PRISON HEALTH RESEARCH PRIORITIES

Introduction
At the ‘Innovation in Prison Healthcare’ conference held in May 2005 participants were invited to spend time discussing research priorities for prison health in groups led by expert facilitators. The group discussions were well-attended and delegates took part enthusiastically. Each Prison Health Research lead (BS, JS, MT and MF) then wrote a short paper (see Appendices A,B,C and D) that summarised research priorities in relation to primary care, mental health, substance misuse and dentistry.

Policy-makers views of research priorities
At the Prison Health Research Programme Board meeting held on September 21st 2005 these individual papers were presented and a discussion took place. It was agreed that the work undertaken to date would be synthesised where there was overlap and that this final paper would be the final draft on which the various Policy leads were consulted (see Appendix E). Initially, research priorities are organised into their best fit with either the SDO or HTA programmes. Where such a division does not fit too easily with the research programme nature of other identified priorities, for example as in mental health, these are identified separately. This exercise took place between October and December 2005 where 15 policy leads returned questionnaires asking them to rate the extent to which the research areas listed below where policy priorities. The top three priorities from each area are listed below in rank order (for the full list of rated priorities please see Appendix F).
Generic Areas (possibly for consideration by the SDO programme)

Rank 1 (8.4) Continuity of care

How can healthcare services be organised to ensure continuity of care for prisoners moving between prisons, between prisons and the community, and across the interface between primary and secondary care? Particular areas of concern centred on chronic disease management, mental health, and substance misuse. Important issues related to this included:

(a) The need to develop IMT systems to facilitate information transfer between healthcare facilities and how best to address the problems this may pose in terms of security and confidentiality;

(b) The need to develop more cost-effective approaches to the provision of hospital care for prisoners. Particular concerns centred on the role of inpatient units within prisons, and hospital outreach and telemedicine as alternatives to transporting prisoners to community-based facilities.

(c) In relation to mental health, it is unclear what the general outcomes were for many of the mentally ill prisoners released from prison? There is a need to identify examples of good practice which aim to ensure the continuity of care of this client group when under the responsibility of CMHTs, e.g. prisoners released with a discharge pack containing recent psychiatric assessments, care plans, etc. Such examples could be systematically trialled across various PCT areas.

Rank 2 (6.9) The Prison healthcare workforce

(a) Skill mix: How can changing professional roles and task delegation to non-clinical staff improve healthcare provision in prisons? For example, can a non-dental professional be trained to use simple methods to assess and prioritise dental health needs?

(b) Education: What additional/special training is needed by staff working in prisons? How can this best be provided? For example, the evaluation of mental health awareness training for prison officers, has ACCT training had a positive effect on suicide and self-harm in prisons.

(c) Occupational health: What are the additional/special needs of staff working in prisons and how can these best be met?

(d) How can recruitment to roles in prison health be maximised?
Rank 3 (6.1) How should prison health services be best organised

How can primary healthcare services (general medical practice, mental health, substance misuse, pharmacy, nursing) be organised to ensure prisons offer the same range and level of service provision as the community? More information is needed about different approaches to service configuration, including models used in other countries such as the USA and Australia. What models exist? Which models work best in what circumstances? What are the costs?

Health Technology Assessment

Rank 1 (7.1) The development of new treatment approaches for substance-misusers to reduce death by overdose on discharge/release.

Rank 2 (6.3) The impact of a psycho-social approach to drug treatment in prison

and the impact on health status including suicide.

Rank 3 (6) What impact does prison environment have on health status?

What are the ways – both positive and negative - in which imprisonment can affect health? Negative impacts may include: depression; diminished choice, voice and opportunities for self-care; increased exposure to transmissible diseases; etc. Positive impacts may include: improved access to healthcare; greater awareness and attention to health; reduced opportunity for self-harm;

WORKSTREAM SPECIFIC PRIORITIES

Dentistry

Rank 1 (4.5) How can services determine which patients truly have dental pain?

Mental Health

Rank 1 (7.4) Transfer of prisoners to acute care

A better understanding is needed about the criteria and decision-making processes which determine whether and when a prisoner should be transferred to a secure psychiatric hospital, especially when clinicians disagree when making such decisions. Are there any objective measures of the prisoner's need to be transferred, with proven reliability and validity amongst prisoner populations?
Rank 2 (7.0) Support services for suicidal prisoners and for prison staff.

- How effective can fellow prisoners be in the prevention of suicide and self-harm?
- Do initiatives such as the ‘Listeners’ program have any effect on the rate of suicide / self-harm by prisoners?
- What support services are available to staff and prisoners following critical incidences, and are they well received or perceived as effective?

Recognising that a person’s risk of suicide and self-harm does not cease when they leave prison, a better understanding is needed of the pathways ‘at-risk’ prisoners follow after their release from custody. Are they successfully plugged into community mental health services, if risk was recognised whilst in custody?

Rank 3 (6.9) Suicide and Self Harm

At an individual level, an improved description is needed of those prisoners who commit suicide or deliberately self harm whilst in custody, and how they compare with other prisoners. Also, what individual interventions have proven efficacy in the prevention of suicide / self-harm by prisoners?

Most of the service level research themes centred on how current provision can affect the risk of suicide and self-harm amongst prisoners.

- Has the implementation of ACCT had a positive effect on the rate of suicide and self-harm in prisons?
- Which aspects of this new process have been most effective at improving the management of at-risk prisoners?
- What barriers exist between staff and prisoners that can impinge on the effectiveness of this new process?
- What improvements still need to be made in the future?
APPENDIX A

PRIMARY CARE RESEARCH PRIORITIES

Models of service provision
How can primary healthcare services (general medical practice, pharmacy, nursing) be organised to ensure prisons offer the same range and level of service provision as the community? More information is needed about different approaches to service configuration, including models used in other countries such as the USA and Australia. What models exist? Which models work best in what circumstances? What are the costs?

Continuity of care
How can healthcare services be organised to ensure continuity of care for prisoners moving between prisons, between prisons and the community, and across the interface between primary and secondary care? Particular areas of concern centred on chronic disease management, mental health, and substance misuse. Important issues related to this included:
(1) The need to develop IMT systems to facilitate information transfer between healthcare facilities and how best to address the problems this may pose in terms of security and confidentiality;
(2) The need to develop more cost-effective approaches to the provision of hospital care for prisoners. Particular concerns centred on the role of inpatient units within prisons, and hospital outreach and telemedicine as alternatives to transporting prisoners to community-based facilities.

Patient choice and voice
How can prisoners’ views best be obtained and used to improve care provision? How do we ensure health services are sensitive to the needs of prisoners from different ethnic or cultural backgrounds? To what extent is it reasonable to promote patient choice within prisons?

Adapting community-based approaches to treatment for use in prisons
Many approaches to health promotion and disease management used in the community cannot easily be transferred into prison settings. More work is needed to adapt community-based treatment approaches for use in prisons, particularly in the areas of:
(1) Patient education and health promotion materials (which recommend interventions unsuited to prison environment and/or use language above the reading age of prisoners).
(3) Transmissible diseases (hepatitis, TB, HIV, STDs) detection and prevention – including health screening strategies, condoms, patient education, infection control, isolation facilities, needle exchange, outbreak plans, contact tracing, vaccination.
**Prevention of re-offending**
What strategies can be adopted to promote continuity of family relationships when a family member is imprisoned (e.g. mother-and-baby units)? Does relationship counselling promote better social adjustment? Do such strategies reduce rates of re-offending?

**Workforce**
Skill mix: How can changing professional roles and task delegation to non-clinical staff improve healthcare provision in prisons?

Education: What additional/special training is needed by staff working in prisons? How can this best be provided?

Occupational health: What are the additional/special needs of staff working in prisons and how can these best be met?

**Prison environment**
What are the ways – both positive and negative - in which imprisonment can affect health? Negative impacts may include: depression; diminished choice, voice and opportunities for self-care; increased exposure to transmissible diseases; etc. Positive impacts may include: improved access to healthcare; greater awareness and attention to health; reduced opportunity for self-harm; etc.
MENTAL HEALTH RESEARCH PRIORITIES

General Issues

Since PCTs are now responsible for the commissioning of healthcare services in prisons, including mental health services, it was felt important for researchers to include their input in discussions of the study design and methods. Also, service user input should be sought, perhaps recruiting assistance from prisoner bodies, e.g. Howard League for Penal Reform, or the Prison Reform Trust. Views expressed by such groups were often found to differ from those expressed by researchers, stakeholders and providers.

Suicide and Self Harm

At an individual level, an improved description is needed of those prisoners who commit suicide or deliberately self harm whilst in custody, and how they compare with other prisoners. Also, what individual interventions have proven efficacy in the prevention of suicide / self-harm by prisoners?

Most of the service level research themes centred on how current provision can affect the risk of suicide and self-harm amongst prisoners.

- Has the implementation of ACCT had a positive effect on the rate of suicide and self-harm in prisons?
- Which aspects of this new process have been most effective at improving the management of at-risk prisoners?
- What barriers exist between staff and prisoners that can impinge on the effectiveness of this new process?
- What improvements still need to be made in the future?

Evaluations of the support services available to staff and prisoners was also felt necessary.

- How effective can fellow prisoners be in the prevention of suicide and self-harm?
- Do initiatives such as the ‘Listeners’ program have any effect on the rate of suicide / self-harm by prisoners?
- What support services are available to staff and prisoners following critical incidences, and are they well received or perceived as effective?

Recognising that a person’s risk of suicide and self-harm does not cease when they leave prison, a better understanding is needed of the pathways ‘at-risk’ prisoners follow after their release from custody. Are they successfully plugged into community mental health services, if risk was recognised whilst in custody?
Personality Disorder

A number of service and individual issues arose concerning the management and treatment of prisoners with personality disorder.

Management of prisoners
- A review is needed of ‘what works’ when managing personality disordered prisoners. Various regimes exist in the large-scale management of such individuals both in and outside of the UK, e.g. therapeutic communities, restricted regimes, token economy systems. What are the effective elements of these regimes, and how can they be incorporated into the prison regime, e.g. models of care, staff discipline mix, integration of prison and community services? Longitudinal studies were suggested since creating change in this client group can often be a longer-term outcome.
- Long-term follow-up studies could improve understanding of the developmental pathways taken by younger offenders experiencing the first signs of personality disorder. Outcomes could include re-offending rates, access to treatment, etc.

Treatment of prisoners
- Evaluations are needed on the various individual interventions available for the treatment of personality disorder, e.g. Cognitive Behavioural, Dialectical Behaviour, Drama and Art therapies. Such evaluations would need to be representative of prisoners with personality disorder and of sufficient scale to be generalisable.

Staff related themes
- Burnout – what are the rates of burnout amongst staff working with prisoners with a personality disorder? How could burnout be better managed by the prison service, e.g. staff rotation, informed recruitment?
- Support services – what support services are available to staff dealing with personality disordered prisoners, and they perceived to be effective?
- Training – what training is currently available for staff dealing with prisoners with a personality disorder? Can training from special hospitals be effectively transferred to the prison service? Following the training of staff, evaluations would be required to assess the impact it had on staff morale, burnout, client response, etc.

Mental Illness

A better understanding is needed on the various models of care in the provision of services for mentally ill prisoners. Good practice and lessons learnt in the general community need to be assessed, in terms of their appropriateness and potential translation, for the prison environment. For example,
• What effective ‘primary care services’ are available to those prisoners with a mild to moderate mental illness, outside of healthcare?
• Can models of care for SMI that have proven effectiveness in the community be transferred into the prison setting, e.g. an early intervention service for psychosis?

In relation to researching the provision of ‘primary care services’ outside of healthcare, an evaluation is needed to identify what training is available for prison officers in order to help them improve in recognising and understanding mental illness and how it can present in prisoners.

On an individual level, a review could be conducted of the current gold standard interventions for persons with severe mental illness, both at a service level and at an individual level, and whether such interventions have been validated in prisoner populations.

Other issues involved the transfer and release of prisoners with mental illness.
• A better understanding is needed about the criteria and decision-making processes which determine whether and when a prisoner should be transferred to a secure psychiatric hospital, especially when clinicians disagree when making such decisions. Are there any objective measures of the prisoner’s need to be transferred, with proven reliability and validity amongst prisoner populations?
• It was unclear what the general outcomes were for many of the mentally ill prisoners released from prison? There is a need to identify examples of good practice which aim to ensure the continuity of care of this client group when under the responsibility of CMHTs, e.g. prisoners released with a discharge pack containing recent psychiatric assessments, care plans, etc. Such examples could be systematically trialled across various PCT areas.
DENTAL RESEARCH PRIORITIES


Two dental workshops were facilitated at this first meeting; one to identify research priorities to help improve dental health of prisoners and the second on priorities to help improve prison dental services.

Research priorities to inform prison dental service development

1. To identify the reasons for missed appointments at prison dental clinics
2. Identify methods to minimise wasted surgery time at prison sites due to either failed appointments or being late for appointments
3. To develop and test simple methods to assess and prioritise dental needs of prisoners, which could be delivered by a non-dental professional.
4. Can skill mix improve the efficiency of prison dental services?
5. Which is the most appropriate and effective way of delivering dental specialist services to prisoners?
6. What is meant by equivalence of service provisions: equal or equitable?
7. What things would make working in prisons more attractive to dentists?
8. How can services tell which patients truly have dental pain?
9. How can continuity of care be maintained in a prison setting?
10. How to identify the key priorities for commissioning prison dental services?
11. What information should be provided to prisoners on induction?

Research priorities to inform dental disease prevention in prisons

1. What vehicle is most appropriate and effective to deliver fluoride in a prison setting?
2. What methods are most effective for conveying health information to prisoners?
3. Who is the most appropriate person to provide health education/promotion?
4. What impact would sugar free methadone have on dental health?
5. Developing a standardised list of healthy foods and drinks to be available within the prison canteens.
6. When is the best time to provide preventive interventions for remand and convicted prisoners?
7. Are health behaviour changes adopted in prison retained on release?
8. What role do prison dental services have in promoting healthy eating smoking cessation?
9. The dental health education video being used in prisons needs to be evaluated.

This conference looked specifically at dental issues and built on the York meeting. In all 6 workshops were held, below is a summary of the workshop that looked at research priorities. Discussions were held around four main themes

2.1 Priorities for Research

These was a long discussion about “need” and “demand” for the prison population, particularly about who is the arbiter of what is a need and a demand. The need to produce a consensus for a definition of what is a reasonable demand on health care was seen as an urgent priority.

There was interest in deepening understanding of why some prisoners with high need often don’t utilise dental services and, conversely, why some with no clinically detectable need demand services.

Research into the role of screening was seen as important to determine if this is an effective means of identifying and prioritising need.

Delegates also stressed how precious clinical time was and wanted to minimise any waste of surgery time. A very strong suggestion for a simple project that prison dentists could complete together was a simple audit to identify the reasons for lost time/sessions. This could suggest likely interventions to address this problem, the effectiveness of which could be tested in research projects.

2.2 Problems of undertaking research in prisons

There will always be a tension in prisons between ensuring security is adequately addressed and providing healthcare. This tension will also have an impact on running research in prisons. There was a concern that prison officers are the gatekeepers to prison dental services and that smooth running of a project in prisons would be dependent on their good will.

The main barrier was seen as obtaining support for research from the prison health care manager. This was seen as unlikely to be forthcoming in many prisons, as clinical time would be lost if dental teams are working on a research project.

Another significant barrier was seen to be the isolation of prison dentists and that there is currently no forum for them to meet and share their views.

Difficulties were also reported about use of equipment necessary to deliver research not being allowed or severely restricted in prisons.
The main solution to gaining good will within prisons and being encouraged to participate in research was seen as developing partnerships. Explicit support from PCTs, in particular, was seen as essential if progress is to be made.

It was seen as very important for clinicians, prison managers and PCT commissioners to have a forum to enable them to meet and develop a dialogue about research needs and delivering research projects in prisons.

2.3 How to build research capacity in prison dental services

Delegates voiced the need for an infrastructure to support individuals with little experience of research. Academic support, expertise and leadership were seen as essential if any progress was to be made.

There was a realisation that support was also needed from the Prison Health Care Manager and that the commissioning PCT must value research. The local Community Dental Service Director and the Consultant in Dental Public Health were seen as individuals who were best placed to gain support from PCTs for research initiatives. PCTs must be willing to free up clinicians’ time to allow them to participate in research. This was currently seen as unrealistic due to pressures on services, however the PCTs and the prisons would have to provide protected time for the dental team if they are to meet their obligations around Clinical Governance, particularly meeting the CPD needs of the dentists.

Delegates were very keen that the dental team of the PHRN run regular national research meetings/courses in Manchester to teach research skills and facilitate dental teams working up and delivering a national project collectively.

The dentists were keen to establish a ‘specialist’ society of prison dentists to enable them to meet and share experiences on a regular basis. There was further talk of this group developing under the umbrella of an established dental society, such as BASCD.

It was seen as essential that funding for small projects is made available. This will get the attention and involvement of other academic groups.
2.4 Dissemination
Methods to effectively disseminate research and other information were discussed. There was agreement that if interventions were clearly demonstrated to have a beneficial effect then practice would change. These products of research could be fed into prison healthcare leads and to PCTs to inform commissioning discussions and decisions. There was thought that a newsletter may help and that findings could be presented at regular meetings of prison dentists.

The discussions of the remaining 5 workshops will also be written up and circulated via the web site.

Prof. Martin Tickle
September 2005
**Prevention of deaths on release**
There is a need for further research to develop approaches to reduce the high rate of deaths in the early release period. The development of new treatment approaches offers the opportunity to assess the impact of these new treatments on deaths post release and this should be a key priority for research in the next period to ensure that the changes underway are fully assessed and their impact fully understood.

**Prevention of deaths on release**
Suicide in the early period of imprisonment is a key challenge for the whole system. The development of a new treatment and psychosocial approach to drug dependence may have some impact on this and need to be fully evaluated.

**Models of service provision**
As new services are commissioned by the PCTs how can we determine what are the optimal models for service delivery and can different models be used to integrate approaches between, illicit drugs, alcohol and tobacco.

**Continuity of care**
How can healthcare services be organised to ensure continuity of care for prisoners moving between prisons, between prisons and the community, and across the interface between primary and secondary care? Developing more standardised care for substance dependence is an important component of continuity of care, in that it ensures that when prisoners are moved that they will continue to have access to treatments such as high dose maintenance opioid agonist treatments. In addition there is an important issue of ensuring continuation of treatment when prisoners are discharged into the community. Currently the DIP programme is the mechanism of promoting continuity, the question that arises is which is the best model for promoting continuity and how can these models be further developed and evaluated.

**Patient choice and voice**
Users views and prisoners views around drug misuse are controversial but remain an important dimension of information if high quality services are to be developed. The question is what sort of pragmatic and acceptable user view could be developed in prisons for substance misuse services.
Adapting community-based approaches to treatment for use in prisons

The prisons are developing services for drug dependence to mirror those provided in the community, and much work is underway but still more work is needed to adapt community-based treatment approaches for use in prisons, particularly in the areas of:

(1) Patient education and health promotion materials (which recommend interventions unsuited to prison environment and/or use language above the reading age of prisoners).


(3) Transmissible diseases (hepatitis, TB, HIV, STDs) detection and prevention – including health screening strategies, condoms, patient education, infection control, isolation facilities, needle exchange, outbreak plans, contact tracing, vaccination.

Prevention of re-offending

There is evidence to show that maintenance treatment for opioid dependence has a significant impact on reducing re-offending, this needs to be fully evaluated.
A. GENERIC AREAS OF PRISON HEALTH RESEARCH PRIORITY

Service development and organisation

1. Continuity of care

How can healthcare services be organised to ensure continuity of care for prisoners moving between prisons, between prisons and the community, and across the interface between primary and secondary care? Particular areas of concern centred on chronic disease management, mental health, and substance misuse. Important issues related to this included:

a. The need to develop IMT systems to facilitate information transfer between healthcare facilities and how best to address the problems this may pose in terms of security and confidentiality;

b. The need to develop more cost-effective approaches to the provision of hospital care for prisoners. Particular concerns centred on the role of inpatient units within prisons, and hospital outreach and telemedicine as alternatives to transporting prisoners to community-based facilities.

c. In relation to mental health, it is unclear what the general outcomes were for many of the mentally ill prisoners released from prison? There is a need to identify examples of good practice which aim to ensure the continuity of care of this client group when under the responsibility of CMHTs, e.g. prisoners released with a discharge pack containing recent psychiatric assessments, care plans, etc. Such examples could be systematically trialled across various PCT areas.

2. How should prison health services be best organised

How can primary healthcare services (general medical practice, mental health, substance misuse, pharmacy, nursing) be organised to ensure prisons offer the same range and level of service provision as the community? More information is needed about different approaches to service configuration, including models used in other countries such as the USA and Australia. What models exist? Which models work best in what circumstances? What are the costs?
3. How might community-based/population-based approaches to treatment best be adopted for use in prison health services?

Many approaches to health promotion and disease management used in the community cannot easily be transferred into prison settings. More work is needed to adapt community-based treatment approaches for use in prisons, particularly in the areas of:

(a) Patient education and health promotion materials (which recommend interventions unsuited to prison environment and/or use language above the reading age of prisoners).


(c) Transmissible diseases (hepatitis, TB, HIV, STDs) detection and prevention – including health screening strategies, condoms, patient education, infection control, isolation facilities, needle exchange, outbreak plans, contact tracing, vaccination.

(d) Adaptation of other broader models of clinical effectiveness such the NICE Guidelines for depression and psychosis and functional service models such as ‘Early Intervention of Psychosis’.

4. How should the key priorities for commissioning prison health services be determined? In the context of commissioning services what is meant exactly by the equivalence of service provision: equal or equitable?

5. What impact does the promotion of family relationships have on the health-care prisoners and on re-offending?

More specifically, what strategies can be adopted to promote continuity of family relationships when a family member is imprisoned (E.g. mother-and-baby units)? Does relationship counselling promote better social adjustment? Do such strategies reduce rates of re-offending? Does the promotion of family relationships improve outcome for psychosis, depression and substance misuse both inside prison and at release?

6. Service user involvement in the delivery of prison health services

How can prisoners’ views best be obtained and used to improve healthcare provision? How do we ensure health services are sensitive to the needs of prisoners from different ethnic or cultural backgrounds? To what extent is it reasonable to promote patient choice within prisons?
7. The Prison healthcare workforce

(a) Skill mix: How can changing professional roles and task delegation to non-clinical staff improve healthcare provision in prisons? For example, can a non-dental professional be trained to use simple methods to assess and prioritise dental health needs?

(b) Education: What additional/special training is needed by staff working in prisons? How can this best be provided? For example, the evaluation of mental health awareness training for prison officers, has ACCT training had a positive effect on suicide and self-harm in prisons.

(c) Occupational health: What are the additional/special needs of staff working in prisons and how can these best be met?

(d) How can recruitment to roles in prison health be maximised?

8. What health-care information should be provided to prisoners at reception?

What is the outcome of receiving such information, for example, the dental health education video? If health behaviours change occurs as a consequence are these changes maintained in the community when the prisoner is released?

B. HEALTH TECHNOLOGY ASSESSMENT PRIORITIES

1. What impact does prison environment have on health status?

What are the ways – both positive and negative - in which imprisonment can affect health? Negative impacts may include: depression; diminished choice, voice and opportunities for self-care; increased exposure to transmissible diseases; etc. Positive impacts may include: improved access to healthcare; greater awareness and attention to health; reduced opportunity for self-harm;

2. The development of new treatment approaches for substance-misusers to reduce death by overdose on discharge/release.

3. The impact of a psycho-social approach to drug treatment in prison and the impact on health status including suicide.

4. An evaluation of the costs and outcomes of prison dental services
5. A trial to determine the most effective manner in which to deliver fluoride in prisons

6. A prospective study to determine the costs and benefits of health-care screening at reception

7. Does maintenance treatment with methadone improve health status and reduce re-offending? To improve dental health should it be delivered in a sugar-free form?

WORKSTREAM SPECIFIC RESEARCH PRIORITIES

1. DENTISTRY

How can services determine which patients truly have dental pain?

The development of a standardised list of healthy foods and drinks to be made available within prison canteens and subsequently evaluated

An investigation into prison dental services and their role in the promotion of healthy eating and smoking cessation.

2. MENTAL HEALTH - FOR CONSIDERATION BY THE NATIONAL FORENSIC R&D COMMITTEE

Suicide and Self Harm

At an individual level, an improved description is needed of those prisoners who commit suicide or deliberately self harm whilst in custody, and how they compare with other prisoners. Also, what individual interventions have proven efficacy in the prevention of suicide/self-harm by prisoners?

Most of the service level research themes centred on how current provision can affect the risk of suicide and self-harm amongst prisoners.

- Has the implementation of ACCT had a positive effect on the rate of suicide and self-harm in prisons?
- Which aspects of this new process have been most effective at improving the management of at-risk prisoners?
• What barriers exist between staff and prisoners that can impinge on the effectiveness of this new process?
• What improvements still need to be made in the future?

Evaluations of the support services available to staff and prisoners were also felt necessary.

• How effective can fellow prisoners be in the prevention of suicide and self-harm?
• Do initiatives such as the ‘Listeners’ program have any effect on the rate of suicide/self-harm by prisoners?
• What support services are available to staff and prisoners following critical incidences, and are they well received or perceived as effective?

Recognising that a person’s risk of suicide and self-harm does not cease when they leave prison, a better understanding is needed of the pathways ‘at-risk’ prisoners follow after their release from custody. Are they successfully plugged into community mental health services, if risk was recognised whilst in custody?

**Personality Disorder**

A number of service and individual issues arose concerning the management and treatment of prisoners with personality disorder.

Management of prisoners

• A review is needed of ‘what works’ when managing personality disordered prisoners. Various regimes exist in the large-scale management of such individuals both in and outside of the UK, e.g. therapeutic communities, restricted regimes, token economy systems. What are the effective elements of these regimes, and how can they be incorporated into the prison regime, e.g. models of care, staff discipline mix, integration of prison and community services? Longitudinal studies were suggested since creating change in this client group can often be a longer-term outcome.

• Long-term follow-up studies could improve understanding of the developmental pathways taken by younger offenders experiencing the first signs of personality disorder. Outcomes could include re-offending rates, access to treatment, etc.

Treatment of prisoners

• Evaluations are needed on the various individual interventions available for the treatment of personality disorder, e.g. Cognitive Behavioural, Dialectical Behaviour, Drama and Art therapies. Such evaluations would need to be representative of prisoners with personality disorder and of sufficient scale to be generalisable.
Staff related themes

- Burnout – what are the rates of burnout amongst staff working with prisoners with a personality disorder? How could burnout be better managed by the prison service, e.g. staff rotation, informed recruitment?
- Support services – what support services are available to staff dealing with personality disordered prisoners, and they perceived to be effective?
- Training – what training is currently available for staff dealing with prisoners with a personality disorder? Can training from special hospitals be effectively transferred to the prison service? Following the training of staff, evaluations would be required to assess the impact it had on staff morale, burnout, client response, etc.

Mental Illness

A better understanding is needed about the criteria and decision-making processes which determine whether and when a prisoner should be transferred to a secure psychiatric hospital, especially when clinicians disagree when making such decisions. Are there any objective measures of the prisoner's need to be transferred, with proven reliability and validity amongst prisoner populations?
## Prison Health Research Priorities

| Generic Areas | Rater 1 | Rater 2 | Rater 3 | Rater 4 | Rater 5 | Rater 6 | Rater 7 | Rater 8 | Rater 9 | Rater 10 | Rater 11 | Rater 12 | Rater 13 | Rater 14 | Overall Mean |
|---------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|---------|---------|---------|---------|---------|----------|-------------|
| GA1           | 10     | 1.5    | 10     | 1.5    | 10     | 1.5    | 10     | 1.5    | 10     | 1.5     | 10      | 1.5     | 10      | 1.5     | 10       | 1.93       |
| GA2           | 2      | 8      | 10     | 1.5    | 6      | 3      | 6      | 4      | 10     | 3       | 4       | 6      | 2       | 6       | 1.5      | 8          |
| GA3           | 4      | 6      | 4      | 6.5    | 6      | 3      | 6      | 4      | 10     | 3       | 4       | 6      | 2       | 6.5     | 6.5      | 6       |
| GA4           | 4      | 6      | 4      | 6.5    | 6      | 3      | 4      | 7      | 6      | 4       | 3       | 6      | 2       | 6.5     | 8        |
| GA5           | 4      | 6      | 6      | 3.5    | 4      | 7      | 4      | 7.5    | 6      | 7       | 4       | 6      | 2.5     | 6.5     | 4.5      |
| GA6           | 6      | 3.5    | 6      | 3.5    | 4      | 5      | 4      | 7      | 6      | 4       | 6      | 4      | 3.5     | 6.5     | 6.5      |
| GA7           | 10     | 1.5    | 4      | 6.5    | 6      | 3      | 6      | 4      | 10     | 3       | 6      | 2       | 4.5     | 6.5     |
| GA8           | 6      | 3.5    | 6      | 4      | 6.5    | 6      | 3      | 4      | 7.5    | 6      | 7      | 4.5     | 6.5     | 6       |

| Health Technology | Rater 1 | Rater 2 | Rater 3 | Rater 4 | Rater 5 | Rater 6 | Rater 7 | Rater 8 | Rater 9 | Rater 10 | Rater 11 | Rater 12 | Rater 13 | Rater 14 | Overall Mean |
|-------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|---------|---------|---------|---------|---------|----------|-------------|
| HTA1              | 4      | 3      | 10     | 1.5    | 6      | 4.5    | 4      | 5.5    | 10     | 2.5     | 4       | 4       | 3       | 6       | 4        | 6.5      |
| HTA2              | 6      | 1      | 10     | 1.5    | 10     | 2      | 10     | 1      | 10     | 2.5     | 4       | 4       | 3       | 6       | 4        |
| HTA3              | 6      | 1      | 6      | 4      | 6      | 4.5    | 6      | 3      | 10     | 2.5     | 4       | 4       | 3.5     | 3       | 8        |
| HTA4              | 4      | 3      | 6      | 4      | 4      | 6.5    | 4      | 5.5    | 6      | 6       | 4       | 4       | 2.5     | 6.5     | 4.5      |
| HTA5              | 4      | 3      | 2      | 5.5    | 10     | 2      | 0      | 7      | 6      | 4       | 6       | 4.5     | 6.5     | 4.5     |
| HTA6              | 4      | 3      | 6      | 4      | 4      | 6.5    | 6      | 3      | 6      | 6       | 4       | 4       | 3       | 6       | 4.5      |
| HTA7              | 4      | 3      | 2      | 5.5    | 10     | 2      | 6      | 3      | 10     | 2.5     | 4       | 4       | 3.5     | 1.5     | 6.5      |

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