriate referrals-lack of competence. Sometimes we get them months after reception with serious mental health problems...only if the illness is absolutely apparent will it find the way to in-reach services. It would be great if in-reach could sit at reception but no capacity.”
"[The reception screening is] good enough but sometimes we get persons who self-harmed when they were 8 or had ADHD when they were 7 or 8 [and they are] referred as a precautionary measure..."

"I think it's not [appropriate] but GP would say differently. But we have a lot of people that we pick up accidentally and they've never been referred although they have a psychiatric history. Primary care acknowledges the problem but they don't refer them. They do assess them in a sense that they tick the boxes but no in-depth analysis [takes place]..."

2.3.3.4 **Sources of referrals to the in-reach team**

Over half of referrals came from primary healthcare (57%), followed by prison officers on the wings (17%) (Figure 8). The number of referrals from prison officers has doubled in the last three years (Figure 9). All remaining sources of referral remained constant between 2004 and 2007.

**Figure 8: Sources of referral to in-reach teams in 2007**

Other less common sources of referral included hospitals/CMHTs, Counselling, Assessment, Referral and Through-care services (CARATs), chaplaincy, other mental health in-reach teams, Dangerous and Severe Personality Disorder Units,
Parole Boards, Independent Monitoring Boards, clinical records and following assessment by the Probation Service Offender Assessment System.

**Figure 9: Mean number of referrals in 2004 and 2007 by source**

![Figure 9: Mean number of referrals in 2004 and 2007 by source](image)

2.3.3.5 **Number of referrals and caseload size**

Figure 10 shows that the number of referrals increased between 2004 and 2007. In 2004, less than 25% of the teams received over 50 referrals in a four-week period; in 2007 this figure had increased to 75%. Additionally in 2004, the mean number of annual referrals per team member was 51, compared to 2007 where the reported figure was 89, an increase of 57%. Although referral volume increased by 57% between 2004 and 2007, in-reach team size has only increased by 20%, from four wte to five wte clinical staff.
Mean caseload size did not differ significantly by type of prison. There was no statistically significant difference between the number of referrals to small and large teams ($Z=1.62$, $p=.10$), or the number of clients taken on to the caseload after the initial assessment ($Z=1.4$, $p=.16$). In this context, it is therefore not surprising that 87% of leaders of small teams and 78% of leaders of large teams considered their teams insufficiently staffed to meet the needs of prisoners.

Below is a sample of illustrative comments made by the team leaders of *small* teams:

"The team is not big enough, PHC is under-structured and the comprehensive needs of clients are not properly evaluated. First problem is lack of in-reach staff, second problem is lack of my own capacity to supervise both healthcare and in-reach and the third problem is lack of tools to assess patients”

“We are acting only as a crisis team due to the volume of referrals and ongoing work”

“I am doing the best I can but everything is missing!”

Team leaders of large teams appear to define their dissatisfaction in different terms:

“[The team is] sufficient to meet assessment and treatment [needs]. However, extended services such as day activities, psychological therapies cannot be met.”

“Specialists are missing; you can argue that sometimes we are sufficient, and sometimes not…”
"We are enough for mental health problems defined in the medical model but not enough to meet emotional needs as defined in the psychosocial model..."

2.3.3.6  **Therapies and interventions**

Figure 11 shows estimates provided by team leaders of the number of interventions offered by teams on a weekly basis. On average, an in-reach team offered 36 sessions weekly. Liaison and support was the most prominent activity with almost 12 weekly sessions, followed by needs assessment, ongoing assessment and discharge planning. Very little time was spent on interventions, which consisted of mainly individual cognitive behaviour therapy (CBT) or anxiety management sessions.

![Figure 11: Interventions offered by in-reach team over an average week](image)

2.3.3.7  **The management of patients on the Care Programme Approach (CPA)**

One of the core functions of in-reach teams is to manage people with SMI under the Care Programme Approach (CPA) and to transfer care to community services with a devised plan for continuation of care after release from prison. Team leaders reported that 27% of prisoners on their caseloads were on standard and
45% on enhanced CPA. There were no significant differences in these proportions by either team size or prison type.

Whilst most team leaders acknowledged that their role included managing patients on CPA and liaison with community services upon release, a minority stated that the implementation of CPA was not their role.

"The reason why we don't know the exact number of patients on CPA is because PHC works with that or CMHT does—for the patients who previously had contact with them. We also do not devise CPA care-plans for those on release, we just connect them to the CMHT."

"I don't put patients on CPA, whether they come in with it I wouldn't know”

Team leaders acknowledged that there were significant barriers to the successful execution of CPA care planning on release including:

• Prisoners being of no fixed abode or of unknown release address;

"No fixed abode, not knowing exactly where the person is released to or when, and sometimes we don't until the last minute. If someone’s moved quickly from one area to another then we don’t know who picked up the care plan and if they did at all.”

• Liaising with external services (CMHTS, probation, social services);

"Lack of local knowledge, of what might be available in particular area-community teams are not very helpful. Then, social fragmentation of resettlement agencies and lack of any kind of forum in which agencies can work together and discuss patients. Also local teams don't attend CPA meetings."

"Probation restrictions sometimes act against sentence and care planning, they can override their [the prisoners’] mental health needs, also service not always available to meet the needs”.

"Not being able to have a CPA meeting with people from outside before the release.”

"Sometimes they are not willing to take on 'difficult' people.”

• Geographic position of CMHTs;

"Distance to go to CMHTs if [they are] outside the region. Complicated for us and complicated for the service users”

"Finding the right care coordinator in the community [is] a problem with women's prisons because there are few CMHTs and they need to travel further.”

"Distance is a problem, if CMHT is far away…”
Bureaucratic arrangements in the prison system;

"You know they [the prisoners] are going to be discharged in a month, and you prepare everything [CPA documentation] and then they get transferred to another prison! Or they get added days—you look at the schedule and you see a day of release you have an outpatient appointment and you have to cancel it as they have to stay more days. It’s matter of question whether you’ll get another one [the appointment] any time soon.”

“Changes in release days, for example: someone was supposed to be released on a Tuesday and we arranged for the service to take the prisoner on, only to find out that he would actually be released on the Friday before and it created a lot of problems.”

Difficulties with IT;

“IT communication, we are not able to execute responsibilities because we cannot retrieve data or access CPA documentation. Also poor internet access, the prison not permitting contractors to access internet via our own system in NHS.”

Team leaders indicated that there were further difficulties encountered in the smooth discharge of service users not under the CPA including:

Not meeting the criteria for acceptance onto CMHTS caseload and the issue of dual diagnosis and personality disorder;

"...Getting external teams to take responsibility, especially for a brand new person. There is a big stigma issue around dual diagnosis and personality disorder...”

"...CMHT might not take on someone with a personality disorder and forensic history, if they don’t reach criteria for crisis teams, no-one will take them on-too many specialist teams around!”

"...Massive problems, a big debate on who is an appropriate team [for a certain patient]... [CMHTs are] disagreeing with our diagnosis-.“

Women prisoners;

"Not all mental health services will accept that women require their input. Conflict over diagnosis and need.”

No appropriate agency for 16-18 year olds;

"Lack of appropriate referral agencies for 16-18 years and lack of appropriately trained clinicians.

In-reach activity not recognised as valid;
“Some CMHTs will not recognise in-reach CPA process and insist all referrals are sent via intake Service”

“They [the CMHT] refuse to acknowledge the diagnosis, unless already diagnosed before, and they refuse to accept a possible change in diagnosis...”

- The service user is not registered with a general practitioner;

We asked team leaders which types of patient are most likely to be rejected by CMHTs and they collectively agreed difficulties placing those with:

- Personality disorder and dual diagnosis;
- Mild to moderate mental health problems which did not meet the criteria for any specialist team;
- Unclear diagnosis;
- Prisoners with no fixed abode and foreign nationals;
- High-risk offender groups, and the issue of “forensic” patients;

“High risk groups such as sex offenders, violent individuals, substance misuse”

"History of serious violence, dual diagnosis, PD”

“Some CMHTs are reluctant to take prisoners onto their caseloads as they believe these individuals are “forensic” clients and insist on a formal risk assessment from local Forensic Services...”

- Offenders in age group 16-18;

"We [the YOIs] don’t fit anywhere really; no service deals specifically with mental health issues of young offenders”

- “Complex” patients;

“...Mental health services can be very unhelpful with people who are “complex”...”

“Difficult, history of abuse, violent, obnoxious, insight-less, antisocial PD”

“PD, complex people, mental health/pd/substance misuse, because there are lots of specialist team and they argue who is actually responsible for them”

Seventy-two percent of team leaders reported that in-reach staff make an attempt to link the service user with a after discharge; however 86% reported difficulties when liaising with General Practitioners (GPs). These problems were similar to ones encountered when liaising with CMHTs and included:

- Prisoners often not registered with a GP prior to custody and GPs unwilling to take them on as a new patient;
- Service users with NFA, and foreign nationals;
Service users who have been “black-listed”;
High turnover of prisoners, particularly in local prisons, and uncertain release dates so difficult to establish firm release plans; and
Transfer between prisons close to time of release making liaison difficult

2.3.3.8 **Role of the in-reach team in court diversion**

Almost two-thirds (64%) of team leaders stated that their teams played no role in court diversion. Only teams in prisons which held remand prisoners appeared to liaise with court diversion schemes on a regular basis.

“Sometimes giving opinion on mental health [of prisoners], when remanded we give opinion whether to keep them in prison or send them to hospital”

Fifteen percent of team leaders reported that their teams always or sometimes liaise with mentally disordered offender teams and forensic teams where they existed and, through them, with court diversion schemes as well.

“The team liaises with MENDOS teams in the area. There is also a protocol for the team to complete a Social Circumstance Report for the magistrates courts locally to speed up the process of making a decision as to whether psychiatric reports are required or not for a particular prisoner…”

Role of the in-reach team in relation to suicide and self-harm Assessment, Care in Custody and Teamwork procedures (ACCT).

The ACCT process identifies and manages prisoners at risk of self-harm or suicide. In-reach team leaders see their relationship with ACCT as multi-faceted, including advising on management and supervision of staff and training. Approximately ninety percent of the in-reach team leaders reported that their teams acted in an advisory and training capacity to ACCT teams.

“[CPN] attends review for those with mental health difficulties”

“We guide and support the ACCT process. Attend appropriate ACCT reviews land advice, and support on self-harm - mainly we offer management plans and best ways to manage the situation. But we are frustrated because the plan is rarely followed through”

“[We] Take part in ACCT training, monthly supervision for ACCT assessor… Attend Safer Custody groups meetings-self-harm issues”

“Provision of 3 x 1-day Mental Health Awareness Training for ACCT Assessors. Peer Group clinical supervision for Assessors in HMP X and HMP Y.”
Fifteen percent of team leaders reported that some members of their teams were trained ACCT assessors, a specific role within ACCT procedures designed to identify a prisoner’s individual needs and formulate an appropriate multi-disciplinary plan of care.

“...Member of team is an ACCT assessor. Involved in the implementation of ACCT document at HMP X. [They] provide mental health input in training of ACCT assessors and to foundation training...”

“[We are] trained ACCT assessors; attendance at review meetings; provision of additional psychological assessment and intervention if necessary...”

“All RMNs are ACCT assessors, mental health co-ordinator can act as case manager”

Approximately ten percent of team leaders expressed the need for a cautious approach in developing their role with ACCT teams.

“If they [the clients] are known to us- on open ACCT document then we see them, ACCT brought in by prison service and for me it felt that they were there to stop medicalising prisoners, which is really positive.”

“We will assess those at risk if somebody asks us to, depending on our assessment we will take on the case or not. Not everyone needs secondary care which is why we do not assess all of him or her. You can't get involved with everyone it is not always appropriate because PHC also can do a good job, you have to set boundaries on how much you are going to help them and how. But it is a blurry area.”

Over three-quarters (77%) of in-reach team leaders stated that they did not routinely assess prisoners placed on ACCT. They further commented that an assessment was performed only when the in-reach team was asked to do so by the members of the ACCT team.

The majority (88%) of in-reach teams provided mental health awareness training for prison officers and ACCT team members.

2.3.3.9 **Acute transfer**

All in-reach teams reported that they were actively involved in the process of transfer of prisoners to hospital under mental health legislation. Sixty-one percent of respondents indicated that they co-ordinated the process, contacting commissioners, external clinical teams and the Home Office Mental Health Unit.
2.3.4 The overall success of the in-reach concept

The final section of the questionnaire aimed to obtain the views of team leaders on the extent to which the establishment of in-reach teams had been successful. All team leaders thought that in-reach had been a good idea and that, as a consequence of its implementation, outcomes for prisoners experiencing mental health disorders had improved.

However, just under half (45%) of team leaders were critical of the way in which in-reach had been implemented.

"Was it a good idea? I am not sure. I don't think it was good to parachute people into prison and tell them to get on with it. We should be accommodated outside of prison as the prisons not yet ready to accommodate NHS style of caring. Not enough thought has gone into supporting the team in terms of supervision, and there is a general lack of understanding of what the team has to cope with. It's difficult to work in prison and that's reflected in the quality of healthcare system. The demands are huge. I don't think it was a good idea overall—it was a naive idea. The politics in prison is horrendous,...In Mental Health Trusts you work with professionals, and then they move you to prison and people don't even understand the issue of confidentiality, let alone anything else..."

2.3.4.1 The barriers to successful in-reach operation

Team leaders were asked to rate, on a scale of 1 to 10, the main barriers to successful operation of their teams (where 0 = "no obstacle", 5 = "moderate barrier" and 10 = "insurmountable" barrier. Table 5 shows that 'limited resources' were regarded as the greatest obstacle, with the mean score 6.3. Limited resources were significantly more of an issue for small teams (Table 6). Several team leaders explained the difficulties of successfully undertaking a healthcare role in a prison environment.

"The politics of prison, conflicts between services, commissioners, etc. conflict in demands, people interfering in our work, sometimes I catch myself running like a headless chicken trying to put up with demand by primary care, also requests for information; there are 6 different people in our organisation who constantly demand information, and we spend time distributing this information around a bit like what I am doing with you at the moment [referring to the researcher]"

Others expanded on the issue of lack of resources and opportunities to provide the services prisoners need.

"Several of the establishments would benefit from the provision of mental health day care units so as to provide specific therapies and treatments i.e. coping skills,
anger management, problem solving etc. These units would then enable those individuals with mental health needs to have individualised interventions tailored to their specific needs as well as relieving the pressure from the primary carers i.e. prison staff. PCT financial restrictions within the prison and healthcare budgets mean the above service is not likely to be high on the list of priorities”

The most common training need cited was training in specific therapeutic techniques (Figure 12).

Table 5: The main barriers to the implementation of prison in-reach

<table>
<thead>
<tr>
<th>In your opinion, what are the main barriers to successful in-reach team operation?</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special nature of prison-restricted area</td>
<td>4.25</td>
</tr>
<tr>
<td>Limited opportunities to engage with prisoners</td>
<td>4.04</td>
</tr>
<tr>
<td>Complexity of service users’ mental health disorders</td>
<td>3.62</td>
</tr>
<tr>
<td>Limited resources</td>
<td>6.30</td>
</tr>
<tr>
<td>Lack of appropriate training</td>
<td>3.50</td>
</tr>
</tbody>
</table>

Table 6: The main barriers to implementing in-reach teams (small and large teams)

<table>
<thead>
<tr>
<th>The main barriers</th>
<th>Mean score (scale from 1 to 10)</th>
<th>Z score and p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Small team</td>
<td>Large team</td>
</tr>
<tr>
<td>Special nature of prison-restricted area</td>
<td>4.3</td>
<td>4.2</td>
</tr>
<tr>
<td>Limited opportunities to engage with prisoners</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Complexity of service users’ mental health disorders</td>
<td>3.7</td>
<td>3.5</td>
</tr>
<tr>
<td>Limited resources</td>
<td>6.9</td>
<td>5.7</td>
</tr>
<tr>
<td>Lack of appropriate training</td>
<td>4.0</td>
<td>3.0</td>
</tr>
</tbody>
</table>
There was no statistically significant difference in training needs by type of prison, or size of team.
2.4 Summary

2.4.1 Resources

- There had been a 20% increase in the size of in-reach teams between 2004 and 2007, but 85% of team leaders stated that teams were not sufficiently well staffed to meet the needs of prisoners;

- Referrals to in-reach teams had increased by 57% and caseloads had increased by 32% between 2004 and 2007; and

- Just under half (45%) of team leaders stated that recruitment to teams was problematic.

2.4.2 The service-users on in-reach team caseloads

- Almost two-thirds (58%) of service users on caseloads had committed a violent offence against the person (32%) or robbery, theft or burglary (26%);

- Thirty-two percent of service users had SMI; 9% had a diagnosis of SMI and PD and 17% had SMI and a co-existing substance misuse problem;

- Sixteen percent had PD alone and 12% has PD and substance misuse problem;

- Black/Black-British patients and Asian/Asian-British patients were over-represented on caseloads in relation to their proportion in the overall prison population; and

- Seventy-two percent of service users were on CPA; 27% on standard CPA and 45% on enhanced CPA.
2.4.3 The modus operandi of prison in-reach teams

2.4.3.1 Expansion of in-reach

- In-reach teams have developed across the prison estate over the last three years and are now established in category B and open/training prisons, following an initial emphasis on providing services in local prisons.

2.4.3.2 In-reach and primary care

- There have been moves to integrate in-reach with primary healthcare services;
- Integration with PHC was more likely in open/training prisons and YOIs than high security and local prisons;
- PHC are the largest referral source for in-reach teams;
- Triage by PHC was regarded as inadequate, due to lack of resources and expertise; and
- Triage by PHC was rated as especially poor in high security, category B and local prisons.

2.4.3.3 Referrals and clinical work

- There has been a doubling of referrals by prison officers over the last three years – this may be due to the mental health awareness training rolled out by the CSIP;
- Most clinical activity is focused on assessment and liaison/support. There was very little face-to-face intervention undertaken by in-reach teams. In addition, skills in face-to-face intervention were cited as the greatest training need;
- Twenty-eight percent of in-reach clients were on enhanced CPA. For clients on CPA there are significant barriers to its implementation, including prisoners not having a release address; problems liaising with
external agencies; geography; the bureaucracy in the prison system itself; and difficulties with IT;

- In-reach teams had highly variable approaches to involvement with ACCT. Some in-reach team members were ACCT assessors and others trained ACCT teams in mental health issues. Other teams believed that involvement with ACCT confused the 'health' and 'security' agenda; and

- External liaison with CMHTs, GPs and social services was problematic. Many team leaders felt that certain diagnostic labels were viewed less sympathetically, especially personality disorder.

2.4.3.4 **The in-reach concept**

- All team leaders thought that in-reach was an excellent idea, improving outcomes for prisoners, but that it was poorly resourced and had been poorly implemented;

- The successful delivery of in-reach was compounded by the prison environment itself; inadequate support from PCTs; difficulties with external liaison; poor resources and a lack of IT infrastructure.
3.1 Method

In order to ensure representation of each type of prison establishment (i.e. local, sentenced, female, open, high security, and young offender institutions), it was proposed to undertake case studies in eight sites. Four sites were chosen from the first wave of prison in-reach team funding (2001/02) and four from the second wave (2002/03).

Nested within the case study design were separate sub-studies using a variety of quantitative and qualitative research methods as follows:

3.1.1 Diary of key events

Each team leader was asked to keep a diary of key events during the evaluation period, including staff turnover (and reasons for joining/leaving), development of relationships within the team and with other agencies, and strategies for coping with team ‘crises’.

3.1.2 Individual interviews

Semi-structured interviews were conducted with key informants. Where possible these interviews were conducted face-to-face, although telephone interviews were conducted when necessary. The interviews were tape-recorded, with the permission of the interviewee, and summary transcripts made to enable researchers to supplement and validate their hand written notes. Interviews conducted at one of the sites (Team G) were fully transcribed because they were part of a larger study being undertaken within that particular prison.

Interviewees were selected using carefully chosen criteria reflecting the issues and priorities arising from each site. The interviewees were drawn from groups including in-reach team leaders, in-reach team members, service users, prison governors and host trust managers. We wished to investigate the experiences and opinions of individuals working across a range of professions in a prison.
setting and believed that the expression of honest opinion would be encouraged by seeking these views by 1:1 semi-structured interview rather than multi-professional focus group. The precise content of interviews was determined from previous research and by issues arising during the early stages of this project.

3.1.3 Focus groups

An important factor that could have influenced local success of the in-reach programme was the culture and context of the setting (i.e. particular prison) within which it was implemented. Focus groups were held with key prison stakeholders within each case study site. Typically this included the healthcare manager, a senior Prison Service manager and prison officers.

3.1.4 Case study analysis

Each component of the case studies was analysed using appropriate methods for the type of data. Overall, transparency and generalisability of the case study analysis was strengthened using a three-part model (Yin, 1984; Robson, 1993) as follows:

3.1.4.1 Detailed description of each case as an individual unit

- A baseline description of operational strategy, staffing, staff training/profession/previous work; staff morale, relationship with other services;
- A time line was constructed for each site to illustrate the diary of key events for each team;
- Qualitative data generated from individual semi-structured interviews was analysed using framework analysis based on grounded data reduction techniques (Miles & Huberman, 1984); and
- The various data sources were integrated, including the team leader diary, the focus group and the interviews. The integrated analysis was then reported.
3.1.4.2  **Cross case analysis**

Each case was compared with the others on an ‘issue by issue’ and ‘case by case’ basis (Yin, 1984). Hypotheses were amended as similar patterns and relationships were observed in diverse cases. Further evidence was sought to test these hypotheses or explanations for every case.

3.1.4.3  **Strengthening generalisability**

Explanations generated from selected study sites were discussed in relation to the nationwide picture, comparing and contextualising findings with the relevant literature.

In reporting the case study analysis below, the results of the cross case analysis are provided first, as they represent a developed overview with regard to the findings from all eight case study sites. Where there was sufficient data to justify reporting cases separately this is provided, as a contrast with the findings from the cross case analysis.
3.2 Results

3.2.1 The case study sites

In this section results from the eight case study sites are reported. Case study sites represented prisons across the North West, North East and Yorkshire, South West, South East and London Regions. Six were male prisons, two female. One was a high secure establishment; two were Young Offender Institutions (YOI); three were local prisons; and one was a category C training prison. Table 7 below provides an overview of each of the case study sites. For the purpose of this report, the identity of the prisons and teams have been removed, as agreed during ethical committee review.

Table 7: Characteristics of the teams and settings selected for case study

<table>
<thead>
<tr>
<th>Team</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
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<tbody>
<tr>
<td><strong>Prison Setting</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
<td>Male Cat B</td>
<td>Male</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
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</tr>
<tr>
<td>High secure</td>
<td>Local</td>
<td>Local + YOI</td>
<td>Juveniles</td>
<td>Young Adults + Juveniles</td>
<td>Local + Juveniles</td>
<td>Cat B Local</td>
<td>Cat C Training</td>
<td></td>
</tr>
<tr>
<td><strong>Team Members</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>Nursing</td>
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<td>Occupational Therapy</td>
<td>Counselling</td>
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<td>Nursing</td>
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<td>Nursing Clinical Psychology</td>
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<tr>
<td><strong>Time Established</strong></td>
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<td>9 mths</td>
<td>18 mths</td>
<td>12 mths</td>
<td>14 mths</td>
<td>3 yrs</td>
<td>5 yrs</td>
<td>6 mths</td>
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</tbody>
</table>

3.2.2 Respondents

In each setting the in-reach team leader was interviewed, together with between one and six other members of the in-reach team. In addition at least one member of the prison healthcare team was interviewed, generally the healthcare manager. In three prisons a focus group with discipline staff was undertaken. Where this was not possible to arrange a prison governor or senior prison officer was interviewed. This ensured that within all the case study sites a range of perspectives on the operation and impact of in-reach teams were available. Table 8 provides details of the range of representation from each of the case study sites.
<table>
<thead>
<tr>
<th>Team</th>
<th>A</th>
<th>B</th>
<th>C</th>
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<th>E</th>
<th>F</th>
<th>G</th>
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</tr>
</thead>
<tbody>
<tr>
<td>In-reach Team Manager</td>
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<td>1</td>
<td>1</td>
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<td>In-reach Team Members</td>
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<td>2</td>
<td>3</td>
<td>5</td>
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<td>Healthcare Staff</td>
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<td>3</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>4</td>
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<td>Discipline Staff, Inc. Governors</td>
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<td>2</td>
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### 3.2.3 Case study results – prison in-reach

In this section the perspectives of stakeholders (from in-reach teams, prison healthcare teams and discipline staff) on the aims, processes and effects of in-reach are reported. Initially the product of the analysis of the combined dataset is described. Following this a brief section is provided detailing specific issues for each of the eight case studies. The emphasis in this final section is on points where informant reports diverge from the more generally reported aims, processes and effects.

In examining data the accounts of the prison in-reach team leaders, prison healthcare managers and prison governors were analysed. Subsequently interviews from other informants were inspected to confirm or modify existing codes and to elaborate new ones.

### 3.3 Aims of the in-reach programme

Three central categories emerged from the analysis with regard to the reported aims of in-reach programmes from different stakeholder perspectives. These were:

- Equivalence
- Balancing different needs
- Wider role
3.3.1 Equivalence

Informants were remarkably consistent in the way they described the aims of the programme, and in the fact that, almost without exception, they could quickly furnish a concise description. Many respondents used the analogy of a Community Mental Health Team (CMHT) for the general population, and made a point about delivering the equivalent service inside a prison:

“...there is a requirement that the level of mental health input into the prison are equal to that in the community and hence the development of the in-reach Services.”

(in-reach consultant psychiatrist)

“...it was linked with government policies to look at equating in-reach mental health services within prisons so that it was run on similar lines to community mental health teams.”

(in-reach team leader)

“...if someone’s well enough to stay in prison to be providing them with the same treatment they would receive in the community.”

(prison healthcare team member)

Several informants went further and placed the development on prison in-reach services into the more specific context of the NHS plan and the prison mental health strategy Changing the Outlook, published in December 2001:

“...according to the Change of Outlook [sic] document, 92 to 95% of prisoners have some kind of mental health problem or substance issue problem... so we deliver a community service to [name of prison], this is our community.”

(in-reach team member)

“The original aims were in line with the NHS plan, and Changing the Outlook document where anybody with an identified mental health problem that had a care co-ordinator in the community should leave prison with a care plan and a care co-ordinator and a community team.”

(in-reach team member)

One prison made the active decision to call themselves a CMHT in response to these documents:

“...and a conscious decision was made to call ourselves a Community Mental Health Team rather than mental health in-reach at that stage as well...The reason...
for that was that the document Changing the Outlook had made reference to the fact that it should be based around a similar service and actually, nationally, people understand Community Mental Health Team. They don’t understand mental health in-reach. And actually if we were looking at an equity of service, I kind of felt “Why would be calling it something different which has different connotations to it?” So, that’s why we consciously did it. But it was also to allow ourselves to benchmark and audit ourselves against an existing tool and there was a policy implementation guideline by the Department of Health that had been produced in the same year. So it kind of made sense really.”

(in-reach team leader)

3.3.2 Balancing different needs

Many respondents described the role of the in-reach team as one of balancing the many different mental health needs of the prison population. The original target group was prisoners with serious psychiatric illnesses but many reported a newer role developing beyond this:

“…development of in-reach has been predominantly in its initial stage about identifying people with serious mental illness and ensuring the removal to hospital in order that that can be treated, but I think that we've gone beyond... it's a broader range of mental health difficulties that we need to address.”

(in-reach consultant psychiatrist)

The following respondent went into some detail, specifying the range of functions and target groups addressed by the in-reach team:

“…thinking about the in-reach service as a whole we might come from slightly different perspectives as different members of the team as well. So the CPNs particularly target more psychiatric disorders plus self-harm, more crisis response as well as... maintaining those people with psychiatric disorders but from a psychological point of view we would probably do less crisis response ... but our main aim would be to alleviate symptomatic distress so we would work with people with particular psychological symptoms but also to feed people into different services within the prison system where they can get longer term therapy if need be. There is a high percentage of people here with personality difficulties and long standing difficulties so our hope is to feed those people on through [named services] or the equivalent to services outside.”

(in-reach clinical psychologist)

This pattern of the development of a wide range of functions emerging from an initial core function on the assessment and management of serious psychiatric illness was repeated by respondents from different professional groups and across prisons.


### 3.3.3 Wider role

Respondents also reported a wider role than simply responding to case-by-case demands. These roles included consultancy to prison discipline and healthcare staff:

"...we have a larger consultancy and liaison function and so that we have a link person for each of the residential areas who'll attend weekly meetings with key staff in those areas to talk through potential referrals and to be part of the case reviews of those that are thought to be at risk of self-harm."

(in-reach team leader)

There was a role for giving advice and information:

"...we can advice over the phone or give them information..."

(in-reach team leader)

"...that is invaluable to have them there, it really is, to be able to give advice over the phone sometimes for a start."

(prison officer)

"Guidance, advice and direction, there’s been support for operation support grades, for prison officers, for psychology. They’ve had a significant impact on all aspects of the establishment."

(prison healthcare manager)

There was a role in linking prison and community NHS services together:

[Before the in-reach programme] "there was no linkage between current mental health services locally and the prison, in fact most consultants and staff didn’t know where the prison was and the prison does a good job in hiding itself."

(in-reach consultant psychiatrist)

"We’re liaising far more quickly with their teams so therefore getting information about their medication about their care plans. We’re actually engaging in contact with these people which they wouldn’t get if we weren’t there. We’re liaising with services so that they know when they’re coming out."

(in-reach nurse)

Another function was the provision of clinical leadership and modelling of good practice:
“One of the roles that I think in-reach has got over the next year or two and in the past, has hopefully been to start to provide clinical leadership and modelling of good practice.”

(in-reach team leader)

There was a role for liaising with other agencies in the prison and gathering information on which clinical decisions could be based:

“...it’s almost like it’s the focal point for the whole of the mental health services so they can collate all the information with probation, input what they have been up to, what they are getting, what’s happened on the outside, what’s happening on the inside and collate it up and make sure the psychiatrists have that information to make their decision.”

(senior medical officer)

Education and training were also acknowledged:

“...we also do mental health awareness training now monthly for the prison officers, which is about you know what things to look out for, what things cause mental health problems, some of the ways in which that can be exacerbated by being in prison with the focus on how to access appropriate services and how to work with our team and a little bit of a low down on what the different aspects of our service do.”

(in-reach team leader)

In this section it is noticeable, though hardly surprising, that the most complete and concise accounts of the in-reach programme’s aims came from members or managers of in-reach teams themselves. This is evident in the spread of respondents quoted above. However in the next sections, on the process and effects of the programme, it was clear that respondents from prison healthcare and discipline staff had plenty of observations to make.

3.3.4 The process of delivering prison in-reach

After analysing responses relating to the aims of the prison in-reach programme, the interviews with participants were then explored for descriptions of the activity process of in-reach teams. The aim was that these accounts would enable any links to be discerned between the stated aims of the programme and its effects for prisoners and staff. Initially the accounts of the prison in-reach team leaders, prison healthcare managers and prison governors were analysed closely. Subsequently, interviews from other informants were inspected to confirm or modify existing codes and to elaborate new ones. A list of over 30 codes was devised to describe the activity of the in-reach teams, from which the following
four central categories emerged:

- Context
- Functions
- Relationships
- Leadership

Table 9: Central categories and sub-categories for case-study analysis of in-reach

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Table 9 provides an overview of the main sub-categories identified relating to the four central categories. The categories are described in detail below.

### 3.3.5 Context

The historical and organisational context in which the teams operate, and related contextual problems were mentioned frequently. For many informants the impact of the in-reach team was directly related to the degree to which they could adapt to the context in which they found themselves operating.
3.3.6 Historical context

The length of time teams had been operational, as well as the length of time that team members had been in post, were important factors:

“We have changed quite considerably in the last five years ’cos when I started in post 1999 I was the only mental health liaison nurse and was for almost 20 months before we got other liaison nurses.”

(in-reach team leader)

The previous informant described a service that had evolved slowly over a considerable period of time, while other interviewees had a very different experience:

“… you’re struggling to do an operational policy and I know I’ve got to do it by March ’cos they’re going to be audited in March but I mean really you would never dream normally, starting a service off, throwing people in without first of all having no clients, no caseload but all working together, training together, doing an operational policy together etc., planning the whole service. We haven’t had that opportunity.”

(in-reach team leader)

Several informants, mostly in-reach team leaders, referred to the novel experience of starting a service from scratch with no existing template to work from. This seemed to be experienced as a mixed blessing:

“…there wasn’t a lot of people out there with a lot of prison experience etcetera to do it so I think that that was a slight sort of negative but in a sense sort of a positive ’cos you bring people in with fresh ideas. So that was good... I think that what was good, it was almost a clean slate as well you know”

(in-reach team manager)

“It has been a very sort of bottom up approach really through me coming in here with a blank canvas and sort of free rein really to do what I wanted to but ... and in a way you’ll know that means I’ve carried a lot of, individually I’ve carried a lot of responsibility and uncertainty for long periods of time.”

(in-reach team leader)

“...nobody's actually said this is your service, nobody's said anything. It's just like 'get on with it'. Nobody's said 'this is the model, do it this way,' so I've modelled the service I feel as near as is possible to a community mental health team that I've got a lot of experience with.”

(in-reach team leader)
3.3.7 Organisational context

Some interviewees found the prison system to be very welcoming and receptive to the new in-reach approach:

“...the prison were incredibly receptive about us going there, they knew there were huge problems in terms of mental health needs and so they, they were incredibly supportive of everything we do, they wanted to be seen warts and all and they realised that actually that was what needed to be seen so that they could actually get the resources.”

(in-reach team leader)

While in another prison even the longer-established prison healthcare service was finding the prison establishment to be an obstacle at times:

“It's an establishment; it's an establishment in the prison service. We're chipping, chipping, chipping away and we're improving things within the prison but we still work within the old system and the Governor over-rules what people say and sometimes I feel clinical decisions are over-ruled by a Governor.”

(prison healthcare manager)

In a couple of the prisons this ‘us-and-them’ was a significant problem:

“And there's great animosity between the...some of the, the [prison] staff and the in-reach team. I think it's probably a new service, always arouses suspicion? I'm not really sure whether their animosity is with us or with the PCT, I don't think it's probably with particular individuals, I'm not really sure.”

(in-reach team leader)

Prison staff at this prison likewise had some reservations about the input of the in-reach team:

“...I find it quite confusing really in that I found that what the healthcare mental health nurses say usually contradicts the in-reach team and vice versa which isn't particularly helpful.”

(prison officer)

In another prison this clash of cultures came to a head when one of the in-reach team members was threatened with sanctions after they identified what they perceived to be poor practice contravening NHS standards. They indicated that they were not alone in this experience:

“I really was asked to leave prison and never tread back again because I highlighted poor practice. There is something very much about you go against
the prison and that’s it. And that’s happened in other prisons, to other mental health in-reach teams as well.”

(in-reach team leader)

One respondent spoke of the emotional cost associated with working in such an environment:

“You know it’s just that on a daily basis yeah, it does it does grind you down. It’s not the actual inmates, it’s not the prisoners that are the problem, it’s the system.”

(in-reach nurse)

Another informant placed this conflict within a broader area of tension between care and custody:

“The problems are with the prison in terms of the culture. They are the main problems. I mean in the broader sense I guess custody versus care. I think they are the major issues.”

(in-reach nurse)

Even in prisons where NHS input was long established and working well, this clash of cultures remained a sore point at times and in some cases, this was related to practical problems associated with working in a custodial environment:

“... prison can be quite an oppressive place to work...I think I’m particularly experiencing that because of the lack of keys at the moment which means that I’m .. dying to go to the loo and I couldn’t get out of my office. It’s just I’m feeling particularly disempowered in the prison at the moment.”

(in-reach clinical psychologist)

“Simple things like it taking a long time to access the prison computer system so I can access people’s locations and what have you. The simple practicalities of not having a healthcare key because I am not on the list to have one... not being able to access records unless somebody else is with me.”

(in-reach nurse)

“To actually arrange to see them in a group room or to even see them individually is very difficult so I think sometimes our ability to deliver the service, or even just seeing people individually, can be undermined by the prison regime itself.”

(in-reach occupational therapist)

On the other hand there were settings where the different culture of the NHS was seen as a positive asset, rather than the source of a culture clash:
"...we have got the in-reach team now so we can, there is someone we can call upon to talk to [the prisoners] that's not, that they’re civilians, they’re not working for the prison so they're not wearing this [discipline staff uniform], they're not wearing nurse’s uniform, they're normal people and they come in and they can say 'Hi Johnny' and sit down and have a chat.”

(prison officer)

While in some cases the organisational battle lines were drawn between elements of the NHS, rather than between NHS and prison:

"...but the [PCT and Mental Health Trust] argued for a long while about how they were going to commission the service, so that took months because the PCT weren't sure who to commission from.... But we had lots of meetings so until we could sort that out we couldn't advertise and so I worked on my own for 10 months.”

(in-reach team leader)

### 3.3.8 Contextual problems and problem-solving

When coding transcripts for this section, ‘problems and problem-solving’ were initially conceptualised as a fifth category alongside ‘context’, ‘functions’, ‘relationships’ and ‘leadership’. On further consideration, the problems that were encountered were seen as forming a part of, and usually arising from, the historical and organisational context of the in-reach teams.

In some settings it had taken time for the expectations of the host prison and the developing in-reach team to be aligned:

"A huge amount of time was wasted trying to establish common ground to aim for.”

(prison healthcare manager)

"There was quite a lot of conflict as well because they were coming saying 'we are not touching that', where we think 'actually that’s what we thought you were touching!'”

(prison healthcare manager)

This conflict around which patients were the core group for the in-reach team was duplicated in other prisons as well:
“...and it’s quite conflicting really ‘cos I’ve spoke to team leader and I’ve spoke to NAME about it and said that I feel that maybe we need to prioritise and perhaps not look at the lads with primary care, look at the lads with SMI because there’s that many people coming through the door.”

(in-reach nurse)

The previous extract hints at the problems caused by the extent of the possible workload, and this was the single most frequent problem identified by participants at one particular prison:

“...but at the moment because our numbers are so small, we’re like fire fighting all the time really which doesn’t give us a lot of opportunity to sit back and think and plan how we could address that problem ‘cos it certainly needs addressing. ‘Cos by the time we get somebody...they can be in relapse.”

(in-reach team leader)

A text search was undertaken of all the interviews in the sample, looking for the word ‘busy’. Interestingly, one prison accounted for seven out of the 20 occurrences of the word, suggesting that the problem was not being felt as acutely at other sites. Indeed, in one prison there was a perception from healthcare staff that the in-reach team were not as busy as they might have been:

“I think there’s a little bit of ....between my staff and the mental health staff because there’s a bit about saying 'hang on a minute why are we running like mad and you’re sitting talking' and that’s the perception about how different people do different jobs.”

(prison healthcare manager)

As hinted above, this was perhaps more a matter of perception than reality. It was a remark made in the context of a prison where a prison governor could say:

“I think it's made a significant difference in that young people are having their mental health needs identified and dealt with much earlier on..... so if I had more resources I would expand the team more to do even more work, even more in-reach but you know I think they’ve made a considerable difference.”

(prison governor)

The single source of problems mentioned most frequently were resource constraints. These were sometimes seen as limiting the quantity of work that the team could offer:
“I think it's just more, more of the same. It comes down to more resources, I just can't explain how invaluable from a unified point of view that, that their role is and how easy it's made our job...so it's just more please.”

(prison officer)

Such resource constraints often related to staffing difficulties or shortages:

“If you've got 1,200 prisoners you can't have four people trying to deal with the whole of that now that about 50% of people have mental health needs.”

(senior medical officer)

While at other times lack of resource also impacted on the quality of the work done:

“You know our biggest difficulty is not enough room .... not actually having enough room to interview people, you know a place where they have confidential interviews. This morning is very typical, the doctor's popped out of his office for ten minutes to have a security talk and mental health go in but actually all the notes from the doctor and all the rest of it are still in there. That's the only interview room so he's interrupted...”

(prison healthcare manager)

One respondent believed that contextual issues prevented the team from delivering an equitable service to prisoners:

“So I think there’s, as I say, I think there’s some things that are out of our control where people will get a worse service from us such as, the frequency we see people or the environment we see them in or our ability to communicate with them.”

(in-reach nurse)

The apparent solution to problems tended to be pragmatic and relationship-based. Some revolved around directly talking the issue out with other parties:

“Well I think we tend to try and sort it out sort of face- to-face with the clinicians involved and senior prison staff involved and...we've had case conferences involving senior people from healthcare, representatives from our service and the senior staff from the area in the prison where they're located and we've come to some kind of plan there which is often a compromise and time limited and we'll review it in two weeks and this is what we can offer.”

(in-reach team leader)
“Yeah we’ve just tried to deal with it, as each problem has occurred we’ve just tried to deal with it, the way, the way we did today, just sit round the table and discuss problems, see if we can find a solution.”

(prison healthcare manager)

These solutions point towards the importance of the third category identified that of relationships.

### 3.3.9 Functions

#### 3.3.9.1 Managing referrals

Most of the discussion in the interviews that related to activity and functions of the in-reach teams related to the processing of referrals. One extract gave a very concise summary of the function of the team in question:

“Referrals come to referral meetings we have and we go through them and we allocate and then we go off and see them, do an assessment,.....and then we’ll basically be in a sense, case managed, you know so for example if it’s necessary, there might be a connection with a community team, before they’re discharged.”

(in-reach team leader)

#### 3.3.9.2 Assessment and care

The single most frequently mentioned function performed was that of assessment:

“They [the prison healthcare team] identify and refer onto others, maybe mental health team if they’ve a history of, of any mental health problems or self-harm ....and we pick up within, hopefully within 48 hours, next day if possible and that’s how we ....doing mental health assessment ...now, you know identify any problems...”

(in-reach nurse)

“I see them almost as a focal point for initiating mental health assessments and needs of whoever it is that needs that input, and then it’s for them to delegate what needs to be done and in what sort of time frame.”

(senior medical officer)

In fact the word ‘assessment’ was used 265 times by interviewees – only seven of the 61 interviews did not contain this word, so it was clearly seen as a core function. By contrast, ‘treatment’ was mentioned much less frequently; the word...
occurred only 76 times and was used by only 27 interviewees. Granted, there are few obvious synonyms for ‘assessment’ and many for ‘treatment’. However, searching for words such as ‘therapy’ and ‘intervention’ found fewer than 40 mentions of either concept. For one interviewee, developing packages of treatment was something that had to wait until the team was properly established:

“… as time has gone on then not only am I coming to realise that to some degree that my job is very much what I want it to be and what I can create it to be, so individual areas that I have an interest in you know I can, within reason, go to that so for example we’re doing a DBT training, Dialectical Behaviour Therapy myself and NAME are doing that, so that’s very much a focus… but initially I think it took a long time for it to feel that we are at a stage where we are a team…”

(in-reach clinical psychologist)

Relatively few interviewees gave as full a description of the care they provided as this:

“…also it’s having ideas to whether or not we’re able to offer them what care, sort of let them I say support because we look at three basic categories - support which might be sort of three, three to four, five sessions, well it’s just around support of a prison judgement? It might be a focussed piece of work to identify, then referral to all sorts of specific…post traumatic distress something maybe still a shorter piece of work or alternatively they’re asked if they want to be more sort of life-style, life-changing stuff …we get loads and loads of chaps I’m pleased to say.”

(in-reach counsellor)

This finding is in broad agreement with the national team survey (Module 1), which suggested that nurses (the largest staff group within in-reach teams) spent slightly less time (29% of the working week) on assessment than they did on providing care (30%).

3.3.9.3 Managing self-harm and PD

There was divergence between the teams interviewed, relating to activity with self-harm and PD. For some interviewees, dealing with these problems fell within the scope of the in-reach team:

“… target population is always going to be people with serious mental illness but what I kind of said is that … to me if someone’s got a personality disorder or some mental illness, substance misuse, that kind of stuff, I think in prison that to me is a serious mental illness, and so I don’t want to get hung up on this black and white dividing lines.”

(in-reach team leader)
However for a minority of interviewees the question of whether PD came under their remit was still not finalised:

"...the problem is, especially with women, there are women there on that level that, who haven't got mental illness, have got severe personality disorders for example and there's a debate as to whether in-reach have these sorts of women, or they just stick to women who've got severe mental illness."

(in-reach consultant psychiatrist)

“There is debate even amongst the team about who should receive secondary mental health services. I work on the premise that PDs are complex needs and that they are included in community mental health teams in the community and we should be replicating that service in prison... Not everybody shares my view on that.”

(in-reach nurse)

3.3.9.4 Care Programme Approach

One specific task in the referral-processing chain was that of organising or contributing to Care Programme Approach (CPA) meetings:

"Now we can liaise with the CPA co-ordinator CPN who is full time based here and they can start the process as soon as we feel that there is any need for that so they can start making the contacts."

(in-reach consultant psychiatrist)

This role in respect of CPA was mentioned frequently, always in relation to transfer or discharge from prison, and the in-reach teams could clearly be seen to be introducing a process which would be standard for a community based patient of a CMHT:

"The first job for us is to get everybody on CPA that isn’t on CPA... Once they are on CPA... then it’s almost as failsafe as if they were in the community. They are reviewed, they are risk assessed. Their needs are documented and we work with them to do a care plan."

(in-reach nurse)

This role in respect of transfer back to community services was clearly seen as a core in-reach function. This was at odds with the findings from the national team survey (see Module 1). Transfers to hospital however were generally seen as presently within the remit of other parts of the prison mental health service:
“I think in-reach needs to move towards working with the patients who are awaiting transfer out of prison into hospital facilities, whereas that hasn't happened just now [in this prison] because there's usually ... a healthcare facility, we kind of ring-fenced that job, and that's their job and they do that.”

(in-reach nurse)

3.3.9.5 Training role

One function which would perhaps not routinely be seen in a CMHT was that of training others. For some teams training prison staff had become part of their core business:

“...we also do mental health awareness training now monthly for the prison officers, which is about you know what things to look out for, what things cause mental health problems, some of the ways in which that can be exacerbated by being in prison.”

(in-reach clinical psychologist)

For others it was a role they aspired to, but could not yet fulfil:

“I don't think we've had the time to do anything but what I did do when I come here and one of my tasks was for the year was to provide mental health awareness for prison officers...and I did do that and I did a three day course but it's not been took up, they say it's too, too long three days.”

(in-reach team leader)

One team which developed a mental health awareness course for prison officers found that the officers were not interested in attending:

“And we do have a training package for the prison officers which has not really taken off... it was going to the wrong people really. You find plumbers and catering staff there and it was all a bit silly really.”

(in-reach nurse)

3.3.9.6 Knowledge of function

Whilst most respondents were able to demonstrate their awareness of the function of in-reach teams, some were unclear quite what in-reach teams were supposed to do, suggesting that more work was needed to publicise their services to other members of staff:

“I don't really feel I know what the role is and what they actually do and what they actually cover... I think it would be beneficial for them to spend an hour or
some time just explaining what their role is, what they do, and telling us a bit more about it.”

(prison healthcare worker)

3.3.9.7 **Relationships**

These codes related to informants’ accounts of the development of relationships between individuals, within and outside the in-reach team, as well as networking and communication going beyond 1:1 relationships.

3.3.9.7.1 Relationship-building

One informant started this whole section of the interview by emphasising the importance of relationship building to the development of the team:

“It’s just built on experience really ... it’s been a long process really built on sort of relationships that we formed here and the experience of the kind of people that are here and how we work with them and they’ve been developed over time...”

(in-reach team leader)

Individual relationships were seen as crucial in making referrals more likely to come through:

“... I feel as though I’ve built up quite good relationships, especially on [a particular wing] which is the reception wing with the senior Prison Custody Officer over there, she’ll phone and say ‘we’ve had a lad through who I think you need to see’. I will go and see him and I will feed back.”

(in-reach nurse)

“...it’s important that you have a working relationship with somebody ‘cos you’ve had a client in common and then they’ll use you as a point of contact if somebody in their team has a client in need.”

(in-reach team leader)

The freeing effect of having close relationships was also valued by prison staff:

“I think it’s a good relationship we have with [NAME], it’s wonderful we can just pick the phone and say ‘I’ve got this... you know there’s no big paperwork thing going on and so that makes it easier for us and I quite like that.”

(prison officer)

And once a referral was received, the flow of further information about a patient was dependent on the quality of the relationship with the custody staff:
“...on the officers side we find that because you've got a good rapport with them you can find that they will say how this inmate's behaving in the house block, so that like I say, it's your relationship with them.”

(in-reach nurse)

It was noted that good, effective relationships were not forged overnight, and for some participants this had been a struggle:

“I think that incidences where we have been supported have been fewer than those where we have not been supported, you can repeatedly tell a personal officer information that is going to assist you in a care plan with someone and the information they completely ignore.”

(in-reach nurse)

“I suppose in setting up any new ideas or in new relationships there's bound to be, I suppose, like teething problems so I suppose it were good for us to say let's persevere and keep coming in and keep trying to break the values and just continue with it and I thought that...well this, why should I be coming here, something I love doing, working with the women, was the staff were making it difficult at times in a way.”

(in-reach nurse)

A colleague from the same prison also noted that there had been difficulties in relationships with existing staff, but that these had improved:

“... because the relationships a bit better now with the rest of the healthcare team I can actually say you know 'I'm a bit worried about so and so.'”

(in-reach nurse)

Individual relationships, between prisons and between prisons and the NHS were also important for some participants:

“That's a bit problem for us because the Prison Service is so full and so we have to have good relationships. It's not based on any kind of mandatory structure as far as I can see, getting a vulnerable young person moved to a healthcare centre in another prison, it's actually based on me knowing the doctor in [other prison]...or the, our local area manager so he can identify somewhere in the prison system. So it's hard.”

(in-reach consultant psychiatrist)

“Yes I have a manager, my line manager NAME, works in the [name of NHS organisation] and she does my kind of supervision so I have support and I have links and also local information team outside, so we have, so we're not as isolated. Yeah, so we're not isolated, sometime, in parts of the prison we were
very much isolated and I feel that there’s also you know that I’ve got managers out there as well, outside the prison as well.”

(in-reach team leader)

For many participants, the development of relationships was a matter of time and perseverance, although some mentioned more formal methods of relationship development:

"I’d be very keen to emphasise the need for us to be reviewing our process and our.....relationships and things like that. So twice a year we have a day with a systemic consultant from the Tavistock who’s very experienced in non-governmental, in all, in public health, public organisational settings who comes and we go through some of the real nitty, gritty stuff, you know the power differentials and the difficulty of working within a prison.”

(in-reach consultant psychiatrist)

3.3.9.7.2 Relationship with prison healthcare

The relationship that was the most frequently described was that between the in-reach team manager and their counterpart in the prison healthcare team. One participant expressed this very clearly – while not idealising the relationship in any way:

“... in the prison I think your healthcare Manager [is] your best friend, and you just have to track really, sort of you know, work closely in collaborative with the healthcare manager and a lot of the time he just wants to hand off mental health to someone else...that’s the person who you have to, to really liaise and work with you know and you just need to keep chipping away at it really, you know there is just enormous frustration and difficulties so you just go and try, you know, from my perspective, help your team try and work through this and keep the morale of the team up.”

(in-reach team leader)

One informant who had a poor relationship with prison healthcare described its effect:

"I discourage people who want to go to healthcare. I discourage it! ‘Cos it’s counter-therapeutic. They’d be worse off. Less of a service.”

(in-reach team leader)

Conversely, one healthcare manager stressed the support given by the in-reach team in their own difficult role:
“Not sure that prisoners are high on the Primary Care Trust agenda and so from that point of view it is a very lonely job... the best support I've had has been from the in-reach team because they're mainstream services clinical experts and I feel quite an affinity with them.”

(prison healthcare manager)

3.3.9.7.3 Networking

Going beyond individual relationships, the building up of networks was seen as particularly important although all teams were not equally successful:

“...although I've been here longest I'm probably not known as well as others who network, and some network more than others. So there's one who networks a lot and is very well known, whereas there's others who don't network in the same way and are just you know waiting or responding to referrals.”

(in-reach team leader)

“There's been an awful lot of resistance and barriers and any new civilian organisation within the statutory system like a prison, walls make barriers so one of the greatest challenges has been networking but one of the greatest accomplishments has been establishing a place within both prisons we work in and being able to work effectively with a lot of our colleagues.”

(in-reach social worker)

3.3.9.8 Leadership

The need for strong leadership of the in-reach team was most starkly illustrated in a quote from a prison healthcare manager, comparing the present manager with their predecessor:

“...he has good management skills in other words he is not trying to learn his management trade, he has done that already and the previous manager and I wouldn’t want to take anything away as an individual but even with their professional hat on but they were learning their management skills and it was their management of staff which was their problem not their individual clinical skills...”

(prison healthcare manager)

Interestingly enough, the new in-reach manager who was the subject of this comment had this to say about the leadership role:
"I think the role of the team is to work in collaboration with the community and the prison people but I think that... one of the roles that I think in-reach has got over the next sort of year or two and in the past, is hopefully been to start to provide clinical leadership."

(in-reach team leader)

There were doubts expressed about the quality of management in other prisons too:

"... NAME interviewed very well and we thought they'd be fabulous and they thought they'd really like it but ... they've only worked on wards and ... tends to go about and treat people like that because they've both been ward based."

(prison healthcare manager)

While other prisons could not have been more complimentary:

Interviewer: "Okay what's, what's helped the setting up of the in-reach team here, anything?"

Informant: "Oh I think the, the enthusiasm of the staff, the enthusiasm of the governor, the enthusiasm of the PCT, everybody's enthusiasm whether and [the In-reach team manager] is incredibly enthusiastic and keyed in and we're very, very lucky to have him. Without his enthusiasm..."

(prison healthcare manager)

In one prison where the in-reach team had only recently been established, it was recognised that good leadership had helped in-reach team members to resist some of the obstacles that the prison context put in their way:

"One of the biggest problems they had was making themselves aware that they were one of the most important groups of staff members in this prison because they turn up on a wing and the officers say 'he's locked up, you can't see them'. I think the way the team's been managed they've changed that around and said 'I am here to see him and I will see him' and they are able to override the lock up regime because they are such an important member of staff... that takes quite something."

(prison healthcare manager)

This extended quote may illustrate the kind of demands made of in-reach managers in particular, and may be an example of an individual who has risen to the challenge of providing leadership both within the team and in the wider prison and health system context:

"What's been good about it I suppose is ... the scope that I've had to be quite creative with it really. I know it's one of the jobs where I've had the most free rein to be quite innovative, try things out and I've had a fair amount of support to
do that as well, you know people have trusted my opinions, let me run with ideas. Yeah, I suppose the senior people in healthcare here, the management in the Trust and the multi-disciplinary team, the medical staff here as well. It’s been very, very exciting and innovative and to be able to start out with a vision and then being able to feed directly into sort of operational as well as strategic forums and health side of the prison side and to actually see, be able to see those things through and where they don’t work be able to see very quickly where the modifications need to be made...I’ve never been in a position to implement such change and see things through and you know have the support of the key people.”

(in-reach team leader)
3.4 Effects of the in-reach programme

In addition to the aims and processes of prison mental health in-reach, informants were asked to outline the effects of the introduction of the teams. Effects varied across teams, reportedly in response to some of the process factors outlined above. However, the interactions between aspects of context, team function, relationships and leadership were complex, and direct impacts on outcome were not possible to establish through the case study method. However, a number of general and specific points could be developed from the data.

The reported effects of in-reach teams were categorised as:

- Improved services;
- Reduction of stigma;
- Provision of an outside perspective;
- Enhanced continuity of care; and
- Beneficial effects for staff.

These categories are elaborated upon below.

3.4.1 Improved services

Almost all respondents had strongly positive views about the effects of the prison in-reach programme. Many responses had to do with perceived improvements in the quality of service available:

"I think the difference is massive...the difference in the prisoners coming in they know where they're at, they know what goals they're trying to achieve ...I think I've got a feeling that the prison is a lot more settled, a lot less self-harm....looking back to what it was like a year ago... people self-harming all over the place, nurses running up and down the prison, it's just so much more stable now."

(prison healthcare manager)

"Brilliant, I mean I don't think we've finished but I mean the sheer amount of mental health issues that we are actually identifying, that we are engaging into some form of treatment, that we're actually notifying support services on release, people have got these problems so that in fact you can carry on engaging with them."

(senior medical officer)
“I think it's made a significant difference in that ... people are having their mental health needs identified and dealt with much earlier on.”

(prison governor)

“Prisoners that have been managed by in-reach teams feel more stable and more able to comply with the prison regime.”

(prison healthcare manager)

“...my understanding is that before we had the CPNs and the in-reach team we kind of, as officers, had to make judgement calls and it was just the officers and the healthcare nurses, there was not you know anybody to actually look into mental health issues.”

(prison officer)

“It’s probably prevented further in-patient admissions to the unit because obviously they manage the lads in the community base like they would outside”

(prison healthcare manager)

“...it's allowed the ones who have mental illness to access mental healthcare more speedily and appropriately. There's no doubt about that.”

(in-reach consultant psychiatrist)

One team leader noted that an important element of good quality service was treating prisoners with respect:

“I mean I think one of the good things we haven’t done is we haven’t dropped our standards. Which after nearly three years I think we should be very proud of as we still call the prisoner by their Christian name and we would not allow that to go. We still treat them with decency and respect ...You know, but they are getting a service and a very professional service. And it would have been easy to have actually gone and actually joined that culture where they’re nothing but a load of bunch of bloody scallies who don’t deserve this, this and this.”

(in-reach team leader)

3.4.2 Reduction of stigma

This was not a part of the initial coding framework, but was mentioned independently by several respondents:
"I think the biggest effect that I’ve seen is taking away the stigma of actually accessing that service."

(prison healthcare team member)

“…prisoners don’t maybe have to hide they’re not well…now they know that there are services they can link into … on the [wings], people are picked up quicker.”

(prison healthcare team member)

3.4.3 Provision of outside perspective

Several respondents saw the external, independent status of the in-reach team as a helpful factor:

“…as a clinician, I think they can offer quite a lot in terms of maybe giving some advice to the prison officers as well about you know, the suicide risks and self-harm and in a way that maybe they’d question a prisoner rather than the way that the prison officer would question them.”

(prison healthcare team member)

“ Well sometimes, I'd say a lot of prisoners have got this thing about prison officers’ lack of trust, they find they can't tell them, he's one of them, and I've been looking at the mental health team. They feel that they can talk to the person, somebody professional who can deal with their problems.”

(in-reach team member)

“…there is something about having services come in from the community that is inherently healthy; it makes things less polarised and potentially less abusive.”

(prison healthcare manager)

3.4.4 Continuity of care

Several respondents mentioned improved continuity of care, both within the prison and, perhaps more importantly, on discharge or transfer:
“...an individual leaving prison it’s quite a precipitous thing you know, it’s like falling off a cliff and you’re out there feeling thoroughly unprepared so those individuals who have a CPA, the way in which that gets followed through seems to be something which wasn’t there before so I think that's entirely down to [name of in-reach team member]’s work.”

(prison healthcare manager)

"Well I can think of several in the last six months, prisoners whose discharge has been hugely improved in the sense of what it would have been."

(in-reach consultant psychiatrist)

"I do think that there is better liaison with people going out of prison and follow up. I think that comes from experts knowing who we should be dealing with and also being able to discuss the clinical requirements of the individual in a competent and convincing manner."

(prison healthcare manager)

3.4.5 Effects on staff

Finally, some respondents identified improvements to do with beneficial effects on other members of prison staff:

"I think there are some issues around the effect that having that service which is a sort of spin off down and the spin off down is that because you have very, very professional services over-riding it, then you begin to drag everything else up to begin to meet those levels and that means that the more professional the service becomes then that the minor part of your service also becomes more professional, also become more directed."

(prison officer)

With regard to training provided by in-reach staff, it was noted:

“...it's all knowledge again isn't it? It gives you more tools with which to do the job, it's a difficult enough job as it is and when you have large amounts of prisoners with mental health, health issues, if you've got a better understanding that's got to be better for everybody all round, from staff to prisoners alike.”

(prison officer)
3.5 Variation between case study sites

During the within-case analyses, the factors outlined above were identified and detailed. There were many similarities in aims, process and effects between case study sites, but also some important differences. These differences could be understood as a function of the historical context of the operation of the in-reach teams, and the particular characteristics of the setting being served by the team. Differences in focus regarding the functions of the team and the leadership provided by the in-reach team leader appeared important with regard to the extent of development and impact of the team, relative to how long any particular team had been in existence.

Team A had been in place, in some form, for over five years. Relationships between the in-reach team, staff within the healthcare centre and discipline staff were well developed, with apparent clarity regarding the functions and limitations of the in-reach team. The team leader and others identified a successful widening of the role of the team to include the provision of training and consultancy to healthcare and prison staff. Mental health awareness training for discipline staff had become an expected part of the role of the team. A high level of respect for the team leader was evident in all interviews with other stakeholders, with many of the positive effects of the team attribution to the team leader’s vision and leadership. Differences of priority between health and discipline staff were reported to be an accepted part of the role, with evident mutual respect for the different professional skills of different staff groups.

Team B was a relatively newly developed team with a team leader who was relatively new in post. Despite this, the team was reported to have a clear focus to its activities, engaging with the women in the prison with serious mental health problems. The team was reported to have good working relationships with other stakeholders and was viewed as delivering a professional service. The role of strong leadership was commented upon as a factor in the early impact that the service was reported to be having on services for prisoners.

Team C had been established slightly longer than some of the other case study site teams, working in the only private prison amongst the sample. Contextual factors associated with the interface between a private company delivering prison services and NHS staff was repeatedly reported as problematic. The focus of Team C was reported to be wider than the other in-reach teams in the case study sites, encompassing both individuals with serious mental illness and those termed ‘primary care’ clients. A large amount of staff time was taken up with assessments following deliberate self-harm, and the team reported being overloaded, with heavy demands for their services, resulting in a sense of dissatisfaction that they were ‘fire-fighting’, acting in a reactive, rather than proactive manner. Team leadership was viewed less positively by other stakeholders than in other settings. Despite these reported difficulties there were
many similarities regarding the reported benefits of the introduction of the in-reach team.

Team D were again a relatively new team. They were different from the other in-reach teams in working only with juveniles within a child and adolescent mental health team covering numerous settings including the Young Offenders Institution. The professional mix of staff was wider than in other teams. The organisational context involved wide-ranging networking and a community as well as institutional focus. Relationships with other stakeholders within the YOI were reported to be developing rapidly, and there was reported problem-solving of contextual issues regarding environmental constraints. Leadership by the team leader was reported to be positive and active. A broad range of stakeholders reported the perception of beneficial impact for the young offenders related to the introduction of the in-reach programme.

Team E were also relatively new. The general focus of the team was reported in a rather diffuse way, but seemed to be mainly an assessment role. The prison context and relationships with discipline staff were reported to continue to be challenging for in-reach team members. Strength of team leadership was reported less often by other stakeholders than in other settings. Beneficial effects of the introduction of the in-reach programme were reported, but generally only in response to prompting questions.

Team F had been in place, in some form, for three years. In-reach team members reported similar contextual difficulties as other teams, but largely as challenges that had been dealt with in the past regarding clarity about their role, responsiveness and an active focus on relationship development. A broad range of stakeholders reported the perception of beneficial impact for the prisoners of the in-reach programme, although wider roles were not reported on.

Team G had been in place, in some form, for over five years. Contextual difficulties were initially a serious obstacle and a cause of low morale. The most problematic relationships were those with other healthcare staff. However, as the team became more established and recognised throughout the prison, their motivation, sense of role efficacy and relationships with other healthcare staff strengthened. Team members were very supportive of the team leader who they saw as the driving-force behind this change. Despite various obstacles the team encountered, it was increasingly recognised that they played an important role in improving mental health services and establishing a more humane environment for prisoners.

Team H had been established for just a few months. It reported a clear focus to its activities and had started to build good relationships with other healthcare staff, particularly the healthcare manager. However, there was some confusion as to its role and who was appropriate to be referred to the team, particularly amongst non-mental healthcare staff. As a training prison, the benefits of the in-reach services for providing continuity of care on discharge from prison were frequently recognised. The prison context and relationships with discipline staff
were reported to be challenging but strong leadership and perseverance were helping to overcome such challenges.

### 3.6 Summary

The aims of the in-reach programme were most clearly enunciated by members of the in-reach teams, who indicated a clear, consistent message based (sometimes explicitly) on NHS Plan elements for mental health and the prison mental health strategy, Changing the Outlook. The principle of extending to prisoners the same mental healthcare they would have received in the community was well entrenched.

Several respondents saw this in terms of a balance, moving beyond the foundation role of addressing serious mental illness and balancing with this a primary mental health role which was more to do with alleviating distress, providing treatment and dealing with self-harm and personality disorder. Other roles included consultancy to other staff, giving advice and information, linking prison and NHS services and providing clinical leadership and training.

Processes that appeared to impact on the effective development of in-reach services related to the categories context, functions, relationships and leadership.

The historical, organisational and physical context in which the teams operated was reported frequently as affecting the operation of the teams. Specifically, there were both opportunities and problems associated with being part of a new team entering an institutional setting with well established procedures and relationships. Capitalising on the opportunity afforded by being part of a new service appeared to require clarity of function, the active development of relationships with other stakeholders, and a degree of professional self-confidence that enabled teams to challenge unhelpful institutional barriers to mental health service delivery. Particularly amongst the longer-established teams, a problem-solving approach to the issues commonly encountered was reported as an opportunity to develop working relationships with other stakeholders.

Most of the discussion in the interviews relating to the functions of the in-reach teams was associated with the processing of referrals. There was a limited degree of reporting of interventional procedures. There was clear divergence between teams regarding the extent to which they should be involved in the assessment and management of individuals who self-harmed, or had personality disorder. The one team which had embraced this activity most was also the one whose team members most often reported a sense of being overloaded by clinical demands.

Active management of relationships with other stakeholders was reported repeatedly as an important role for the in-reach team members by all groups of informants. Good working relationships appeared to be both a function of the length of establishment of the teams, and the reported quality of leadership of
those teams. Wide networks of relationships were often described as necessary for effective working, both within and outside the prison setting.

Many stakeholders identified in different ways the value of strong leadership of in-reach teams as vital to making an impact. Relatively low levels of management guidance and high levels of autonomy were reported by team leaders. It appeared that those individuals who were most able to translate broad policy into specific, focused and sustained service vision were most likely to be perceived as good leaders and managers.

While prison healthcare and discipline staff had less to say about the aims, roles and process of in-reach services, they could clearly identify the effects of those services. Some described very dramatic improvements in the quality of mental healthcare provision, and in the atmosphere of the prison, preventing admissions to in-patient care and speeding up access to appropriate services.

More than one prison healthcare team member commented that the introduction of the in-reach service had led to a reduction in stigma associated with mental illness, and several respondents saw the external, independent position of the in-reach team as helpful. Improved continuity of care for prisoners on discharge was also noted. Finally, the declared aims of introducing some clinical leadership and providing training to prison staff seems to have been met in at least some of the prisons studied.
4 Module 3

4.1 Aims

In order to evaluate the operation and effectiveness of the in-reach programme, Module 3 aimed:

- To examine the proportion of prisoners with severe and enduring mental illness (SMI) detected and receiving input from the prison in-reach programme; and
- To examine the proportion of prisoners on the mental health in-reach team caseload with SMI.

4.2 Phase one

4.2.1 Research question 1:

What proportion of people with SMI is referred to the prison in-reach programme in six prisons?

The following section describes the proportion of prisoners with SMI who were a) identified and b) treated by in-reach teams in the six prisons. It then examines a) the factors which increased the likelihood of being identified by in-reach services b) the characteristics of those receiving input.

4.2.2 Methods

This section describes the procedures used to determine the study sample size and participant recruitment, and methods of data collection.
4.2.2.1 Prison establishments

The fieldwork took place in six prisons, chosen to reflect a range of different prisoners and prison types. The following section provides some basic information on the services offered at each establishment.

Prison A was a busy local remand establishment with a high secure function. It had an operational capacity of over 800. Prison A provided twenty-four hour healthcare, with primary care and psychiatric services contracted in from local NHS providers on a full-time basis. The in-patient unit had 38 beds, mainly used for mental healthcare. General practitioner surgeries were held daily and there were a total of 42 nursing staff. In addition to this the multi-disciplinary mental health in-reach team provided a day-care centre and one-to-one services, including eight sessions a week of psychiatrists’ time and four mental health nurses, who each managed a caseload of approximately 10-12 patients at any one time.

Prison B was a local establishment for adult and young women. It had an operational capacity of 450. The prison accommodated both remand and sentenced females and operated a mother and baby unit. The prison had in-patient healthcare facilities and a multi-disciplinary mental health in-reach team. This included mental health nurses, a consultant psychiatrist, psychologists and administration support staff. The team provided services to prisoners with personality disorder as well as SMI.

Prison C was a privately run local prison for adult and young men. It accommodated both remand and sentenced prisoners and had an operational capacity of over 1,000. Prison C had twenty-four hour nursing facilities with a 20 bed in-patient unit. The in-reach team was established in 2004 and consisted of 5.5 whole time equivalent staff, including mental health nurses and administrative support. The in-reach caseload capacity was approximately 85 patients at any one time.

Prison D was a busy local remand establishment for adult men, with an additional high secure function. It had an operational capacity of over 1,000. It had twenty-four hour nursing facilities with an in-patient unit. There was a multi-disciplinary mental health in-reach team which provided day-care and one-to-one services to those with personality disorder and SMI. The team included a clinical team leader, two consultant psychiatrists, five mental health nurses, a day care centre co-ordinator, a day care therapist and a dual diagnosis specialist. The in-reach caseload capacity was approximately 80 patients at any one time.

Prison E was a male local prison with an operational capacity of over 500. It had 24 hour in-patient facilities. There was a multi-disciplinary mental health in-reach team which provided specialist mental health services for those with SMI. The mental health in-reach team consisted of six team members including a team leader, three mental health nurses, a consultant psychiatrist who provided a total of five sessions a week, and an administrator. Additional sessional support was
provided by specialist psychiatric registrars from the local medium secure unit. The in-reach team had a caseload capacity of approximately 70 patients at any one time.

Prison F was a male training prison which had an operational capacity of over a 1,000. It had a multi-disciplinary in-reach team which provided specialist mental health services to those with SMI. The team included a clinical team leader, a consultant psychiatrist who provided three sessions a week, two senior mental health practitioners and administrative support. The in-reach caseload capacity was approximately 35 patients at any one time.

4.2.2.2 Sampling

The minimum sample size for phase one was determined using an estimate of the proportion of prisoners with SMI to a confidence level of 95% (5% error). The proportion of SMI was estimated by combining rates for psychosis and/or major depression from existing research literature. Psychosis rates for male and females both on remand and sentenced were obtained from Singleton et al. (1998). Rates were calculated for the six individual sites based on their type of prison population (using legal status and gender). For the four sites dealing with both remand and sentenced prisoners the mid-point between the two relevant rates was selected. Psychosis rates were then combined with rates of severe depression reported by Brooke et al. (1996). These rates of severe depression were added to the psychosis rates to yield aggregate rates for each establishment type.

Estimated rates of SMI and operational capacity figures (obtained from the Prison Service website) were used to determine the number of participants to be recruited at each study site. Table 10 provides details of numbers of participants required, and subsequently recruited at each of the six sites.
Table 10: Sample size calculations for phase one by research site

<table>
<thead>
<tr>
<th>Research site</th>
<th>Type of establishment</th>
<th>Operational capacity</th>
<th>$\text{SMI}^2$</th>
<th>Sample needed</th>
<th>Sample recruited</th>
<th>Diff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Adult male local, high secure</td>
<td>915</td>
<td>0.11</td>
<td>188</td>
<td>168</td>
<td>-20</td>
</tr>
<tr>
<td>B</td>
<td>Adult &amp; young female local</td>
<td>450</td>
<td>0.16</td>
<td>189</td>
<td>212</td>
<td>25</td>
</tr>
<tr>
<td>C</td>
<td>Adult male local</td>
<td>1040</td>
<td>0.11</td>
<td>192</td>
<td>262</td>
<td>70</td>
</tr>
<tr>
<td>D</td>
<td>Adult male local, high secure</td>
<td>1269</td>
<td>0.11</td>
<td>199</td>
<td>210</td>
<td>11</td>
</tr>
<tr>
<td>E</td>
<td>Adult male local</td>
<td>697</td>
<td>0.11</td>
<td>176</td>
<td>129</td>
<td>-47</td>
</tr>
<tr>
<td>F</td>
<td>Adult male training</td>
<td>1046</td>
<td>0.09</td>
<td>166</td>
<td>200</td>
<td>34</td>
</tr>
<tr>
<td>Totals</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1110</td>
<td>1181</td>
<td>+71</td>
</tr>
</tbody>
</table>

Overall the total number of prisoners recruited to Module 3 was higher than required. Despite this, site specific recruitment targets were not achieved at two prisons due to operational difficulties at these prisons.

4.2.2.3 Recruitment and initial screening

A consecutive sample of prisoners, taken from the list of new receptions each day, were approached for inclusion in the study. Participants were given an information sheet and informed consent was obtained. Prisoners were asked to complete the PriSnQuest (Shaw et al. 1999), an eight item questionnaire validated to screen for mental illness in a criminal justice system population.

4.2.2.4 Clinical interviews

Participants who scored three or more on PriSnQuest and who were thus ‘screen positive’ and 5% of those who were ‘screen negative’ (scoring two or less) were asked to complete a longer clinical interview, incorporating the following instruments:

- A demographic and criminological proforma designed for the study;
- The Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978);

2 *Based on Singleton et al. (1998) and Brooke et al. (1996)
• The Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962; Ventura et al. 1993);
• Michigan Alcoholism Screening Test (MAST; Selzer et al. 1975); and
• The Drug Abuse Screening Test (DAST; Skinner, 1982).

4.2.2.5 **Administrative tracking – case note analysis**

Case notes, including core clinical records and mental health in-reach records, were routinely reviewed in order to establish whether prisoners with SMI were identified and treated by mental health in-reach services at each prison. Specifically, for each prisoner with a current SMI, evidence was sought to establish whether individuals a) received a mental health assessment and/or b) were subsequently accepted onto in-reach caseloads. This administrative tracking continued for one month following reception into custody, or until the prisoner was discharged or transferred, whichever was sooner.

4.2.2.6 **Data entry and analysis**

Data were double-entered and errors in data entry identified and corrected, thus producing a valid data set for analysis. Data were analysed using Stata version 10 software (StataCorp, 2008).

Following screening using PriSnQuest, screen positive and screen negative sampling probability weights for each prison were derived (Table 11) and applied to all prevalence estimates and regression analyses in order to derive valid point and variance estimates from the two-phase sampling design. Weighted prevalence estimates were obtained from the coefficients generated by logistic regression models, as described by Dunn et al. (1999). Where analyses were performed across all six prisons sampled variance estimates (confidence intervals) were further corrected for prison clustering effects using the Huber/White sandwich estimator (Rogers, 1993). All differences referred to in the text were significant at the 5% level. Analyses in Stata were performed using valid percents, which excluded missing data.
4.2.2.7 Ethics

Ethical approval for the research was obtained from the Thames Valley Multi-Centre Research Ethics Committee. Research governance approval was sought from the relevant NHS primary care and mental health trusts and the private sector company providing in-reach services to the research prisons.

4.2.2.8 Sample

Table 11 shows the number of participants approached and recruited at each prison. It shows the numbers and proportions of prisoners who screened positive and negative on PriSnQuest at each prison, and the proportion of the screened sample that undertook the full clinical interview. All screen positives and a 5% sample of screen negatives (for comparison purposes) were approached for interview; however, some interviews could not be completed due to prisoners being transferred, released or withdrawing from the study.
Table 11: Percentage of all prisoners who screened positive vs. negative on PriSnQuest (screening status); by screening status, percentage of screened prisoners interviewed, and sampling probability weights

<table>
<thead>
<tr>
<th>Prison</th>
<th>Prisoners approached</th>
<th>% Screening status</th>
<th>Transferred, released or withdrew before interview</th>
<th>% Interviewed</th>
<th>Sampling probability weights</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Positive³ Negative</td>
<td>Positive⁴</td>
<td>Negative</td>
<td>Positive⁵</td>
</tr>
<tr>
<td>A</td>
<td>602</td>
<td>26% (148)</td>
<td>74% (429)</td>
<td>2</td>
<td>99% (146)</td>
</tr>
<tr>
<td>B</td>
<td>572</td>
<td>44% (228)</td>
<td>56% (285)</td>
<td>28</td>
<td>88% (200)</td>
</tr>
<tr>
<td>C</td>
<td>760</td>
<td>38% (262)</td>
<td>62% (427)</td>
<td>40</td>
<td>85% (222)</td>
</tr>
<tr>
<td>D</td>
<td>830</td>
<td>34% (231)</td>
<td>66% (452)</td>
<td>36</td>
<td>84% (195)</td>
</tr>
<tr>
<td>E</td>
<td>704</td>
<td>37% (228)</td>
<td>63% (389)</td>
<td>96</td>
<td>55% (125)</td>
</tr>
<tr>
<td>F</td>
<td>403</td>
<td>45% (180)</td>
<td>55% (223)</td>
<td>0</td>
<td>100% (180)</td>
</tr>
<tr>
<td>All</td>
<td>3871</td>
<td>37% (1277)</td>
<td>63% (2205)</td>
<td>202</td>
<td>84% (1068)</td>
</tr>
</tbody>
</table>

Inspectorate reports for individual prisons were used to establish the extent to which the prisoners recruited at each site were representative of their respective prison populations. The prisoners interviewed were broadly representative of their prison populations with respect to age distribution, ethnicity, legal status and offence characteristics (see Appendix 2).

³ Figure in parentheses gives the number of prisoners per prison by screening outcome (+ vs. -) at screen.
⁴ Figure in parentheses gives the number of prisoner per prison interviewed according to screening status.
⁵ Probability sampling weights calculated as the reciprocal of: no. of subjects interviewed divided by the no. within each screening status stratum (see Dunn et al. 1999).
4.2.3 Results

4.2.3.1 Overview of population prevalence rates of SMI and substance misuse

The Schedule for Schizophrenia and Affective Disorders (SADS; Endicott & Spitzer, 1978) was used to diagnose a current episode of SMI, defined as major depressive disorder, hypomania, bipolar disorder and/or any form of psychosis including schizophrenia, schizoaffective disorder and any other non-affective, non-organic psychosis. Substance misuse problems, defined as drug and/or alcohol misuse, were also diagnosed in clinical interviews using the Michigan Alcoholism Screening Test (MAST; Selzer at al. 1975) and the Drug Abuse Screening Test (DAST; Skinner, 1982).

Population prevalence rates calculated using the SADS, MAST and DAST are reported below in Table 12. From this it can be seen that SMI was estimated to be present in 23% of the prison population. At individual sites, the prevalence of SMI ranged from 16% at prison A to 35% at prison F. Two-thirds (66%) of prisoners had a substance misuse problem. Dual diagnosis (that is both SMI and a coexisting alcohol and/or drug misuse problem) was present in 18% of the population. Overall, 71% of the prison population was estimated to have a current SMI, substance misuse problem or both.

Table 12: Prevalence (%) of SMI, substance misuse and dual diagnosis by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>SMI</th>
<th>Substance misuse</th>
<th>Dual diagnosis</th>
<th>Substance misuse, SMI or both</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% (CI)</td>
<td>n</td>
<td>% (CI)</td>
</tr>
<tr>
<td>A</td>
<td>53</td>
<td>16 (8-28)</td>
<td>137</td>
<td>69 (52-82)</td>
</tr>
<tr>
<td>B</td>
<td>108</td>
<td>33 (21-47)</td>
<td>160</td>
<td>58 (41-73)</td>
</tr>
<tr>
<td>C</td>
<td>115</td>
<td>21 (16-27)</td>
<td>216</td>
<td>71 (61-80)</td>
</tr>
<tr>
<td>D</td>
<td>72</td>
<td>17 (9-28)</td>
<td>176</td>
<td>69 (50-83)</td>
</tr>
<tr>
<td>E</td>
<td>72</td>
<td>21 (11-38)</td>
<td>112</td>
<td>64 (30-88)</td>
</tr>
<tr>
<td>F</td>
<td>131</td>
<td>35 (26-45)</td>
<td>121</td>
<td>58 (45-70)</td>
</tr>
<tr>
<td>All</td>
<td>551</td>
<td>23 (18-29)</td>
<td>922</td>
<td>66 (61-70)</td>
</tr>
</tbody>
</table>

Note that these categories are not mutually exclusive and therefore do not add up to 100%.
A breakdown of the prevalence of individual psychiatric diagnoses contributing to the overall rate of SMI is given in Table 13. These include all those diagnoses identified by SADS, with the addition of one further measure, that of major depressive disorder (SADS) combined with clinically significant symptoms of suicidality (as measured by the BPRS).

Table 13: Prevalence of SMI\(^7\) (%\(^8\)) by psychiatric diagnosis and prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Major Depressive Disorder (MDD)</th>
<th>MDD + BPRS suicidality</th>
<th>Schizoaffective disorder</th>
<th>Hypomania</th>
<th>Bipolar disorder</th>
<th>Schizophrenia</th>
<th>Other psychosis</th>
<th>Any psychosis</th>
<th>SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>14% (43)</td>
<td>7% (20)</td>
<td>0% (0)</td>
<td>1% (3)</td>
<td>0% (1)</td>
<td>1% (3)</td>
<td>1% (7)</td>
<td>2% (14)</td>
<td>16% (53)</td>
</tr>
<tr>
<td>B</td>
<td>31% (100)</td>
<td>9% (40)</td>
<td>0% (2)</td>
<td>1% (3)</td>
<td>1% (3)</td>
<td>1% (6)</td>
<td>n/a (0)</td>
<td>3% (12)</td>
<td>33% (108)</td>
</tr>
<tr>
<td>C</td>
<td>17% (90)</td>
<td>5% (27)</td>
<td>3% (17)</td>
<td>0% (0)</td>
<td>0% (3)</td>
<td>2% (12)</td>
<td>0% (1)</td>
<td>5% (32)</td>
<td>21% (115)</td>
</tr>
<tr>
<td>D</td>
<td>13% (52)</td>
<td>2% (10)</td>
<td>2% (11)</td>
<td>0% (1)</td>
<td>n/a (0)</td>
<td>1% (7)</td>
<td>1% (5)</td>
<td>4% (22)</td>
<td>17% (72)</td>
</tr>
<tr>
<td>E</td>
<td>15% (52)</td>
<td>6% (19)</td>
<td>4% (14)</td>
<td>1% (2)</td>
<td>0% (3)</td>
<td>1% (4)</td>
<td>1% (4)</td>
<td>6% (21)</td>
<td>21% (72)</td>
</tr>
<tr>
<td>F</td>
<td>32% (718)</td>
<td>2% (9)</td>
<td>2% (7)</td>
<td>0% (1)</td>
<td>0% (1)</td>
<td>1% (6)</td>
<td>1% (2)</td>
<td>3% (13)</td>
<td>35% (131)</td>
</tr>
<tr>
<td>Total</td>
<td>19% (455)</td>
<td>5% (125)</td>
<td>2% (51)</td>
<td>0% (10)</td>
<td>0% (11)</td>
<td>1% (38)</td>
<td>1% (19)</td>
<td>4% (114)</td>
<td>23% (551)</td>
</tr>
</tbody>
</table>

Across all sites, the prevalence of major depressive disorder was 19% (CI 14-26%). Particularly high rates of major depressive disorder were observed at prisons F (32%) and B (31%). The rate of psychosis observed across the sample was 4% (CI 3-6%), ranging from 2% at prison A to 6% at prison E.

4.2.3.2 **Prisoners with SMI: demographic characteristics**

In total, 551 prisoners within the sample were identified to have a current SMI. These had a mean age of 33 years (range 21-83 years). Table 14 shows the percentage of prisoners with SMI from each ethnic background.

---

\(^7\) Henceforth, all psychiatric diagnoses referred to were made using the SADS. All diagnoses of alcohol and drug misuse problems referred to were made using the MAST and DAST respectively.

\(^8\) Henceforth, all prevalence figures (percentages) using the study sample have been weighted to account for the two-phase sampling design.

\(^9\) Henceforth, all figures in brackets indicate \(n\) (number of prisoners) unless otherwise specified.
### Table 14: Prisoners with SMI: ethnicity (%) by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Ethnic background</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Black</td>
<td>White</td>
<td>Asian</td>
<td>Mixed</td>
<td>Chinese/other</td>
</tr>
<tr>
<td>A</td>
<td>30% (9)</td>
<td>62% (37)</td>
<td>4% (4)</td>
<td>3% (3)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>B</td>
<td>24% (16)</td>
<td>70% (83)</td>
<td>2% (3)</td>
<td>3% (4)</td>
<td>1% (2)</td>
</tr>
<tr>
<td>C</td>
<td>3% (4)</td>
<td>91% (104)</td>
<td>3% (4)</td>
<td>2% (2)</td>
<td>1% (1)</td>
</tr>
<tr>
<td>D</td>
<td>4% (4)</td>
<td>89% (61)</td>
<td>3% (3)</td>
<td>2% (2)</td>
<td>2% (2)</td>
</tr>
<tr>
<td>E</td>
<td>1% (1)</td>
<td>94% (68)</td>
<td>1% (1)</td>
<td>1% (1)</td>
<td>1% (1)</td>
</tr>
<tr>
<td>F</td>
<td>4% (5)</td>
<td>96% (125)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>All</td>
<td>11% (39)</td>
<td>84% (478)</td>
<td>2% (15)</td>
<td>2% (12)</td>
<td>1% (6)</td>
</tr>
</tbody>
</table>

As can be seen from the table above, the proportion of prisoners with SMI from black and minority ethnic groups was highest in prisons A and B, a finding which perhaps reflects the diversity of the local populations served by these prisons. Prison B is also the closest female prison to a major international airport and consequently has a high number of foreign national prisoners.

**4.2.3.3 Prisoners with SMI: index offence and legal status**

All participants with SMI were asked about the index offence with which they had been charged or convicted. The results for each research site are shown in Table 15.
The three commonest offences within the SMI group were other offences (25%); violence against the person (18%); and theft and/or handling stolen goods (18%). The ‘other offences’ category covered a wide range of criminal acts including motoring offences, immigration offences, possession of an offensive weapon and arson, but comprised mostly breach of probation and/or community orders.

Prisoners with SMI were also asked for their current legal status at the time of the interview. The proportion of prisoners in each category at the various research establishments is shown in Table 16.
Table 16: Prisoners with SMI: current status (%) by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Status</th>
<th>Remand</th>
<th>Convicted sentenced</th>
<th>Convicted unsentenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td>74% (30)</td>
<td>19% (17)</td>
<td>7% (6)</td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>59% (67)</td>
<td>39% (38)</td>
<td>2% (3)</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>56% (70)</td>
<td>42% (44)</td>
<td>1% (1)</td>
</tr>
<tr>
<td>D</td>
<td></td>
<td>35% (34)</td>
<td>63% (36)</td>
<td>2% (2)</td>
</tr>
<tr>
<td>E</td>
<td></td>
<td>33% (24)</td>
<td>54% (39)</td>
<td>13% (9)</td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>0% (0)</td>
<td>100% (131)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td>43% (225)</td>
<td>54% (304)</td>
<td>4% (21)</td>
</tr>
</tbody>
</table>

Of those with a current SMI, approximately half (54%) were sentenced prisoners, 43% were on remand and 4% had been convicted and were awaiting sentencing.

4.2.3.4 **Prisoners with SMI: substance misuse**

Table 17 shows the proportion of prisoners currently in an episode of SMI who also had a substance misuse (alcohol and/or drug) problem at each establishment (as measured by MAST and DAST).
Table 17: Prisoners with SMI: prevalence (%) of dual diagnosis by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Alcohol misuse</th>
<th>Drug misuse</th>
<th>Alcohol and drug misuse</th>
<th>Alcohol misuse, drug misuse or both</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>55% (31)</td>
<td>64% (39)</td>
<td>49% (26)</td>
<td>70% (44)</td>
<td>30% (9)</td>
</tr>
<tr>
<td>B</td>
<td>41% (40)</td>
<td>51% (75)</td>
<td>23% (34)</td>
<td>68% (81)</td>
<td>32% (27)</td>
</tr>
<tr>
<td>C</td>
<td>49% (60)</td>
<td>72% (80)</td>
<td>34% (42)</td>
<td>86% (98)</td>
<td>14% (17)</td>
</tr>
<tr>
<td>D</td>
<td>45% (43)</td>
<td>76% (49)</td>
<td>30% (29)</td>
<td>91% (63)</td>
<td>9% (9)</td>
</tr>
<tr>
<td>E</td>
<td>68% (49)</td>
<td>71% (51)</td>
<td>51% (37)</td>
<td>88% (63)</td>
<td>13% (9)</td>
</tr>
<tr>
<td>F</td>
<td>39% (45)</td>
<td>47% (67)</td>
<td>21% (29)</td>
<td>66% (83)</td>
<td>34% (48)</td>
</tr>
<tr>
<td>All</td>
<td>49% (268)</td>
<td>63% (361)</td>
<td>33% (197)</td>
<td>78% (432)</td>
<td>22% (119)</td>
</tr>
</tbody>
</table>

Table 17 shows the percentage of prisoners who have both SMI and a substance misuse problem in each research establishment. From this it can be seen that overall 78% of the sample with SMI had a dual diagnosis.

4.2.3.5 **Prisoners with SMI: prior service contact**

Table 18 provides an overview of the proportion of prisoners currently in an episode of SMI who had prior contact with drug, alcohol and/or mental health services.
Table 18: Prisoners with SMI: percentage that reported prior contact with substance misuse and mental health services by psychiatric diagnosis

<table>
<thead>
<tr>
<th>Service</th>
<th>Psychiatric diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MDD</td>
</tr>
<tr>
<td>Drug services pre-custody</td>
<td>26%</td>
</tr>
<tr>
<td>Alcohol services pre-custody</td>
<td>12%</td>
</tr>
<tr>
<td>Mental health services (ever)</td>
<td>59%</td>
</tr>
<tr>
<td>Mental health services (current&lt;sup&gt;10&lt;/sup&gt;)</td>
<td>16%</td>
</tr>
<tr>
<td>Prison mental health services (ever)</td>
<td>29%</td>
</tr>
</tbody>
</table>

Figures 13-15 show; the proportion of prisoners with a current diagnosis of SMI in each research establishment who: have ever had prior contact with mental health services (Figure 13); were receiving treatment from psychiatric services in the community immediately before entering prison (Figure 14); and have previously received mental health services in prison (Figure 15).

<sup>10</sup> Henceforth, ‘current’ contact refers to ongoing contact with community mental health services immediately prior to custody.
Almost two-thirds (63%) of prisoners with a current diagnosis of SMI had prior contact with mental health services ever; however it is notable that just 18% of those with SMI were in contact with services immediately prior to reception into custody. As we would expect, those with a current diagnosis of SMI were significantly more likely to have been receiving psychiatric treatment prior to reception into custody than those without SMI ($\chi^2 = 14.3$, df=1, $p<.001$). Figure 16 shows the type of intervention received by those with SMI prior to reception into custody.

Figure 16: Prisoners with SMI: type of intervention received prior to reception into prison (%) by psychiatric diagnosis

4.2.3.6 Prisoners with SMI: prior prescribed medication use

Table 19 shows the percentage of prisoners with SMI in receipt of prescribed medication before reception into custody. Approximately half (53%) of those with schizophrenia were taking antipsychotics and 27% of those with major depressive disorder were taking antidepressants.
### Table 19: Prisoners with SMI: percentage that reported being in receipt of prescribed medication immediately prior to custody by psychiatric diagnosis

<table>
<thead>
<tr>
<th>Medication type</th>
<th>MDD</th>
<th>MDD + BPRS suicidality</th>
<th>Schizoaffective disorder</th>
<th>Hypomania</th>
<th>Bipolar disorder</th>
<th>Schizophrenia</th>
<th>Other psychosis</th>
<th>Any psychosis</th>
<th>SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detoxification</td>
<td>11% (57)</td>
<td>15% (19)</td>
<td>15% (7)</td>
<td>0% (0)</td>
<td>8% (1)</td>
<td>11% (4)</td>
<td>13% (2)</td>
<td>13% (13)</td>
<td>11% (69)</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>17% (77)</td>
<td>20% (27)</td>
<td>16% (7)</td>
<td>19% (2)</td>
<td>22% (2)</td>
<td>19% (7)</td>
<td>14% (3)</td>
<td>19% (20)</td>
<td>17% (90)</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>27% (129)</td>
<td>40% (37)</td>
<td>26% (12)</td>
<td>9% (1)</td>
<td>7% (1)</td>
<td>16% (6)</td>
<td>53% (9)</td>
<td>27% (28)</td>
<td>26% (148)</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>5% (28)</td>
<td>10% (14)</td>
<td>17% (9)</td>
<td>16% (1)</td>
<td>22% (2)</td>
<td>53% (18)</td>
<td>19% (4)</td>
<td>27% (29)</td>
<td>8% (51)</td>
</tr>
<tr>
<td>Mood stabilisers</td>
<td>4% (8)</td>
<td>14% (4)</td>
<td>2% (1)</td>
<td>0% (0)</td>
<td>8% (1)</td>
<td>5% (2)</td>
<td>0% (0)</td>
<td>3% (4)</td>
<td>4% (11)</td>
</tr>
</tbody>
</table>

4.2.3.7 *What proportion of those with SMI are identified and treated by mental health in-reach services?*

The previous section of this report confirmed that the rates of SMI and substance misuse were high in the prisons sampled. The following section will examine the proportion of prisoners with SMI who were identified and treated by prison in-reach services.

---

11 Mood stabilisers refer to a class of psychiatric medication used to treat mood disorders such as bipolar disorder and hypomania e.g. lithium, carbamazepine and sodium valproate.
Table 20: Prisoners with SMI: percentage assessed and accepted onto in-reach caseloads by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Assessed</th>
<th>Accepted onto caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% (CI)</td>
</tr>
<tr>
<td>A</td>
<td>17</td>
<td>25 (12-46)</td>
</tr>
<tr>
<td>B</td>
<td>18</td>
<td>30 (12-57)</td>
</tr>
<tr>
<td>C</td>
<td>28</td>
<td>23 (16-32)</td>
</tr>
<tr>
<td>D</td>
<td>17</td>
<td>18 (9-33)</td>
</tr>
<tr>
<td>E</td>
<td>30</td>
<td>45 (33-57)</td>
</tr>
<tr>
<td>F</td>
<td>16</td>
<td>11 (7-18)</td>
</tr>
<tr>
<td>All</td>
<td>126</td>
<td>25 (17-36)</td>
</tr>
</tbody>
</table>

From Table 20 it can be seen that 25% (CI 17-36%) of prisoners with a current SMI were assessed by in-reach services and 13% (CI 10-17%) were accepted onto their caseloads. Thus the vast majority of prisoners with SMI were not identified by prison in-reach services.

In view of these findings, a narrower definition of SMI was devised, which included (i) all those with psychosis and (ii) those with major depressive disorder with a clinical level of suicidality (as measured by the BPRS), as we would argue that these sub-groups should have been under the care of secondary mental healthcare in-reach services.

Table 21 below shows the proportions of prisoners fulfilling these narrower SMI criteria that were assessed by in-reach teams and/or accepted onto caseloads.

Table 21: Prisoners with SMI (narrow): percentage assessed and accepted onto in-reach caseloads by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Assessed</th>
<th>Accepted onto caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>% (CI)</td>
</tr>
<tr>
<td>A</td>
<td>12</td>
<td>41 (25-60)</td>
</tr>
<tr>
<td>B</td>
<td>11</td>
<td>22 (13-36)</td>
</tr>
<tr>
<td>C</td>
<td>21</td>
<td>38 (26-52)</td>
</tr>
<tr>
<td>D</td>
<td>11</td>
<td>35 (21-54)</td>
</tr>
<tr>
<td>E</td>
<td>20</td>
<td>54 (38-69)</td>
</tr>
<tr>
<td>F</td>
<td>7</td>
<td>32 (16-54)</td>
</tr>
<tr>
<td>All</td>
<td>82</td>
<td>38 (32-45)</td>
</tr>
</tbody>
</table>

12 This includes prisoners who received an initial ‘pre-assessment’ to decide whether or not they required a more thorough assessment by the in-reach team.
Even with SMI redefined in this narrower context, the proportion of prisoners with SMI assessed by in-reach teams and/or accepted onto caseloads remained low. Rates of assessment averaged just 38% (CI 32-45%) across the sample, while rates of acceptance onto the caseload averaged 26% (CI 21-33%).

This next section of the report will continue to use the redefined definition of SMI (narrow) in order to focus upon the needs of those who were the most severely ill.

Table 22 below shows the proportion of prisoners assessed by in-reach services and accepted onto their caseload by psychiatric diagnosis.

<table>
<thead>
<tr>
<th>Psychiatric diagnosis</th>
<th>Assessed by in-reach</th>
<th>Accepted onto caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDD + BPRS suicidality</td>
<td>29% (33)</td>
<td>17% (19)</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>42% (21)</td>
<td>33% (16)</td>
</tr>
<tr>
<td>Hypomania</td>
<td>56% (5)</td>
<td>48% (4)</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>53% (5)</td>
<td>53% (5)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>60% (22)</td>
<td>50% (18)</td>
</tr>
<tr>
<td>Other psychosis</td>
<td>54% (9)</td>
<td>34% (6)</td>
</tr>
<tr>
<td>Any psychosis</td>
<td>47% (51)</td>
<td>35% (38)</td>
</tr>
<tr>
<td>Dual diagnosis</td>
<td>38% (69)</td>
<td>26% (46)</td>
</tr>
</tbody>
</table>

From the table above, it can be seen that prisoners with psychotic disorders were more likely to be assessed (47% vs. 29%) and accepted (35% vs. 17%) onto in-reach team caseloads than those with major depressive disorder (with clinically significant symptoms of suicidality); univariate analyses showed that these differences were statistically significant ($\chi^2=9.53$, df=1, p=<.01; $\chi^2=39.28$, df=1, p=<.001). Those prisoners with a dual diagnosis were no more likely to be assessed or accepted onto the in-reach caseload than those with SMI alone ($\chi^2 = 0.00$, df=1, p=.99; $\chi^2 = 0.04$, df=1, p=.85).

---

13 Note n/a has been used where no cases of a particular psychiatric illness were diagnosed by the research team, therefore there were no opportunities for in-reach teams to initiate contact.

14 Assessment and acceptance figures by psychiatric diagnosis for individual prisons are presented in Appendix 3.
The impact of prior contact with mental health services on in-reach assessment and acceptance rates is shown in Tables 23 and 24.

**Table 23: Prisoners with SMI (narrow): percentage assessed by in-reach services by psychiatric diagnosis and prior history of contact with mental health services (MHS)**

<table>
<thead>
<tr>
<th>Psychiatric diagnosis</th>
<th>MHS contact type</th>
<th>MHS contact type</th>
<th>Prison MHS contact type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contact</td>
<td>None</td>
<td>Contact</td>
</tr>
<tr>
<td>MDD + BPRS suicidality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypomania</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other psychosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any psychosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dual diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMI (narrow)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric diagnosis</th>
<th>Contact</th>
<th>None</th>
<th>Contact</th>
<th>None</th>
<th>Contact</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHS contact (ever)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32% (28)</td>
<td>17% (5)</td>
<td>43% (11)</td>
<td>24% (22)</td>
<td>45% (17)</td>
<td>21% (16)</td>
<td></td>
</tr>
<tr>
<td>MHS contact (current)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53% (21)</td>
<td>0% (0)</td>
<td>65% (8)</td>
<td>35% (13)</td>
<td>56% (10)</td>
<td>35% (11)</td>
<td></td>
</tr>
<tr>
<td>Prison MHS contact (ever)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>68% (5)</td>
<td>0% (0)</td>
<td>100% (2)</td>
<td>47% (3)</td>
<td>80% (3)</td>
<td>39% (2)</td>
<td></td>
</tr>
<tr>
<td>MDS + BPRS suicidality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypomania</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar disorder</td>
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<td></td>
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<tr>
<td>Schizophrenia</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other psychosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any psychosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dual diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMI (narrow)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric diagnosis</th>
<th>Contact</th>
<th>None</th>
<th>Contact</th>
<th>None</th>
<th>Contact</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHS contact (ever)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61% (20)</td>
<td>50% (2)</td>
<td>67% (11)</td>
<td>57% (11)</td>
<td>62% (14)</td>
<td>57% (8)</td>
<td></td>
</tr>
<tr>
<td>MHS contact (current)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64% (8)</td>
<td>21% (1)</td>
<td>62% (4)</td>
<td>50% (5)</td>
<td>67% (5)</td>
<td>44% (4)</td>
<td></td>
</tr>
<tr>
<td>Prison MHS contact (ever)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53% (48)</td>
<td>15% (3)</td>
<td>64% (22)</td>
<td>40% (29)</td>
<td>58% (29)</td>
<td>38% (22)</td>
<td></td>
</tr>
<tr>
<td>MDS + BPRS suicidality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypomania</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bipolar disorder</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other psychosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any psychosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dual diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMI (narrow)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 24: Prisoners with SMI (narrow): percentage accepted onto in-reach caseloads, by psychiatric diagnosis and prior history of contact with MHS

<table>
<thead>
<tr>
<th>Psychiatric diagnosis</th>
<th>MHS contact (ever)</th>
<th>MHS contact (current)</th>
<th>Prison MHS contact (ever)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Contact</td>
<td>None</td>
<td>Contact</td>
</tr>
<tr>
<td>MDD + BPRS suicidality</td>
<td>18% (15)</td>
<td>14% (4)</td>
<td>30% (7)</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>41% (16)</td>
<td>0% (0)</td>
<td>50% (6)</td>
</tr>
<tr>
<td>Hypomania</td>
<td>58% (4)</td>
<td>0% (0)</td>
<td>50% (1)</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>53% (5)</td>
<td>n/a</td>
<td>0% (0)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>53% (17)</td>
<td>25% (1)</td>
<td>67% (11)</td>
</tr>
<tr>
<td>Other psychosis</td>
<td>44% (6)</td>
<td>0% (0)</td>
<td>40% (3)</td>
</tr>
<tr>
<td>Any psychosis</td>
<td>41% (37)</td>
<td>5% (1)</td>
<td>52% (18)</td>
</tr>
<tr>
<td>Dual diagnosis</td>
<td>30% (42)</td>
<td>10% (4)</td>
<td>43% (20)</td>
</tr>
<tr>
<td>SMI (narrow)</td>
<td>30% (50)</td>
<td>10% (5)</td>
<td>44% (24)</td>
</tr>
</tbody>
</table>

Overall, prisoners with SMI who had prior contact with mental health services were significantly more likely to be assessed and/or accepted onto in-reach team caseloads than those that had no prior contact ($\chi^2=7.75$, df=1, $p<=.01$; $\chi^2=7.50$, df=1, $p<=.01$). Of the three contact types identified, in-reach assessment and acceptance rates were highest amongst those with SMI who had been in current contact with services prior to custody, with 57% of these prisoners assessed and 44% accepted onto caseloads overall.

It has already been shown that rates of assessment and acceptance were highest amongst those with psychotic disorders; further statistical analyses showed that amongst those with psychosis, those that had prior contact with mental health services (ever) were significantly more likely to be assessed ($\chi^2=7.48$, df=1, $p<=.01$) and/or accepted ($\chi^2=6.94$, df=1, $p<=.01$) onto in-reach caseloads than those with no prior contact. For those with major depressive disorder, comparatively higher in-reach assessment and acceptance rates were also observed for those reporting prior contact with services (ever); however, when compared with rates amongst prisoners with no prior contact, these differences were not statistically significant ($\chi^2=3.76$, df=1, $p=.053$; $\chi^2=0.80$, df=1, $p=.37$).
4.3 Phase two

4.3.1 Research question 2: 
What proportion of clients on in-reach caseloads have a current severe and enduring mental illness (SMI)?

The following section examines the characteristics of prison mental health in-reach clients in five prisons. It then examines the proportion of in-reach clients with a current diagnosis of SMI.

4.3.2 Methods

This section describes the procedures used to determine sample size, recruitment of the sample of prisoners and data collection.

4.3.3 Sampling

The minimum sample size for phase two was determined using an estimate of the proportion of prisoners with SMI on the in-reach caseload with a confidence level of 95% (5% error). There were no figures available to indicate the prevalence of SMI amongst prisoners on in-reach caseloads. Therefore, rates from Greenwood et al. (2000) reporting prevalence of SMI on caseloads of community mental health teams were used. While these findings allowed a comparable definition of SMI to be used, they assumed an equal gender ratio across the caseload. Therefore, it was expected that there may be some discrepancies between the two caseloads.

The estimated rate of SMI and the number of people on in-reach caseloads (obtained from the individual prison establishments) were used to determine the number of participants to be recruited overall. Sample size calculations indicated that a minimum of 160 participants should be recruited in order to estimate the proportion of prisoners on in-reach caseloads with SMI (to within 5% of the true value with 95% confidence) when it is estimated that the rate of SMI was approximately 0.68.
4.3.4 Recruitment

In order to examine the composition of in-reach caseloads and the proportion of in-reach clients with SMI, a random sample of prisoners receiving mental health in-reach services were approached to take part in phase two of the study. Potential participants were given an information sheet and informed consent was obtained.

4.3.5 Clinical interviews

Participants who consented to take part were asked to complete the same clinical interview as participants in phase one, incorporating the following instruments:

A demographic and criminological proforma;

- The SADS;
- The BPRS;
- The MAST; and
- The DAST

In addition to this, participants were asked to complete the Schedule for Clinical Interviews for DSM IV Axis II Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams & Benjamin, 1997). SCID-II is a semi-structured interview for assessing and identifying the ten DSM-IV (American Psychiatric Association, 1994) Axis II personality disorders, as well as depressive personality disorder and passive-aggressive personality disorder.

4.3.6 Data entry and analysis

Data were double entered to enable the identification and correction of data entry errors, thereby producing a valid data set for analysis. All statistical analyses were conducted using Stata 10 software (StataCorp, 2008). Differences referred to in the text were significant at the 5% level. Analyses in Stata were performed using valid percents, which exclude missing data.
4.3.7 Ethics

Ethical approval for the research was obtained from the Thames Valley Multi-Centre Research Ethics Committee. Research governance and management approval was sought from the relevant NHS primary care and mental health trusts. Organisational approval was also sought from the private sector company providing in-reach services to a contracted research site.

4.3.8 Sample

In total, 177 participants were randomly recruited from the caseloads of prison mental health in-reach services across five\footnote{Prison E did not participate in phase two of the study. See prison establishments for a description of each prison where phase two fieldwork was undertaken.} prisons. The prisoners had a mean age of 35 years (range 21-73). Eighty-five percent of prisoners (n=151) were male and 15% (n=26) were female.
4.3.9 Results

4.3.9.1 Demographic characteristics

Table 25 shows the distribution of ethnicity at each research site. Official ethnicity figures, taken from HM Chief Inspector of Prisons Inspectorate (HMCIP) Reports\textsuperscript{16}, are shown in brackets. From this it can be seen that overall, the majority of in-reach clients sampled were White (82%), with the remaining 18% of prisoners comprising Black and Minority Ethnic (BME) groups. The proportion of prisoners from BME groups was highest at prisons A (29%) and D (26%), reflecting the diversity of local community populations.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
Prison & Black & White & Asian & Mixed & Chinese or other \\
\hline
A & 16\% (28\%) & 71\% (56\%) & 3\% (9\%) & 10\% (6\%) & 0\% (1\%) \\
B & 4\% (28\%) & 80\% (62\%) & 4\% (3\%) & 8\% (4\%) & 4\% (2\%) \\
C & 5\% (5\%) & 89\% (84\%) & 5\% (6\%) & 0\% (5\%) & 0\% (0\%) \\
D & 16\% (10\%) & 75\% (75\%) & 4\% (10\%) & 6\% (3\%) & 0\% (2\%) \\
F & 3\% (3\%) & 97\% (92\%) & 0\% (5\%) & 0\% (1\%) & 0\% (1\%) \\
\hline
All & 10\% & 82\% & 3\% & 5\% & 1\% \\
\hline
\end{tabular}
\caption{Ethnicity (\%) of in-reach clients within the sample and HMCIP figures (\% in brackets) by prison\textsuperscript{17}}
\end{table}

A comparison of the ethnic background of those in the research sample and the distribution of ethnicity across each establishment gathered from HMCIP reports revealed that prisoners from White ethnic backgrounds were over-represented in the in-reach caseload sample as a whole, and in particular at prisons C (89%) and F (97%).

\textsuperscript{16} The relevant HMCIP reports are, however, not included in the reference list as this would breach the anonymity of the participating sites.
\textsuperscript{17} Official figures do not always add up to 100\% due to rounding.
4.3.9.2 **Index offence and legal status**

All in-reach clients were asked about the index offence with which they had been charged or convicted during the most recent reception into custody. Table 26 presents these findings for each research site.

Table 26: Index offence of in-reach clients (%) within the sample and HMCIP figures (% in brackets) by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Violence against the person</th>
<th>Sexual offences</th>
<th>Robbery</th>
<th>Burglary</th>
<th>Theft &amp; handling</th>
<th>Fraud &amp; forgery</th>
<th>Drug offences</th>
<th>Other offences</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>48% (37%)</td>
<td>6% (9%)</td>
<td>6% (4%)</td>
<td>6% (6%)</td>
<td>6% (6%)</td>
<td>3% (2%)</td>
<td>0% (8%)</td>
<td>23% (28%)</td>
</tr>
<tr>
<td>B</td>
<td>31% (7%)</td>
<td>0% (0%)</td>
<td>12% (5%)</td>
<td>8% (3%)</td>
<td>4% (18%)</td>
<td>0% (2%)</td>
<td>8% (11%)</td>
<td>38% (55%)</td>
</tr>
<tr>
<td>C</td>
<td>21% (17%)</td>
<td>8% (4%)</td>
<td>15% (10%)</td>
<td>5% (13%)</td>
<td>15% (12%)</td>
<td>0% (3%)</td>
<td>0% (12%)</td>
<td>36% (33%)</td>
</tr>
<tr>
<td>D</td>
<td>37% (20%)</td>
<td>8% (10%)</td>
<td>14% (15%)</td>
<td>16% (6%)</td>
<td>0% (6%)</td>
<td>2% (2%)</td>
<td>0% (3%)</td>
<td>24% (23%)</td>
</tr>
<tr>
<td>F</td>
<td>10% (11%)</td>
<td>59% (49%)</td>
<td>17% (11%)</td>
<td>3% (7%)</td>
<td>0% (1%)</td>
<td>0% (0%)</td>
<td>3% (10%)</td>
<td>7% (11%)</td>
</tr>
<tr>
<td>All</td>
<td>30%</td>
<td>15%</td>
<td>13%</td>
<td>9%</td>
<td>5%</td>
<td>1%</td>
<td>2%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Table 26 shows that violence against the person (30%), other offences (26%) and sexual offences (15%) were the most common index offences. The ‘other offences’ category encompassed a wide range of criminal acts including motoring offences, immigration offences and possession of an offensive weapon, but mostly comprised of arson (29%) and breach of probation and/or community orders (10%).

Comparison of the distribution of the offences with the research sample with, the distribution of index offences across each establishment, gathered from HMCIP reports, showed that violent offences were over-represented in the research sample. Furthermore, two-thirds (59%) of the in-reach clients recruited at prison F were convicted of sexual offences. This is unsurprising since this prison allocates up to half of its accommodation to vulnerable prisoners.

In-reach clients were also asked to report their current legal status (Table 27). At the time of interview a third (30%) of in-reach clients were on remand, 63% were convicted sentenced and 7% had been convicted and were awaiting
sentencing. Prison F was a wholly sentenced establishment. Overall, prisoners who were convicted and awaiting sentencing were under-represented across all research sites in comparison to HMCIP figures.

Table 27: Current status (%) of in-reach clients within the sample and HMCIP figures (% in brackets) by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Status</th>
<th>Remand</th>
<th>Convicted sentenced</th>
<th>Convicted unsentenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td>35% (15%)</td>
<td>42% (51%)</td>
<td>23% (31%)</td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>62% (37%)</td>
<td>38% (42%)</td>
<td>0% (21%)</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>46% (64%)</td>
<td>51% (25%)</td>
<td>3% (11%)</td>
</tr>
<tr>
<td>D</td>
<td></td>
<td>16% (17%)</td>
<td>76% (69%)</td>
<td>8% (12%)</td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>0% (0%)</td>
<td>100% (100%)</td>
<td>0% (0%)</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td>30%</td>
<td>63%</td>
<td>7%</td>
</tr>
</tbody>
</table>

4.3.9.3 Prior substance misuse

Table 28 shows the prevalence of substance misuse problems among prison in-reach clients sampled at each research establishment.

---

18 Figures do not always add up to 100% as official figures include additional categories relating to detainees and civil prisoners, which are not included here.
Table 28: Prevalence (%) of substance misuse problems amongst in-reach clients by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Alcohol misuse</th>
<th>Alcohol services pre-custody</th>
<th>Drug misuse</th>
<th>Drug services pre-custody</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>32% (10)</td>
<td>6% (2)</td>
<td>58% (18)</td>
<td>10% (3)</td>
</tr>
<tr>
<td>B</td>
<td>65% (17)</td>
<td>12% (3)</td>
<td>65% (17)</td>
<td>23% (6)</td>
</tr>
<tr>
<td>C</td>
<td>50% (20)</td>
<td>21% (8)</td>
<td>65% (26)</td>
<td>18% (7)</td>
</tr>
<tr>
<td>D</td>
<td>49% (25)</td>
<td>10% (5)</td>
<td>57% (29)</td>
<td>24% (12)</td>
</tr>
<tr>
<td>F</td>
<td>31% (9)</td>
<td>7% (2)</td>
<td>45% (13)</td>
<td>10% (3)</td>
</tr>
<tr>
<td>All</td>
<td>46% (81)</td>
<td>11% (20)</td>
<td>58% (103)</td>
<td>18% (31)</td>
</tr>
</tbody>
</table>

Table 28 shows the percentage of prisoners who have both SMI and a substance misuse problem in each research establishment. From this it can be seen that overall 78% of the sample with SMI had a dual diagnosis.

Table 28 further illustrates that 46% of the in-reach clients had an alcohol misuse problem; these proportions were highest at prisons B (65%) and C (50%). It can also be seen that 58% of the sample had a drug misuse problem, with rates highest at prisons B (65%) and C (65%). Overall, 11% of the sample reported contact with specialist alcohol services and 18% contact with specialist drug services immediately prior to reception reported into custody.

4.3.9.4 Previous contact with mental health services

Over three-quarters (90%) of the sample had a prior history of contact with mental health services (Figure 17).
Within the sample, 43% reported contact with mental health service immediately prior to prison reception (Figure 18).

Two-thirds (66%) of prisoners had previously received mental health services in prison (Figure 19).
4.3.9.5 *Prior prescribed medication use*

Prisoners on the in-reach caseload were asked if they were in receipt of any prescribed medication immediately prior to their reception into custody. The results for each research site are shown in Table 29.
Table 29: Percentage of prisoners that reported being in receipt of prescribed medication immediately prior to custody by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Detoxification</th>
<th>Benzodiazepines</th>
<th>Antidepressants</th>
<th>Antipsychotics</th>
<th>Mood stabilisers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>10% (3)</td>
<td>13% (4)</td>
<td>13% (4)</td>
<td>26% (8)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>B</td>
<td>8% (2)</td>
<td>12% (3)</td>
<td>31% (8)</td>
<td>35 (9)</td>
<td>4% (1)</td>
</tr>
<tr>
<td>C</td>
<td>5% (2)</td>
<td>18% (7)</td>
<td>36% (14)</td>
<td>31% (12)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>D</td>
<td>2% (1)</td>
<td>6% (3)</td>
<td>33% (17)</td>
<td>37% (19)</td>
<td>8% (4)</td>
</tr>
<tr>
<td>F</td>
<td>0% (0)</td>
<td>10% (3)</td>
<td>45% (13)</td>
<td>31% (9)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>All</td>
<td>5% (8)</td>
<td>11% (20)</td>
<td>32% (56)</td>
<td>32% (57)</td>
<td>3% (5)</td>
</tr>
</tbody>
</table>

Table 29 shows that a third (32%) of in-reach clients had been prescribed antipsychotic medication and a third (32%) had been prescribed antidepressant medication immediately prior to reception into custody. From this it can also be seen that overall, a third (32%) of in-reach clients had been prescribed antidepressant medication immediately prior to reception into custody.

4.3.9.6 Prevalence of SMI amongst prisoners receiving in-reach services

The prevalence of SMI amongst in-reach clients at each research site is shown in Table 30.
Table 30: Percentage of in-reach clients with SMI by psychiatric diagnosis and prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>MDD</th>
<th>MDD + BPRS suicidality</th>
<th>Schizoaffective disorder</th>
<th>Hypomania</th>
<th>Bipolar disorder</th>
<th>Schizophrenia</th>
<th>Other psychosis</th>
<th>Any psychosis</th>
<th>SMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>23% (7)</td>
<td>6 (2)</td>
<td>3% (1)</td>
<td>0 (0)</td>
<td>3% (1)</td>
<td>6 (2)</td>
<td>6 (2)</td>
<td>16% (5)</td>
<td>35% (11)</td>
</tr>
<tr>
<td>B</td>
<td>42% (11)</td>
<td>38% (10)</td>
<td>0% (0)</td>
<td>4% (1)</td>
<td>0% (0)</td>
<td>8% (2)</td>
<td>0% (0)</td>
<td>12% (3)</td>
<td>50% (13)</td>
</tr>
<tr>
<td>C</td>
<td>23% (9)</td>
<td>3% (1)</td>
<td>10% (4)</td>
<td>0% (0)</td>
<td>18% (7)</td>
<td>0% (0)</td>
<td>23% (9)</td>
<td>45% (18)</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>6% (3)</td>
<td>6% (3)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>0% (0)</td>
<td>22% (11)</td>
<td>0% (0)</td>
<td>22% (11)</td>
<td>25% (13)</td>
</tr>
<tr>
<td>E</td>
<td>21% (6)</td>
<td>7% (2)</td>
<td>28% (8)</td>
<td>3% (1)</td>
<td>0% (0)</td>
<td>7% (2)</td>
<td>0% (0)</td>
<td>38% (11)</td>
<td>55% (16)</td>
</tr>
<tr>
<td>Total</td>
<td>20% (36)</td>
<td>10% (18)</td>
<td>7% (13)</td>
<td>1% (2)</td>
<td>1% (1)</td>
<td>14% (24)</td>
<td>1% (2)</td>
<td>22% (39)</td>
<td>40% (71)</td>
</tr>
</tbody>
</table>

Overall, 40% of prisoners on the in-reach caseload had a current diagnosis of SMI. The highest rates of SMI were observed at prison F (55%). The most prevalent individual disorder reported was major depressive disorder (20%), half (50%) of whom also presented with clinically significant symptoms of suicidality. Amongst the 22% of in-reach clients with psychosis, 62% were diagnosed with schizophrenia.

Notably, two-thirds (60%) of prisoners on the in-reach caseload did not have a diagnosis of current SMI.

4.3.9.7 Prevalence of personality disorder

This following section explores the prevalence of personality disorder amongst in-reach clients. The SCID-II was used to diagnose personality disorders. Table 31 shows the percentage of in-reach clients diagnosed with individual personality disorders across each research site.
## Table 31: Percentage of in-reach clients by PD\(^\text{19}\) and prison

<table>
<thead>
<tr>
<th>Personality disorder</th>
<th>Prison</th>
<th>Avoidant</th>
<th>Dependant</th>
<th>Obsessive compulsive</th>
<th>Passive aggressive</th>
<th>Depressive</th>
<th>Paranoid</th>
<th>Schizotypal</th>
<th>Schizoid</th>
<th>Narcissistic</th>
<th>Borderline</th>
<th>Anti-social (full criteria) Disorder</th>
<th>NOS</th>
<th>Any PD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
<td>10%</td>
<td>6%</td>
<td>0%</td>
<td>3%</td>
<td>6%</td>
<td>13%</td>
<td>3%</td>
<td>3%</td>
<td>0%</td>
<td>3%</td>
<td>23%</td>
<td>3%</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3)</td>
<td>(2)</td>
<td>(0)</td>
<td>(1)</td>
<td>(2)</td>
<td>(4)</td>
<td>(1)</td>
<td>(0)</td>
<td>(0)</td>
<td>(1)</td>
<td>(7)</td>
<td>(1)</td>
<td>(13)</td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>27%</td>
<td>8%</td>
<td>8%</td>
<td>0%</td>
<td>35%</td>
<td>27%</td>
<td>23%</td>
<td>31%</td>
<td>4%</td>
<td>50%</td>
<td>46%</td>
<td>0%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7)</td>
<td>(2)</td>
<td>(0)</td>
<td>(0)</td>
<td>(9)</td>
<td>(7)</td>
<td>(6)</td>
<td>(8)</td>
<td>(1)</td>
<td>(13)</td>
<td>(12)</td>
<td>(0)</td>
<td>(17)</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>13%</td>
<td>3%</td>
<td>5%</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>3%</td>
<td>3%</td>
<td>0%</td>
<td>3%</td>
<td>20%</td>
<td>0%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5)</td>
<td>(1)</td>
<td>(2)</td>
<td>(2)</td>
<td>(4)</td>
<td>(6)</td>
<td>(1)</td>
<td>(1)</td>
<td>(0)</td>
<td>(1)</td>
<td>(8)</td>
<td>(0)</td>
<td>(14)</td>
</tr>
<tr>
<td>D</td>
<td></td>
<td>2%</td>
<td>0%</td>
<td>4%</td>
<td>0%</td>
<td>4%</td>
<td>0%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>22%</td>
<td>18%</td>
<td>2%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1)</td>
<td>(0)</td>
<td>(2)</td>
<td>(0)</td>
<td>(2)</td>
<td>(0)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(11)</td>
<td>(9)</td>
<td>(1)</td>
<td>(15)</td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>17%</td>
<td>0%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>10%</td>
<td>3%</td>
<td>7%</td>
<td>0%</td>
<td>7%</td>
<td>24%</td>
<td>7%</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5)</td>
<td>(0)</td>
<td>(1)</td>
<td>(1)</td>
<td>(1)</td>
<td>(3)</td>
<td>(1)</td>
<td>(2)</td>
<td>(0)</td>
<td>(2)</td>
<td>(7)</td>
<td>(2)</td>
<td>(16)</td>
</tr>
<tr>
<td>All</td>
<td></td>
<td>12%</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
<td>9%</td>
<td>12%</td>
<td>5%</td>
<td>7%</td>
<td>1%</td>
<td>16%</td>
<td>24%</td>
<td>2%</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(21)</td>
<td>(5)</td>
<td>(7)</td>
<td>(4)</td>
<td>(16)</td>
<td>(22)</td>
<td>(9)</td>
<td>(13)</td>
<td>(2)</td>
<td>(28)</td>
<td>(43)</td>
<td>(4)</td>
<td>(75)</td>
</tr>
</tbody>
</table>

Across all sites, the prevalence of at least one PD was 42%, ranging from 29% at prison D to 65% at prison B. Anti-social PD was the most prevalent PD (24%), ranging from 18% at prison D to 46% at prison B. Borderline PD was the second most prevalent PD (16%); again this proportion was particularly high at prison B (50%).

### 4.3.9.8 In-reach caseload composition summary

Table 32 shows the diagnostic breakdown of the in-reach caseload at each research site. From this is can be seen that the proportion of in-reach clients with SMI ranged from 25% at prison D\(^\text{20}\) to 55% and prison F\(^\text{21}\).

---

\(^{19}\) Henceforth, all PD diagnoses referred to were made using the SCID II.

\(^{20}\) 22% (n=11) had SMI alone and 4% (n=2) had both PD and SMI, therefore 25% (n=13) overall had a current diagnosis of SMI.

\(^{21}\) 28% (n=8) had SMI alone and 28% (n=8) had both PD and SMI, therefore 55% (n=16) overall had a current diagnosis of SMI.
Table 32: Prevalence (%) of SMI, MI and/or PD amongst in-reach clients by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>PD alone</th>
<th>SMI alone</th>
<th>Both PD and SMI</th>
<th>No PD or SMI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>26% (8)</td>
<td>19% (6)</td>
<td>16% (5)</td>
<td>39% (12)</td>
<td>100% (31)</td>
</tr>
<tr>
<td>B</td>
<td>31% (8)</td>
<td>15% (4)</td>
<td>35% (9)</td>
<td>19% (5)</td>
<td>100% (26)</td>
</tr>
<tr>
<td>C</td>
<td>18% (7)</td>
<td>28% (11)</td>
<td>18% (7)</td>
<td>38% (15)</td>
<td>100% (40)</td>
</tr>
<tr>
<td>D</td>
<td>25% (13)</td>
<td>22% (11)</td>
<td>4% (2)</td>
<td>49% (25)</td>
<td>100% (51)</td>
</tr>
<tr>
<td>F</td>
<td>28% (8)</td>
<td>28% (8)</td>
<td>28% (8)</td>
<td>17% (5)</td>
<td>100% (29)</td>
</tr>
</tbody>
</table>

Figure 20: In-reach caseload composition: percentage of in-reach client by psychiatric diagnosis across all prison sites

Figure 20 shows the diagnostic breakdown of in-reach caseloads across all research sites. From this is can be seen that 23% (n=40) had a diagnosis of SMI alone, 25% (n=44) had PD alone, 17% (n=31) had a diagnosis of both PD and SMI; however 36% (n=62) had neither a diagnosis of SMI nor PD.
**Characteristics of prisoners on the in-reach caseload without SMI**

The results have shown that 60% (n=106)\(^{22}\) of prisoners on the in-reach caseload had no current diagnosis of SMI. These individuals were examined further to establish if they had a PD or any other type of mental illness. Mental illness (MI) has been defined as minor depressive disorder, dysthymia, generalized anxiety disorder, obsessive compulsive disorder or phobia, as diagnosed by SADS.

Table 32 shows the percentage of in-reach clients with a diagnosis of PD or MI with no current diagnosis of SMI across each research site.

Table 33: Prevalence (%) of PD and MI amongst in-reach clients with no current SMI by prison\(^{23}\)

<table>
<thead>
<tr>
<th>Prison</th>
<th>PD alone</th>
<th>MI alone</th>
<th>Both PD and MI</th>
<th>No PD or MI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>25% (5)</td>
<td>25% (5)</td>
<td>15% (3)</td>
<td>35% (7)</td>
<td>100% (20)</td>
</tr>
<tr>
<td>B</td>
<td>46% (6)</td>
<td>15% (2)</td>
<td>15% (2)</td>
<td>23% (3)</td>
<td>100% (13)</td>
</tr>
<tr>
<td>C</td>
<td>19% (4)</td>
<td>19% (4)</td>
<td>14% (3)</td>
<td>52% (11)</td>
<td>100% (22)</td>
</tr>
<tr>
<td>D</td>
<td>18% (7)</td>
<td>11% (4)</td>
<td>16% (6)</td>
<td>55% (21)</td>
<td>100% (38)</td>
</tr>
<tr>
<td>F</td>
<td>38% (5)</td>
<td>15% (2)</td>
<td>23% (3)</td>
<td>23% (3)</td>
<td>100% (13)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25% (27)</td>
<td>16% (17)</td>
<td>16% (17)</td>
<td>42% (45)</td>
<td>100% (106)</td>
</tr>
</tbody>
</table>

From Table 32 we can see that, of those in-reach clients who were identified to have no current diagnosis of SMI, 42% had a PD\(^{24}\) and 32% had a current MI\(^{25}\); however, 42% had neither a PD nor a MI.

Further analysis was conducted on in-reach clients with no current diagnosis of SMI, PD or MI (n=45).

Table 33 describes the characteristics of this sub-group.

---

\(^{22}\) 25% (n=44) had PD alone and 36% (n=62) had neither a diagnosis of SMI nor PD, therefore 60% (n=106) overall had a no diagnosis of SMI

\(^{23}\) n=106

\(^{24}\) 25% (n=27) had PD alone and 16% (n=17) had both PD and MI, therefore 42% (n=44) overall had a current diagnosis of PD.

\(^{25}\) 16% (n=17) had MI alone and 16% (n=17) had MI and PD, therefore 32% (n=34) overall had a current diagnosis of MI.
Table 34: Characteristics of in-reach clients with no current diagnosis of SMI, PD or MI by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Mental health services (ever)</th>
<th>Mental health services (current)</th>
<th>Prison mental health services (ever)</th>
<th>Above threshold for BPRS suicidality</th>
<th>Substance misuse</th>
<th>No prior contact with services</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>86% (6)</td>
<td>29% (2)</td>
<td>43% (3)</td>
<td>0% (0)</td>
<td>57% (4)</td>
<td>14% (1)</td>
</tr>
<tr>
<td>B</td>
<td>100% (3)</td>
<td>67% (2)</td>
<td>67% (2)</td>
<td>33% (1)</td>
<td>67% (2)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>C</td>
<td>80% (8)</td>
<td>22% (2)</td>
<td>60% (6)</td>
<td>0% (0)</td>
<td>73% (8)</td>
<td>20% (2)</td>
</tr>
<tr>
<td>D</td>
<td>100% (21)</td>
<td>38% (8)</td>
<td>100% (21)</td>
<td>10% (2)</td>
<td>71% (15)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>F</td>
<td>100% (3)</td>
<td>67% (2)</td>
<td>33% (1)</td>
<td>0% (0)</td>
<td>67% (2)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>All</td>
<td>93% (41)</td>
<td>37% (16)</td>
<td>75% (33)</td>
<td>7% (3)</td>
<td>69% (31)</td>
<td>7% (3)</td>
</tr>
</tbody>
</table>

Table 33 above shows that whilst prisoners in this sub-group had no current diagnosable mental illness, the sample reported high rates of substance misuse (69%), prior contact with mental health services generally (93%) and in prison (75%). Notably three in-reach clients (7%) had no current SMI, MI or PD or prior contact with mental health services, in or out of prison.
4.4 Summary

4.4.1 Prevalence of SMI in the prison population

Population prevalence rates of SMI were calculated. The analysis showed that:

- SMI was estimated to be present in 23% of the prison population, with major depression in 19% and psychosis in 4% of the prison population;
- Substance misuse (drug or alcohol) problems were present in 66% of the prison population; and
- Dual diagnosis (SMI and co-existing substance misuse problem) was present in 18% of the prison population.

Overall, 71% of the prison population had a current SMI, substance misuse problem or both.

4.4.2 Intervention by prison mental health in-reach services

The findings of this study indicate that the vast majority of prisoners with SMI are not identified or treated by prison mental health in-reach services:

- Twenty-five percent of prisoners with a current SMI were assessed by in-reach services; and
- Thirteen percent of prisoners with a current SMI were accepted onto in-reach caseloads.

Furthermore:

- Prisoners with psychosis were significantly more likely to be assessed and/or accepted onto in-reach caseloads than prisoners with major depressive disorder.
- Prisoners with SMI that had prior contact with mental health services were significantly more likely to be assessed and/or accepted onto in-reach caseloads than those that had no prior contact.

4.4.3 Prevalence of SMI amongst prisoners receiving in-reach services
• SMI was estimated to be present in 40% of the in-reach client caseload. Twenty-two percent had a current diagnosis of psychosis and 20% percent had major depressive disorder.

• Sixty percent of prisoners on the in-reach caseload did not have a current SMI.

Of the 60% of in-reach clients who had no current SMI:

• Forty-two percent had at least one PD; 32% had a MI; and 42% had neither.

• In-reach clients with no current diagnosis of SMI, PD or MI exhibited high rates of prior contact with mental health services (ever) (93%) and substance misuse (69%) prior to custody.
5 DISCUSSION

This study was an evaluation of mental health in-reach teams nationally using mixed methods. The study comprised three Modules, a national study of in-reach teams; a series of in-depth case studies at eight prisons; and a prospective study examining outcomes of those assessed as having a serious mental illness upon reception to prison.

5.1 Methodological limitations

Conducting research in prison poses a series of challenges (Sheard et al. 2008): obtaining ethical approval from both the NHS and HM Prison Service; obtaining research governance approval; problems associated with the population, including low rates of literacy; problems with the prison environment, including the staffing implications of having to be escorted; and security issues, including the abrupt nature of lock downs. We overcame these difficulties as far as possible by doing detailed preparatory work with each prison, ensuring that all staff, including health and discipline staff from the governor downwards were aware of the aims and process of the research. For Module 3, we employed prison staff to be directly involved in data collection, and this greatly enhanced the acceptability of the research in the prisons.

In the national survey of prison in-reach (Module 1), we had a 73% response rate. This compared favourably with the 2003 response rate of 50% (Brooker et al. 2006). The main reason for the improvement in response rate was that we offered team leaders the opportunity to participate in a telephone interview whereas a self-completion postal questionnaire was used in 2003. We examined response rates by region and by type of prison. There was significant regional variation in response with the London and North East regions being the lowest (43% and 53% respectively) and the Eastern, East Midlands and South West regions the highest (all had a 100% response rate). It is possible that the non-responders could have had different views from participants; however there was no significant difference in prison type between the responders and non-responders. The survey was based on self report; however most of the questions were factual and not opinion based and therefore likely to be accurate.

In the detailed case studies (Module 2), we interviewed members of staff from different disciplines and with varying roles across eight prisons. We chose the prisons to be representative of the prison estate, but certain types of prisons were not included, for example open prisons and young offender establishments. It is therefore possible that the views expressed by the teams were not
representative of staff across the whole prison estate. However, the themes emerging from the detailed case studies were not dissimilar to the themes emerging from the national study, which was representative of all prison types.

We conducted the prospective clinical study (Module 3) in four male local prisons, including one in London, and one with an additional high secure function; one women’s prison; and one male category B prison. Therefore the prisons included were not representative of the whole prison estate. In particular we did not include the full range of establishments holding sentenced prisoners, nor a young offender institution. We tried to ensure a geographical spread of establishments.

The sample of prisoners required within each of the six prisons for the prospective study was estimated using power calculations. We recruited 71 prisoners more than required (1,181 versus 1,110). However there was under-recruitment at Prison A (male, local, high secure) and Prison E (male local) due to operational difficulties beyond researchers’ control. Overall, the under-recruitment in those prisons would have made little difference to the overall analysis as in this report we generally reported findings for the whole population. Participants in each establishment were sampled randomly at reception. This sample was representative of prisoners at each site in terms of ethnicity, age and offence type.

We used an initial screen specifically developed to identify possible severe and enduring mental illness (SMI) in prison populations, the PriSnQuest. We tried to interview all of the screen positives and a 5% sample of the screen negatives with a second stage interview, the SADS. Previous research has shown that the PriSnQuest is a sensitive screen (Shaw et al. 2003). Analysis of the ‘screen negatives’ revealed that seven of them had a SMI, diagnosed by SADS. The estimation of prevalence of SMI in the prisons took into account the proportion of false positives and negatives on PriSnQuest (Rogers, 1993; Dunn et al. 1999).

The SADS was used at the second stage to make a psychiatric diagnosis. SADS has been used successfully in previous prison research (Birmingham et al. 1996). Non clinicians can administer SADS, following appropriate training. The tool’s authors note that “...raters should usually be limited to psychiatrists, clinical psychologists, or psychiatric social workers. If other research personnel are to be used, much more training is generally necessary” (Endicott & Spitzer, 1978). For this study SADS was administered by research assistants, some of whom had clinical training and some of whom did not. They were trained in the use of the instrument by a psychiatrist and had regular ‘top-up’ training and inter-rater reliability checks. The other main mental health tool used in the study, the BPRS, has also been previously used successfully in prisons to rate the severity of psychiatric symptoms (Senior et al. 2005a). Researchers were trained in the use of these instruments by psychiatrists and had regular top-up training and inter-rater reliability checks.

The proportion of prisoners with SMI in our sample was not significantly different to some previous studies (Singleton et al. 1998) but significantly higher than others (Gunn et al. 1991). The latter study used research psychiatrists and
utilised a non-standardised clinical interview; the former used a structured
standardised diagnostic instrument.

It is possible that the difference in prevalence rates of SMI between the Gunn et
al. findings and our study relate to changes in the prison population over time. It
is also however possible that standardised interviews administered by non-
clinicians ‘over-diagnose’ mental illness (Anthony et al. 1985; Romanoski et al.
1992; Henderson, 2000; Brugha et al. 2001). However, even if there is an
‘over-diagnosis’ of SMI with standardised interviews, there is no reason to believe
that this would have affected our main finding, i.e. the proportion of people
detected and assessed by in-reach teams.

In order to establish the proportion of people with SMI on the caseload of the in-
reach teams, we took a random cross-sectional sample of prisoners at each site.
This was therefore a ‘snap-shot’ of cases and it would have been preferable, and
potentially more representative, to have taken a series of such ‘snap-shots’ over
a period of time.

5.2 Summary of findings

In the subsequent discussion of our findings we used the mental healthcare
pathway as our guide. Therefore, we move from assessment at screening on
entry into prison, through to triage in primary care, then on to the work of
secondary in-reach teams, and finally we consider issues related to release and
the interface with mainstream community mental health services.

5.2.1 Screening for serious mental illness at reception to
prison

The detection of mental health problems begins at reception. There has been
recent increased research interest in prison mental health reception screening
(Brooker, 2007). All of the prisons used the Grubin reception screening tool
(Grubin et al. 1999). This screen relies on prisoners reporting symptoms and
previous contact with health services. Previous studies have shown that only a
quarter of people with psychosis are detected at reception (Birmingham et al.
1996) This may be because of the nature of the reception screening process and
the environment in which screening takes place (Mitchison, 1994).

On reception into prison there are several procedures and tasks requiring
completion, of which healthcare assessment is but one. The health assessment
may be considered less important than the legal procedures required to ensure a person’s custody is lawful. In busy local prisons, many prisoners arrive in large numbers from the courts in the late afternoon and early evening, and the imperative is to move prisoners from the reception area onto the wings as quickly as possible. Health screens may be completed in areas which are barely private and often noisy. This is not an environment conducive to the effective assessment of mental health need.

It is our view that health screening upon initial reception should accurately establish whether a prisoner has an acute health problem requiring immediate treatment, or whether there is an acute risk of suicide. Following initial reception screening, all prisoners should then be ‘kept safe’ overnight, and a comprehensive mental health assessment then conducted on everyone the following day in a private area by trained staff. This will enable a comprehensive assessment of current symptoms and more accurate ‘case-finding’.

5.2.2 Identifying SMI at screening and subsequent acceptance by prison in-reach team

Following this initial case finding process, there then needs to be clear pathways into the appropriate level of mental healthcare. There therefore needs to be an effective triage mechanism whereby those with SMI are routed to in-reach services and those with common mental disorders remain in primary care where appropriate treatment and self-help materials are available.

Whist prisons have input from doctors, usually local general practitioners, at primary care level, the primary care mental health team in most prisons is under developed. Our previous work has shown that most of the mental health problems in prison could be treated in primary care (Senior, 2005b). There is therefore a need to establish ‘what works’ in terms of primary care mental health provision in the community and how this would need to be adapted for prisons. It is only by establishing quality primary care mental health team models that mental health in-reach teams can focus on those with complex mental health problems.
5.2.3 The current caseload composition of in-reach teams

The Module 1 survey revealed that a significant proportion of in-reach team leaders nationally had staff vacancies and considered that their staffing complement was inadequate for the tasks required. Many of the teams had altered their remit over time to include providing assessment and intervention services for a wider group than those with SMI. Further exploration of this in Modules 1 and 2 revealed that this was due to a number of factors, including inadequate triage and a lack of primary care mental health input. This led to teams feeling ‘swamped’ by inappropriate referrals.

The cross sectional study confirmed that 40% of those on in-reach caseloads had a current diagnosis of SMI. Across the in-reach caseload sample: 23% (n=40) had a diagnosis of SMI alone; 25% (n=44) had PD alone; 17% (n=31) had a diagnosis of both PD and SMI; and finally 36% (n=62) had neither a diagnosis of SMI nor PD. In the national survey of in-reach, reported in Module 1, slightly different estimates were obtained, but whilst Module 3 figures are based on a sample of six prisons they are likely to be very precise. The estimates from the survey had been provided by in-reach team leaders, which, whilst including many more prisons, are likely to be less robust clinical estimates.

This pattern of expansion of the remit of teams to encompass more minor mental disorders mirrors what happened following the establishment of CMHTs in the community (Greenwood et al. 2000; Burns et al. 2007). Analysis of CMHT community caseloads show varied case mix including, for example, psychoses, neuroses, substance abuse, eating disorders and personality disorders (Greenwood et al. 2000; Hunter et al. 2002). In prison this is of concern as three-quarters of those with SMI remained un-assessed and only 14% are accepted onto in-reach caseloads. These findings are in line with those of the recent HM Prison Inspectorate mental health thematic review which found that of 237 new prisoners, 17% were assessed at reception as having a psychiatric history, however only half of this group were then triaged by primary care, and one-third subsequently referred to in-reach (HMIP, 2007). Of particular concern is that, of those with psychosis or a major depressive disorder with a clinical level of suicidality, only 38% were assessed by in-reach and 26% taken on to caseload.

A series of factors were identified that were significantly associated with being assessed by in-reach teams including having previous contact with psychiatric services; and being on certain types of medication, indicating a reliance on historical factors. Policy pronouncements make it clear that a key role for prison mental health in-reach teams is a focus of on those with serious mental illness; our research shows that, prospectively, only 26% of those diagnosed at reception with a narrow definition of SMI (psychosis and/or major depression with clinical suicidality) end up on in-reach caseloads. Moreover, approximately one-third of
prisoners on in-reach caseloads have neither a serious mental illness nor a personality disorder.

5.3 What factors explain in-reach team’s ‘mission-creep’?

5.3.1 Resources

The findings from the national survey of prison in-reach and the case studies (Modules 1 & 2) help us to understand the reasons behind the lack of targeting by prison in-reach teams. Firstly, resources are a key issue. In-reach teams are small, with little change in team size between 2003 and 2007. Whilst there has been small growth in in-reach team size, the volume of work has increased significantly in terms of referrals (57%). In addition, the recruitment and retention of staff continues to be challenging. Indeed, 165 of teams have been unable to recruit a substantive team leader.

5.3.2 The care pathway and emerging organisational models

Earlier in this discussion we showed how a small proportion of those prisoners assessed as having SMI at reception screening, went on to assessment by prison in-reach teams and ultimately acceptance on to in-reach caseloads. However, those proportions varied according to the referral system in place. In Prison B for example, only 22% of prisoners assessed as having SMI were referred to in-reach. In this prison, only GPs could refer prisoners to the in-reach team, thus the system was reliant on either efficient reception screening or the prisoner independently going to see the GP. Alternatively, in Prison E, the in-reach team accepted referrals from all sources, including self-referral, which led to 49% of those with SMI being seen by in-reach. This wide variation is clearly a function of the organisation models in place within each prison.

The findings from Module 1 indicate that there are three basic in-reach models in relation to joint-working with prison primary care: fully merged with primary care; joint management; and totally separate working and management. However, it was clear that when triage of referrals to in-reach was undertaken within primary healthcare, it was generally regarded as poor, with 67% of prison in-reach team leader rating primary care triage as inadequate. Triage was rated
significantly worse in high secure, category B and local prisons. The major reasons given for poor triage were a lack of staff; a lack of funding for prison primary care mental health; and the lack of skills in assessment.

If the issues identified above are indicative and the triage is rated so poorly by in-reach team leaders\(^{26}\) it is unsurprising that SMI identified in reception is missed and that this then has an overall impact on in-reach team caseload composition.

5.3.3 Confusion about operational policies and the in-reach remit

Data from Modules 1 and 2 clearly reveal that there is confusion about the role of in-reach teams. When in-reach teams were originally established there was a much clearer sense that their function was to work with people with serious mental illness. However, by 2007, this perception had changed. The national survey findings showed that, whilst the proportion of in-reach teams with operational policies had increased from 87% to 96%, 44% of team leaders stated that these policies had changed to reflect a greater emphasis on working with primary care mental health problems. It is also noticeable that there had been a decrease in teams with operational policies that detailed specific exclusion criteria (from 52% to 38%). This change in orientation was reflected in the qualitative data obtained in the case studies. Here, it was clear, that particularly when working with people with personality disorder who sometimes self-harmed, there was a lack of clarity about the role of in-reach. However there was a general perception that prisoners with complex needs should be cared for by mental health in-reach.

5.4 Conclusion

It is salient to reflect that ‘mission creep’ has been previously described in the context of mainstream community mental health team delivery in the 1990’s. For example, King (2001) noted that CMHT team members had different perceptions of what constituted serious mental illness and thus how to interpret and implement a prioritisation process. In his in-depth study the team appeared to use the term 'severe mental illness' in two contrasting ways. First, as a strict medical category serving the function of an effective gate criterion for prioritising

\(^{26}\) Poor triage is in prison primary care is perhaps not a surprising finding given that the Thematic Review (HMIP, 2007) found that few qualified mental health nurses worked in prison primary care and most GP lacked specialist training for complex mental health needs.
referral access to the team, and secondly as a descriptive term used to guide its clinical practice, informed by the team's broader perception of what constituted SMI health problems. The co-existence of these two differing perceptions of SMI resulted from, and further contributed to, the tension between the team's need to manage referral pressure, to comply with strategic demands, and its members' clinical experience and valued practice.

In this study of prison mental health in-reach services, similar parallels can be drawn. In-reach resources, given the needs and demands, are scant and organisational models are only just emerging and evolving. The skills needed to assess complex mental health disorder within prison primary care are not apparent. The policy focus on serious mental illness within prisons must remain as clearly much remains to be improved.

5.5 Implications and recommendations

Module 1 revealed that in-reach teams had a good understanding of the concept of equivalence and the need for their services. However, whilst the introduction of in-reach teams was felt to have been necessary, it is apparent that teams are unable to function appropriately without a corresponding streamlining of all other mental health service provision to the prisons. Specifically, in-reach teams cannot concentrate their attention on those with SMI and complex needs, whilst primary care mental health input remains inadequate or missing and with no proper systems of triage. In order to achieve the goal of equivalence, there needs to be a comprehensive system of primary and secondary mental healthcare services in prison to enable each part of the system to target appropriate clients and thus function appropriately.
### GLOSSARY

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ACCT</td>
<td>Assessment, Care in Custody and Teamwork</td>
</tr>
<tr>
<td>BPRS</td>
<td>Brief Psychiatric Rating Scale</td>
</tr>
<tr>
<td>CARATs</td>
<td>Counselling, Advice, Referral and Through-care service – for drug treatment in prison</td>
</tr>
<tr>
<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
</tr>
<tr>
<td>CMHTs</td>
<td>Community Mental Health Teams</td>
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<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
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<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
</tr>
<tr>
<td>CSIP</td>
<td>Care Services Improvement Partnership</td>
</tr>
<tr>
<td>DAST</td>
<td>Drug Abuse Screening Test</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DSPD</td>
<td>Dangerous and Severe Personality Disorder Units</td>
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<tr>
<td>GHQ</td>
<td>General Health Questionnaire</td>
</tr>
<tr>
<td>GPs</td>
<td>General Practitioners</td>
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<tr>
<td>HMCIP</td>
<td>Her Majesty’s Chief Inspector of Prisons</td>
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<tr>
<td>HMP</td>
<td>Her Majesty’s Prison</td>
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<tr>
<td>HMPS</td>
<td>Her Majesty’s Prison Service</td>
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<tr>
<td>IMR</td>
<td>Inmate Medical Record</td>
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<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>MI</td>
<td>Mental illness</td>
</tr>
<tr>
<td>NFA</td>
<td>No Fixed Abode</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PD</td>
<td>Personality Disorder</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PMS</td>
<td>Prison Medical Service</td>
</tr>
<tr>
<td>PSM</td>
<td>Prison Medical Officer – prison physician</td>
</tr>
<tr>
<td>PSQ</td>
<td>Psychosis Screening Questionnaire</td>
</tr>
<tr>
<td>MAST</td>
<td>Michigan Alcoholism Screening Test</td>
</tr>
<tr>
<td>SADS</td>
<td>Schedule for Affective Disorders and Schizophrenia</td>
</tr>
<tr>
<td>SMI</td>
<td>Severe and enduring mental illness</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
</tr>
<tr>
<td>YOI</td>
<td>Young Offender Institution</td>
</tr>
</tbody>
</table>


Senior J. (2005b) *The development of prison mental health services on a community mental health model*. Unpublished PhD thesis submitted to The University of Manchester: Manchester


Evaluation of prison mental health in-reach services

Dear In-reach team leader,

The first national survey of prison in-reach took place during 2003/4. We are now undertaking the second national survey of in-reach services, which is a part of a joint project between the Universities of Sheffield, Manchester and Southampton together with the Institute of Psychiatry. In April 2004, these four institutions were commissioned by the National Forensic R&D Programme to evaluate the effectiveness of prison mental health in-reach services.

Enclosed you will find the letter of support for the research, signed by Richard Bradshaw, Head of Prison Health, DH, and Kieron Murphy, National Programme Lead – Health & Social Care in Criminal Justice, CSIP. We would appreciate it if you would spare a moment to read it.

We recognise that you are extremely busy people and would wish to conduct the survey in the way that best suits you! There are two options. First, you complete the questionnaire and return it to us in the pre-paid envelope - this should take only 30/40 minutes of your time. The second option is for us to phone you at your convenience and for us to go through the questionnaire with you. If you choose this option you might need some time to prepare.

Consenting to the interview would be an opportunity for you to provide us with valuable information on your in-reach teams’ dynamics, as well as to identify changes that have occurred in the in-reach team work over time. We will shortly be phoning you to ask which option you would prefer to pursue.

It is important to note that we have submitted our proposal to an NHS Research Governance Committee who inform us that the study should be classified as ‘service evaluation’. We have also received ethical clearance for the study. Nonetheless, we would wish to stress that interviews are entirely voluntary and you are under no obligation to consent to them. Nonetheless, the validity of the study will be greatly increased if we receive responses from all in-reach team leaders so we hope you will be able to participate.

If you have any questions please contact: Charlie Brooker, Professor of Mental Health and Criminal Justice, Tel: 01623819154; Email: cbrooker@lincoln.ac.uk; or Dina Gojkovic, PhD student Tel: 01522837396, email: dgojkovic@lincoln.ac.uk

Thank you very much for your time.
1. Team Profile

A: Details

A1. Name of CSIP patch

A2. Name of the team

A3. Name of PCT

A4. Name(s) of prison(s) served

A5. Date team commenced working

B: Staffing and composition of the team

B1. How many whole time equivalents of the following staff are in the in-reach team?

<table>
<thead>
<tr>
<th></th>
<th>Establishment w.t.e.</th>
<th>Actual w.t.e.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td></td>
<td></td>
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<tr>
<td>Social workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical psychology</td>
<td></td>
<td></td>
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<tr>
<td>OT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin/secretarial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total w.t.e.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B2. Over the last year, have all your established posts been full by 100%?
   Yes □  No □

B3. If not, which posts have been unfilled and for how long?

B4. Has the size of the team changed over the last year?
   Yes □  No □

B5. If yes, has it got higher or lower and if so, by how much?

B6. Has that change been appropriate?
   Yes □  No □

If yes, please specify:
B7. To your knowledge, will the size of the team change over the next 12 months?
   Yes    | No

If yes, will it increase or decrease and if so, by how much?

B8. Have you had any difficulties in recruiting staff?
   Yes    | No

If yes, please specify:

B9. Have you experienced any difficulties in retaining staff?
   Yes    | No

If yes, please specify:

C: Funding of the team

C1. Since the establishment of the team, which of the following aspects have changed?

<table>
<thead>
<tr>
<th>worsened</th>
<th>no change</th>
<th>most improved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>Investment in training</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>Relationships with prison staff</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

2. Operational policy

1. Has the operational policy changed since the establishment of the team?
   Yes    | No

If yes please send a copy

2. To what extent are you integrated with Primary Healthcare?
   No integration | Moderate integration | Full integration
   0 1 2 3 4 5 6 7 8 9 10

If the respondent scores ‘5’ or above in what specific ways are the teams integrated?

3. Does the team have explicit criteria required to accept a referral for initial assessment?
   Yes    | No

Please specify
4. Does the team have explicit criteria required to accept a service user onto the caseload following initial assessment?
   
   Yes  |  No  |  
   
   Please specify

5. Does the team have any explicit exclusion criteria?
   
   Yes  |  No  |  
   
   Please specify

3. Liaison with Primary Healthcare

1. In your experience, is there adequate triage of cases by primary care?
   
   Yes  |  No  |  
   
   If, no, is it because of any of the following?
   a) Not enough staff
   b) Lack of expertise
   c) Lack of resources
   d) Other

2. Do primary care staff assess:
   a) All prisoners claiming to be on psychiatric medication at reception?
      
      Yes  |  No  |  
      
      b) All prisoners with a past history of mental health contact at reception?
      
      Yes  |  No  |  
      
      c) All prisoners with a past history of self-harm at reception?
      
      Yes  |  No  |  

3. Do members of the In-reach team routinely perform a mental health assessment on all prisoners placed on ACCT?
   
   Yes  |  No  |  

4. Which proportion of referrals do you get from the following (the proportions assigned should add up to 100%):
   
   Primary healthcare staff  %
   Prison wing staff  %
   Probation  %
   Psychology  %
   Self-referral  %
   Other (specify)  %

   100 %
4. The role of the in-reach team

A: Therapies and interventions

Following initial assessment, what are the most common interventions that the team offers to the service users?

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Number of sessions provided per week</th>
<th>Approx. No of clients on total caseload receiving this intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaison &amp; support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive behaviour therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B: Caseload

B1. How many referrals have been received by the in-reach team in the last 3 months?

B2. To your knowledge, what was the approximate number of referrals to the in-reach team in the following periods:
   a) 2004
   b) 2005
   c) 2006

B3. What proportion of the referrals to the team is ONLY given an assessment?

   %

B4. How many service users do the in-reach team have on their caseload at the moment?

B5. We would like you to provide us with some information about the following matters, regarding the service users on your caseload:

MENTAL DISORDERS

What percent of service users have been diagnosed with the following disorders:
   a) Mental illness (schizophrenia, psychotic disorder, anxiety disorder, mood disorder) %
   b) Personality disorder %
   c) Dual diagnosis of a) and b) %
   d) Dual diagnosis of a) and substance misuse dis %
   e) Dual diagnosis of b) and substance misuse dis. %
   f) Other form of dual diagnosis (please specify) %
   g) No primary diagnosis %
ETHNICITY

a) White %
b) Black/Black-British %
c) Asian/Asian-British %
d) Mixed-White and Black %
e) Mixed-White and Asian %
f) Mixed–Black and Asian %
g) Other Ethnic background %
h) We do not possess this information

OFFENCE

a) Violence against the person %
b) Sexual offences %
c) Robbery %
d) Burglary %
e) Theft and handling stolen goods %
f) Fraud and forgery %
g) Criminal damage %
h) Drug offences %
i) Other offences %
j) We do not possess this information

B6. What is the proportion of your patients currently on standard CPA? %

B7. What is the proportion of your patients currently on enhanced CPA? %

B8. What proportion of a typical working week does your team spend on prison premises %

B9. What proportion of a typical working week do they spend on these activities:

  a) Face to face client contact (assessment/triage) %
b) Face to face client contact (interventions and therapy) %
c) Administration %
d) Research and evaluation %
e) Service development %
f) Mentorship/supervision %
g) Teaching %
h) Other (specify) %
Total 100%

B10. In your opinion is the team in its current form sufficient to meet the needs of prisoners with mental health problems in the prison (s) you serve?
Yes □ No □
If no, please specify
C: The role of the in-reach team in self-harm and suicide prevention

C1. What is the role of the in-reach team in relation to ACCT?

C2. Is there anything you would add to the above in relation to the following categories:
   - Assessment
   - Intervention
   - Educational programs for staff

D: Education and training

D1. Do you provide any form of mental health awareness training for POs or ACCT team members?
   - Yes □
   - No □

D2. If yes, could you specify the kind of training that you provide?

D3. Do you provide any form of training for primary healthcare team members?
   - Yes □
   - No □

D4. If yes, could you specify the kind of training that you provide?

D5. In your opinion, what are the key training needs for the in-reach team?

Please enter in rank order where 4= most important and 1= least important
   a) assessment techniques (screening tools)
   b) specific therapeutic techniques
   c) care co-ordination for a prisoner on CPA
   d) knowledge-transfer between in-reach and other groups and teams, inside and outside of the prison

5: Relationship with mainstream NHS during the prisoner’s sentence

A: Acute transfer

A1. In an emergency, what is the average access time for a patient to a mental health assessment by
   a) psychiatrists
   b) RMNs
A2. Do you routinely identify and inform the responsible PCT commissioner when a prisoner requiring transfer is identified:
   a) Always
   b) Sometimes
   c) Never

A3. In your opinion what is the single most helpful action you undertake to enable timely transfer once a prisoner requiring transfer has been identified?

B: Patients with former psychiatric history

B1. To your knowledge, what proportion of your caseload has a history of mental illness prior to imprisonment?

B2. What are the sources that you normally use to obtain this kind of information?
   a) PCT/CMHT records
   b) Patients themselves
   c) Other, please specify

6. Relationship with mainstream NHS at release, and wider criminal justice system

1. Does the in-reach team routinely ensure that all service users are linked to appropriate GP after discharge?
   Yes ☐  No ☐

2. Do you encounter any problems in this activity?
   Yes ☐  No ☐
   If yes, please specify

3. Does the in-reach team routinely ensure that all service users are linked to appropriate mental health services after discharge?
   Yes ☐  No ☐

4. Do you encounter any problems in this activity?
   Yes ☐  No ☐
   If yes, please specify

5. Can you estimate the proportion of the service users taken on by GP after discharge?

6. Can you estimate the proportion of the service users taken on by mental health services after discharge?
7. Are there particular types of prisoners that are less likely to be taken on by mental health services on release? 
   Yes □   No □
   If yes, please specify

8. Overall, how would you rate your liaison with mainstream NHS services?

<table>
<thead>
<tr>
<th></th>
<th>No liaison</th>
<th>Moderate liaison</th>
<th>Strong liaison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

9. What are the key aspects of this liaison?

10. Overall, how would you rate your liaison with social services?

<table>
<thead>
<tr>
<th></th>
<th>No liaison</th>
<th>Moderate liaison</th>
<th>Strong liaison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

11. What are the key aspects of this liaison?

12. Is it a usual practice for your team to devise CPA care plan for a service user on release?

13. What are the potential barriers to successful execution of this plan?

14. What role does the in-reach team play in court diversion?

7. Success and barriers

1. To which extent do you agree or disagree with each of the following statements? 
   Please circle appropriate number

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>...was a good idea</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>...helped improve service and quality</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>...helped to provide better outcomes for prisoners with mental health problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
2. In your opinion, what are the main barriers to successful operation of your in-reach team? (0=not a barrier; 5=moderate barrier; 10=insurmountable barrier)

<table>
<thead>
<tr>
<th>Special nature of prison-restricted area</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited opportunities to engage with prisoners</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Complexity of service users’ mental health disorders</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Limited resources</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Lack of appropriate training</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>
### 9 APPENDIX 2

**Table 35: Age (%) within the sample and HMCIP figures (% in brackets) by prison**

<table>
<thead>
<tr>
<th>Prison</th>
<th>21-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70+</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>56% (40%)</td>
<td>35% (33%)</td>
<td>4% (19%)</td>
<td>5% (7%)</td>
<td>0% (1%)</td>
<td>0% (0%)</td>
</tr>
<tr>
<td>B</td>
<td>39% (41%)</td>
<td>28% (35%)</td>
<td>31% (14%)</td>
<td>2% (4%)</td>
<td>1% (1%)</td>
<td>0% (0%)</td>
</tr>
<tr>
<td>C</td>
<td>44% (45%)</td>
<td>35% (32%)</td>
<td>17% (9%)</td>
<td>3% (2%)</td>
<td>2% (0%)</td>
<td>0% (0%)</td>
</tr>
<tr>
<td>D</td>
<td>40% (46%)</td>
<td>43% (32%)</td>
<td>16% (15%)</td>
<td>1% (5%)</td>
<td>0% (2%)</td>
<td>0% (1%)</td>
</tr>
<tr>
<td>E</td>
<td>46% (42%)</td>
<td>28% (29%)</td>
<td>8% (21%)</td>
<td>2% (6%)</td>
<td>16% (3%)</td>
<td>0% (1%)</td>
</tr>
<tr>
<td>F</td>
<td>42% (42%)</td>
<td>31% (29%)</td>
<td>16% (21%)</td>
<td>7% (6%)</td>
<td>4% (3%)</td>
<td>1% (1%)</td>
</tr>
<tr>
<td>All</td>
<td>45%</td>
<td>34%</td>
<td>15%</td>
<td>3%</td>
<td>4%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Table 36: Ethnicity (%) within the sample and HMCIP figures (% in brackets) by prison**

<table>
<thead>
<tr>
<th>Prison</th>
<th>Black</th>
<th>White</th>
<th>Asian</th>
<th>Mixed</th>
<th>Chinese/other</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>28% (28%)</td>
<td>64% (55%)</td>
<td>1% (9%)</td>
<td>7% (6%)</td>
<td>0% (1%)</td>
</tr>
<tr>
<td>B</td>
<td>21% (28%)</td>
<td>76% (62%)</td>
<td>1% (3%)</td>
<td>1% (4%)</td>
<td>1% (2%)</td>
</tr>
<tr>
<td>C</td>
<td>3% (5%)</td>
<td>93% (84%)</td>
<td>3% (6%)</td>
<td>1% (5%)</td>
<td>0% (0%)</td>
</tr>
<tr>
<td>D</td>
<td>3% (10%)</td>
<td>90% (75%)</td>
<td>1% (10%)</td>
<td>5% (3%)</td>
<td>1% (2%)</td>
</tr>
<tr>
<td>E</td>
<td>1% (9%)</td>
<td>97% (84%)</td>
<td>1% (4%)</td>
<td>1% (1%)</td>
<td>0% (0%)</td>
</tr>
<tr>
<td>F</td>
<td>5% (3%)</td>
<td>95% (92%)</td>
<td>0% (5%)</td>
<td>0% (1%)</td>
<td>0% (1%)</td>
</tr>
<tr>
<td>All</td>
<td>9%</td>
<td>86%</td>
<td>1%</td>
<td>3%</td>
<td>0%</td>
</tr>
</tbody>
</table>
### Table 37: Index offence within the sample and HMCIP figures (% in brackets) by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Violence against the person</th>
<th>Sexual offences</th>
<th>Robbery</th>
<th>Burglary</th>
<th>Theft &amp; handling</th>
<th>Fraud &amp; forgery</th>
<th>Drug offences</th>
<th>Other offences</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>21% (37%)</td>
<td>4% (9%)</td>
<td>1% (4%)</td>
<td>9% (6%)</td>
<td>16% (6%)</td>
<td>4% (2%)</td>
<td>5% (8%)</td>
<td>40% (28%)</td>
</tr>
<tr>
<td>B</td>
<td>12% (7%)</td>
<td>0% (0%)</td>
<td>6% (5%)</td>
<td>2% (3%)</td>
<td>31% (18%)</td>
<td>12% (2%)</td>
<td>20% (11%)</td>
<td>16% (55%)</td>
</tr>
<tr>
<td>C</td>
<td>17% (17%)</td>
<td>3% (4%)</td>
<td>8% (10%)</td>
<td>12% (13%)</td>
<td>15% (12%)</td>
<td>2% (3%)</td>
<td>4% (12%)</td>
<td>39% (33%)</td>
</tr>
<tr>
<td>D</td>
<td>25% (20%)</td>
<td>2% (10%)</td>
<td>15% (15%)</td>
<td>7% (6%)</td>
<td>11% (6%)</td>
<td>5% (2%)</td>
<td>2% (3%)</td>
<td>32% (23%)</td>
</tr>
<tr>
<td>E</td>
<td>27% (24%)</td>
<td>0% (9%)</td>
<td>2% (7%)</td>
<td>5% (11%)</td>
<td>37% (7%)</td>
<td>1% (2%)</td>
<td>2% (13%)</td>
<td>26% (27%)</td>
</tr>
<tr>
<td>F</td>
<td>15% (11%)</td>
<td>20% (49%)</td>
<td>21% (11%)</td>
<td>14% (7%)</td>
<td>1% (1%)</td>
<td>3% (0%)</td>
<td>17% (10%)</td>
<td>9% (11%)</td>
</tr>
<tr>
<td>All</td>
<td>20%</td>
<td>4%</td>
<td>8%</td>
<td>8%</td>
<td>19%</td>
<td>4%</td>
<td>7%</td>
<td>29%</td>
</tr>
</tbody>
</table>

### Table 38: Legal status (%) within the sample and HMCIP figures (% in brackets) by prison

<table>
<thead>
<tr>
<th>Prison</th>
<th>Remand</th>
<th>Convicted sentenced</th>
<th>Convicted unsentenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>54% (15%)</td>
<td>33% (51%)</td>
<td>13% (31%)</td>
</tr>
<tr>
<td>B</td>
<td>56% (37%)</td>
<td>43% (42%)</td>
<td>1% (21%)</td>
</tr>
<tr>
<td>C</td>
<td>47% (64%)</td>
<td>53% (25%)</td>
<td>0% (11%)</td>
</tr>
<tr>
<td>D</td>
<td>43% (17%)</td>
<td>51% (69%)</td>
<td>6% (12%)</td>
</tr>
<tr>
<td>E</td>
<td>28% (26%)</td>
<td>37% (63%)</td>
<td>35% (11%)</td>
</tr>
<tr>
<td>F</td>
<td>0% (0%)</td>
<td>100% (100%)</td>
<td>0% (0%)</td>
</tr>
<tr>
<td>All</td>
<td>40%</td>
<td>50%</td>
<td>10%</td>
</tr>
</tbody>
</table>
### Table 39: Prisoners with SMI (narrow): percentage assessed and accepted on to in-reach caseloads by psychiatric diagnosis and prison

<table>
<thead>
<tr>
<th>Psychiatric diagnosis</th>
<th>Type of contact</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MDD + Suicidality</strong></td>
<td>Assessment</td>
<td>29%</td>
<td>21%</td>
<td>33%</td>
<td>30%</td>
<td>38%</td>
<td>22%</td>
<td>29%</td>
</tr>
<tr>
<td></td>
<td>Accepted onto caseload</td>
<td>18%</td>
<td>13%</td>
<td>19%</td>
<td>20%</td>
<td>25%</td>
<td>0%</td>
<td>17%</td>
</tr>
<tr>
<td><strong>Schizoaffective disorder</strong></td>
<td>Assessment</td>
<td>n/a</td>
<td>50%</td>
<td>35%</td>
<td>36%</td>
<td>50%</td>
<td>43%</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>Accepted onto caseload</td>
<td>n/a</td>
<td>0%</td>
<td>24%</td>
<td>27%</td>
<td>43%</td>
<td>43%</td>
<td>33%</td>
</tr>
<tr>
<td><strong>Hypomania</strong></td>
<td>Assessment</td>
<td>33%</td>
<td>0%</td>
<td>n/a</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>Accepted onto caseload</td>
<td>33%</td>
<td>0%</td>
<td>n/a</td>
<td>100%</td>
<td>100%</td>
<td>0%</td>
<td>48%</td>
</tr>
<tr>
<td><strong>Bipolar disorder</strong></td>
<td>Assessment</td>
<td>100%</td>
<td>0%</td>
<td>33%</td>
<td>n/a</td>
<td>100%</td>
<td>0%</td>
<td>53%</td>
</tr>
<tr>
<td></td>
<td>Accepted onto caseload</td>
<td>100%</td>
<td>0%</td>
<td>33%</td>
<td>n/a</td>
<td>100%</td>
<td>0%</td>
<td>53%</td>
</tr>
<tr>
<td><strong>Schizophrenia</strong></td>
<td>Assessment</td>
<td>67%</td>
<td>50%</td>
<td>58%</td>
<td>29%</td>
<td>100%</td>
<td>67%</td>
<td>60%</td>
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<tr>
<td></td>
<td>Accepted onto caseload</td>
<td>33%</td>
<td>17%</td>
<td>50%</td>
<td>29%</td>
<td>100%</td>
<td>67%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Other psychosis</strong></td>
<td>Assessment</td>
<td>43%</td>
<td>n/a</td>
<td>0%</td>
<td>40%</td>
<td>100%</td>
<td>0%</td>
<td>54%</td>
</tr>
<tr>
<td></td>
<td>Accepted onto caseload</td>
<td>43%</td>
<td>n/a</td>
<td>0%</td>
<td>20%</td>
<td>50%</td>
<td>0%</td>
<td>34%</td>
</tr>
<tr>
<td><strong>Any psychosis</strong></td>
<td>Assessment</td>
<td>50%</td>
<td>33%</td>
<td>41%</td>
<td>36%</td>
<td>67%</td>
<td>38%</td>
<td>47%</td>
</tr>
<tr>
<td></td>
<td>Accepted onto caseload</td>
<td>43%</td>
<td>8%</td>
<td>31%</td>
<td>27%</td>
<td>52%</td>
<td>31%</td>
<td>35%</td>
</tr>
<tr>
<td><strong>Dual diagnosis</strong></td>
<td>Assessment</td>
<td>42%</td>
<td>23%</td>
<td>41%</td>
<td>35%</td>
<td>48%</td>
<td>33%</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td>Accepted onto caseload</td>
<td>33%</td>
<td>8%</td>
<td>26%</td>
<td>26%</td>
<td>36%</td>
<td>25%</td>
<td>26%</td>
</tr>
</tbody>
</table>