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Day 1

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See today's Agenda here:

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Chairs Opening Address

Dr Eamonn O'Moore MD FFPH
Chief Director of National Health Protection
National Health Protection Service of Ireland

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This will take you through to Slido, where you can interact with us.

SCAN ME

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Keynote Presentation

Professor Nicola Ranger

Chief Nurse - Royal College of Nursing

Professor Nicola Ranger

Chief Nurse

Royal College of Nursing

Royal College of Nursing

- Putting patients/people first
- Looking inward: how unrelenting pressures affect our own behaviour
- The 3 Cs
- From a Chief Nurse's perspective: my own experiences and reflections

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The entire health and social care workforce is under unrelenting pressure, caused by years of underinvestment and neglect.

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The 3 Cs…

- Curiosity
- Civility
- Collaboration

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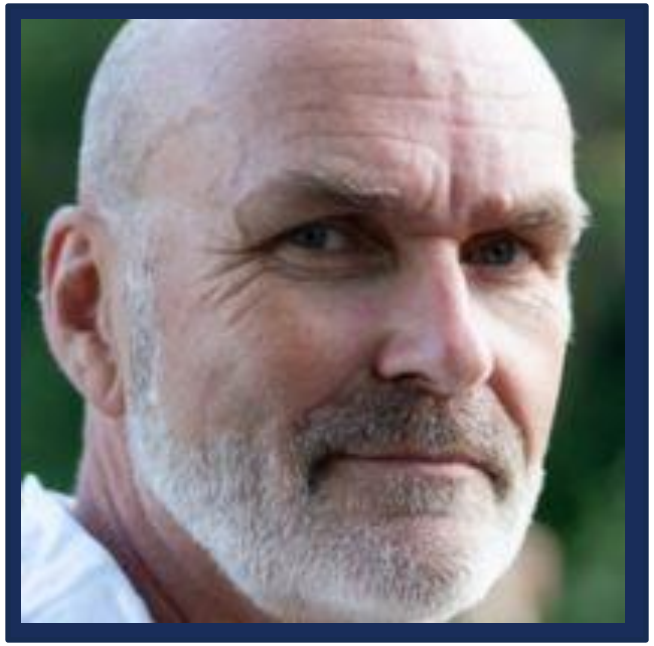
FAIR PAY FOR NURSING

SAFE STAFFING SAVES LIVES

NCEPOD Prison Healthcare Study



Dr Mark Juniper
NCEPOD Clinical Coordinator
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

NCEPOD Prison Healthcare Study

NCEPOD

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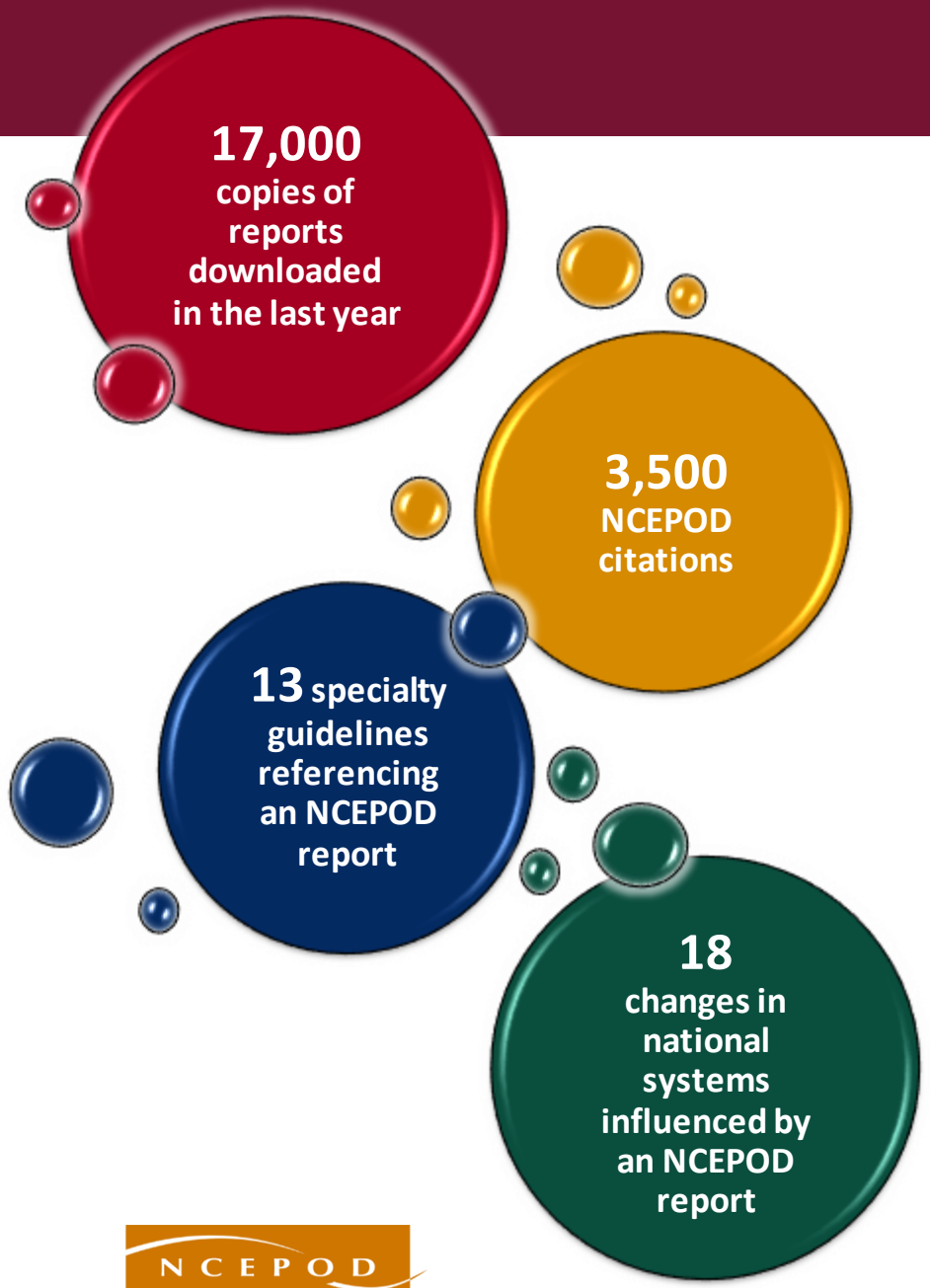

- CEPOD theatres are well known
- Trauma centres: Trauma, Who Cares? (2007)
- Think Kidneys : Adding Insult to Injury (2009)
- NICE guidelines : AKI, Acute Pancreatitis, deteriorating patients, sickle cell pain
- Service specification for cancer care in young people: On the Right Course (2018)
- Already we are working on the impact for current studies
- Lots of local examples too, it is not just national

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Prison Healthcare Study

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Aims of the study

To identify remediable factors in the clinical and organisation of healthcare for people who died from a ‘natural’ or other ‘non-natural’ death whilst detained in prison.

To produce focused, evidence-based recommendations to improve the commissioning, monitoring, provision and quality of healthcare in prisons.

Data collection

Clinical case data collection for peer review

- A multidisciplinary group of clinicians from prison, acute and community healthcare settings has reviewed a sample of ‘natural’ and other ‘non-natural’ deaths (as defined by the PPO).
- The focus of the peer review was the management of long-term health conditions, recognition of acute deterioration in health and end of life care

Study population

Study Population

- Published PPO report by December 31st 2021
- Natural deaths in 2019-2020 (332)
- Non-natural deaths 2018-2020 (78)

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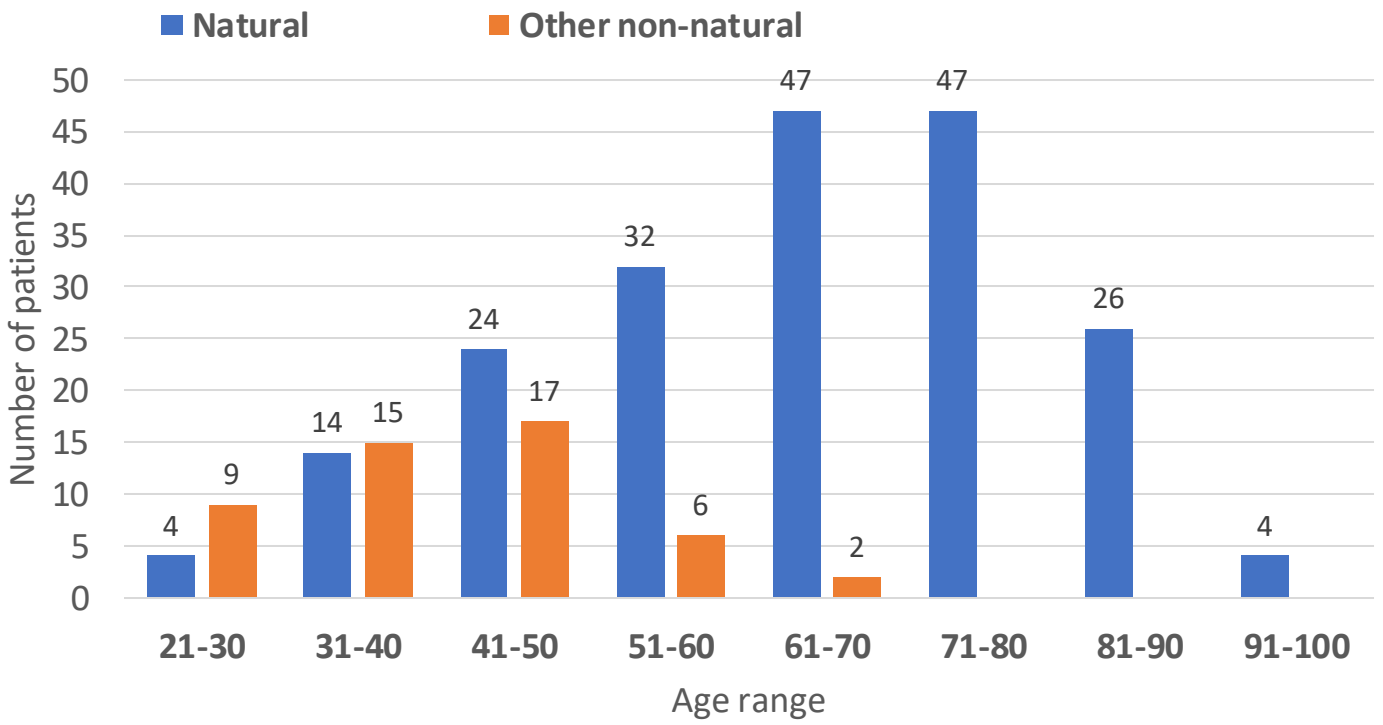
Age range



	Natural (n=198)	Other non-natural (n=49)
Mean	63.8	40.4
Median	66	41
Range	21-93	22-67

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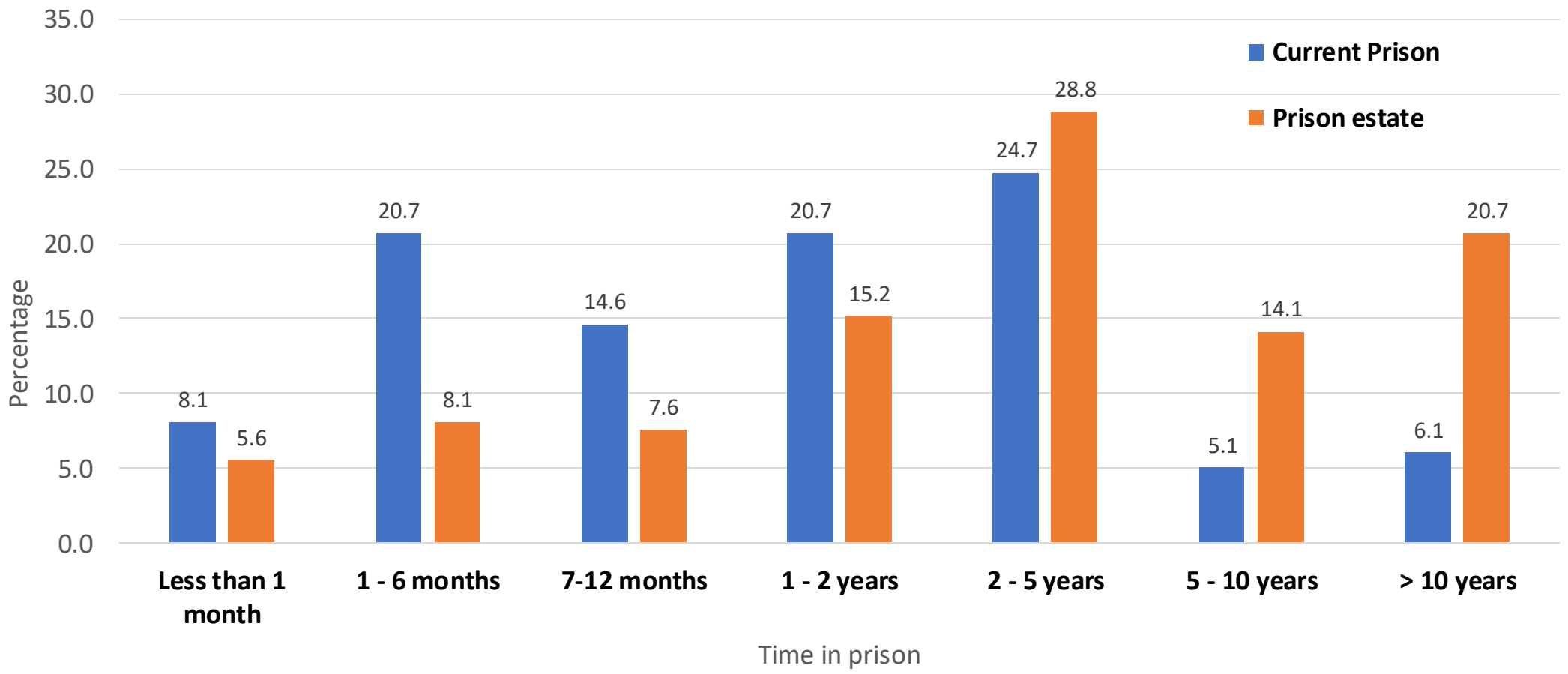
Time in prison (natural deaths)



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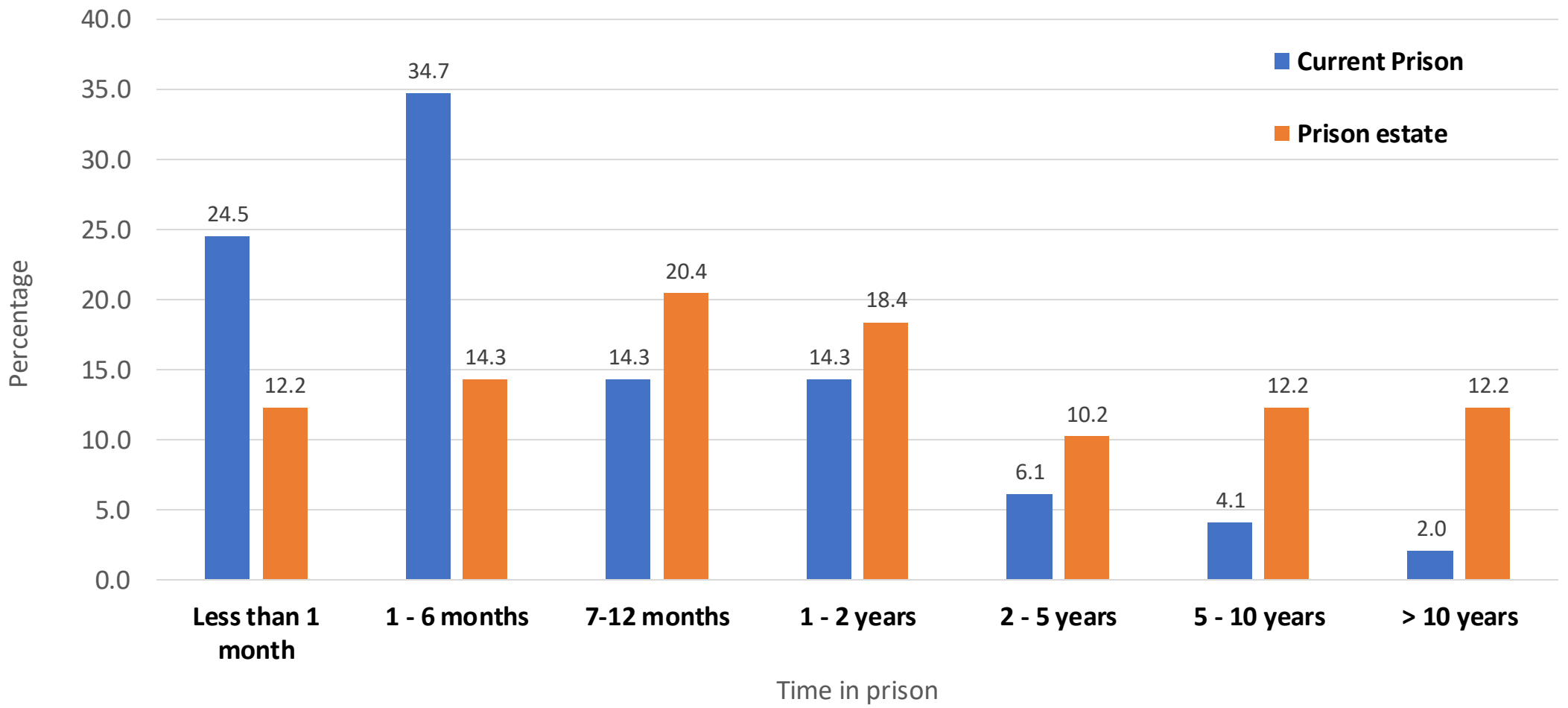
Time in prison (Other ‘non-natural’ deaths)



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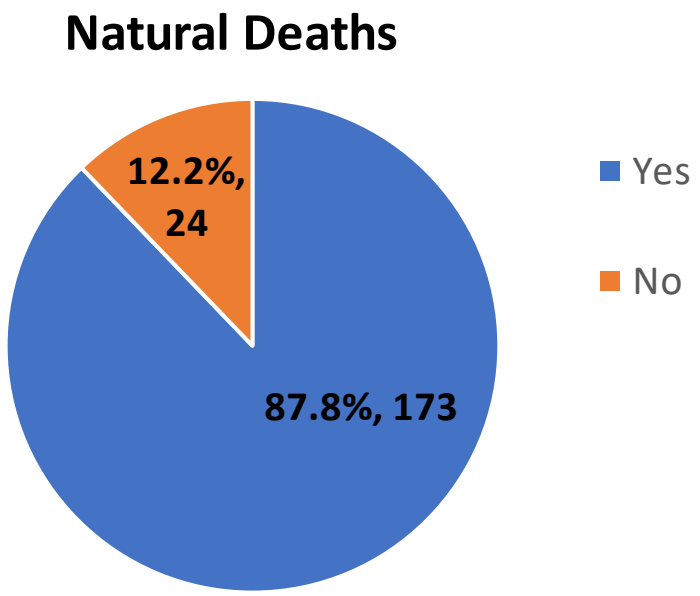
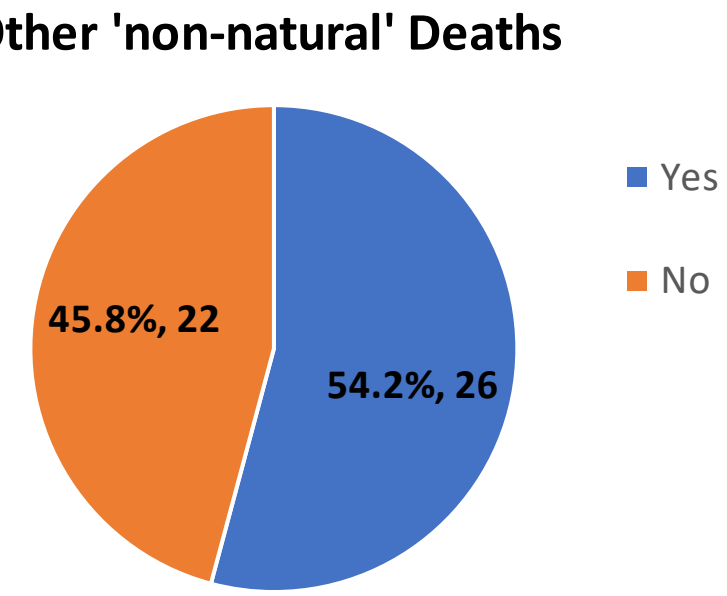
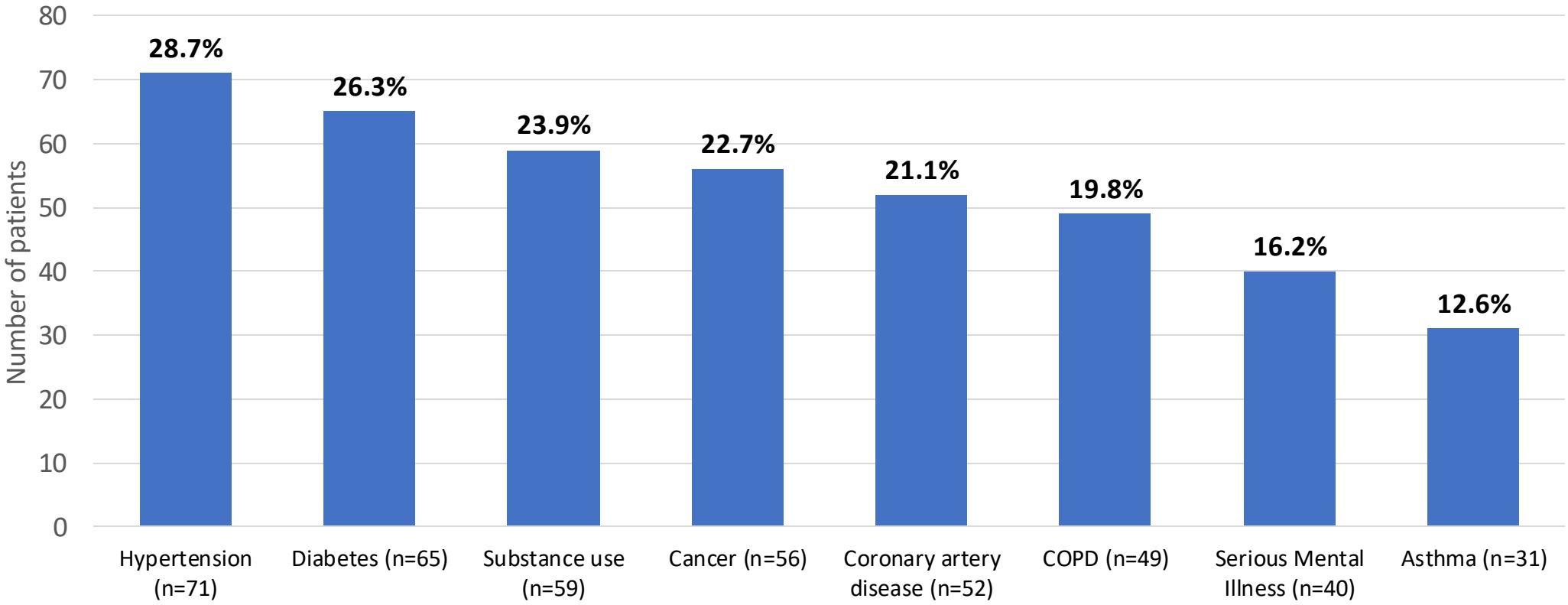
Long-term medical conditions





Health conditions



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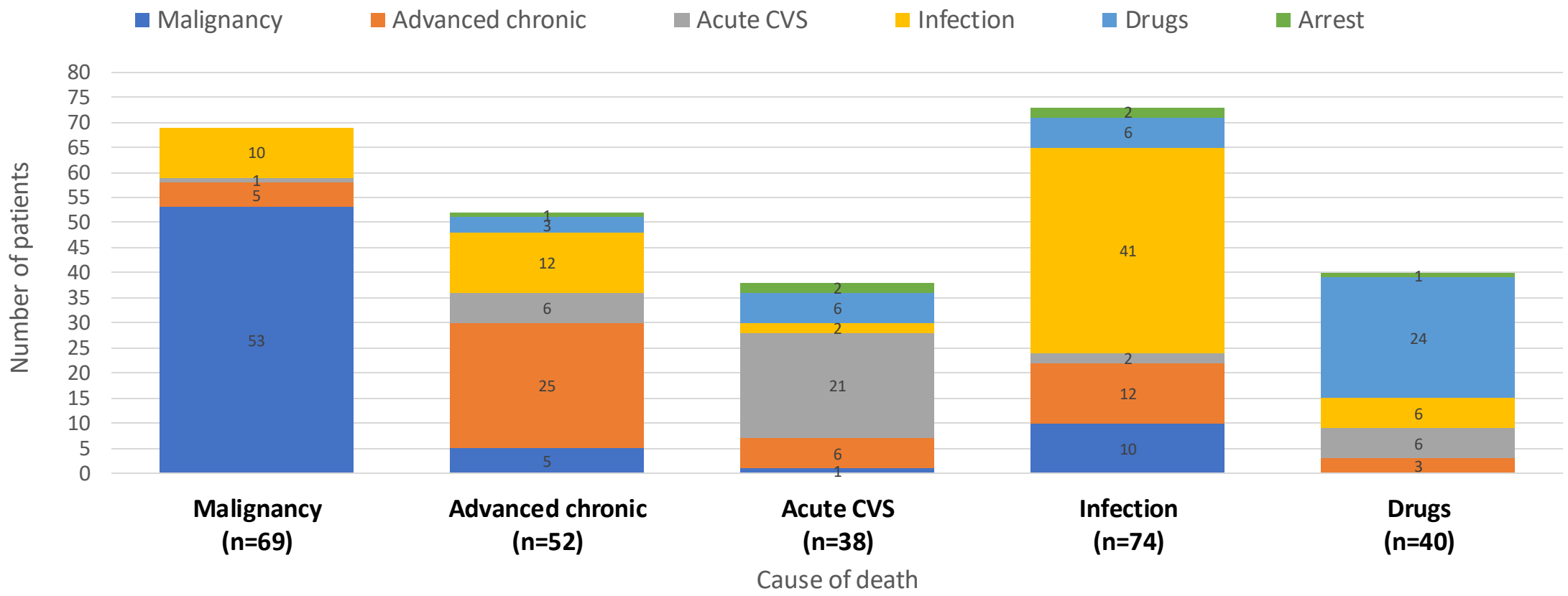
Clinical pathways

Cause of death



	Malignancy	Advanced chronic	Infection	Acute CVS	Drugs
Average age	64.4	66.5	61.0	61.6	40.5
Median age	66	70.5	64	61.5	41.5

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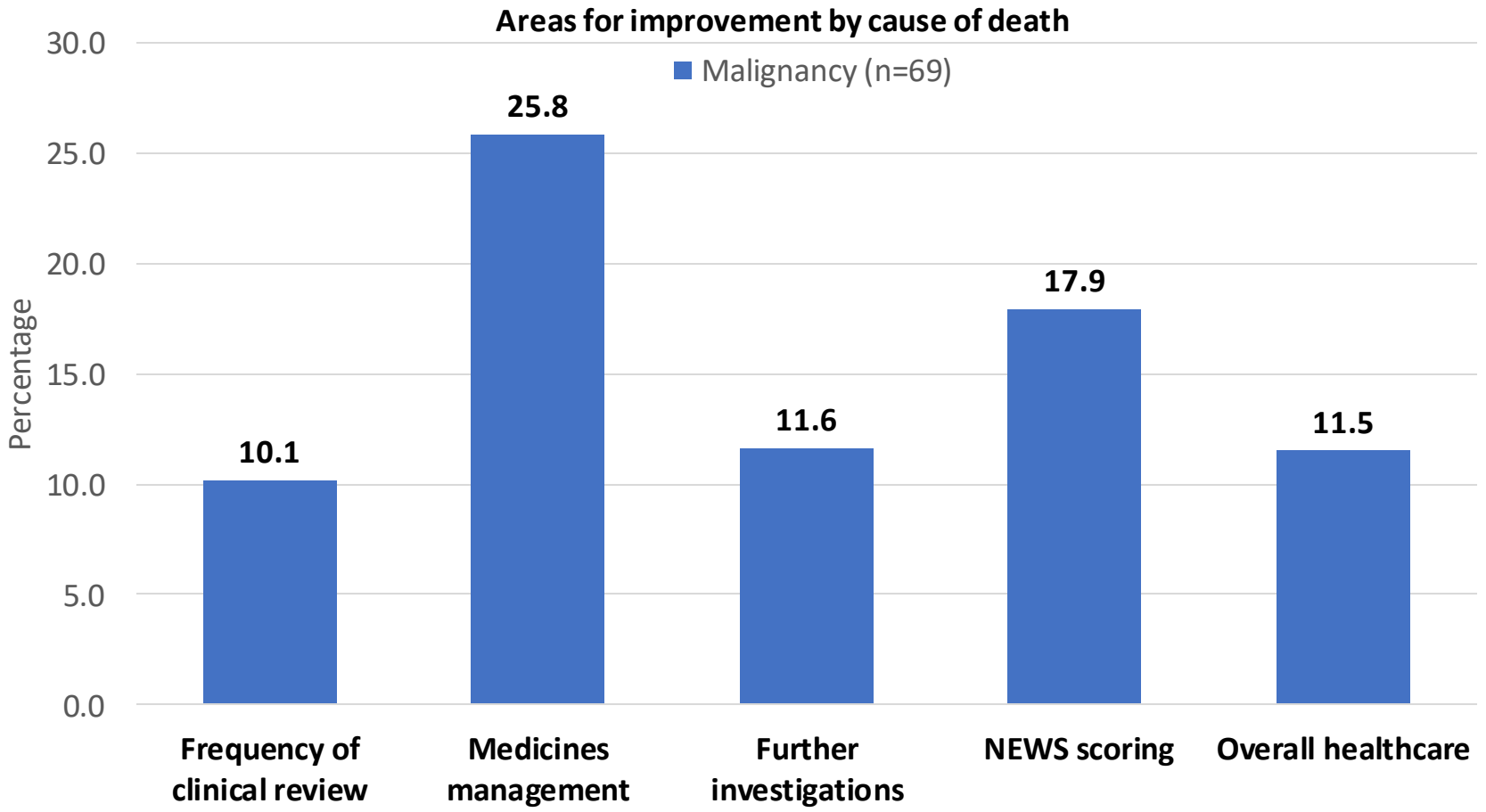
Areas for improvement

- Frequency of clinical review
- Medicines management
- Investigations
- Recognition of deterioration – NEWS2 scoring
- Overall healthcare

Malignancy



Age (years)
Mean 64.4
Median 66

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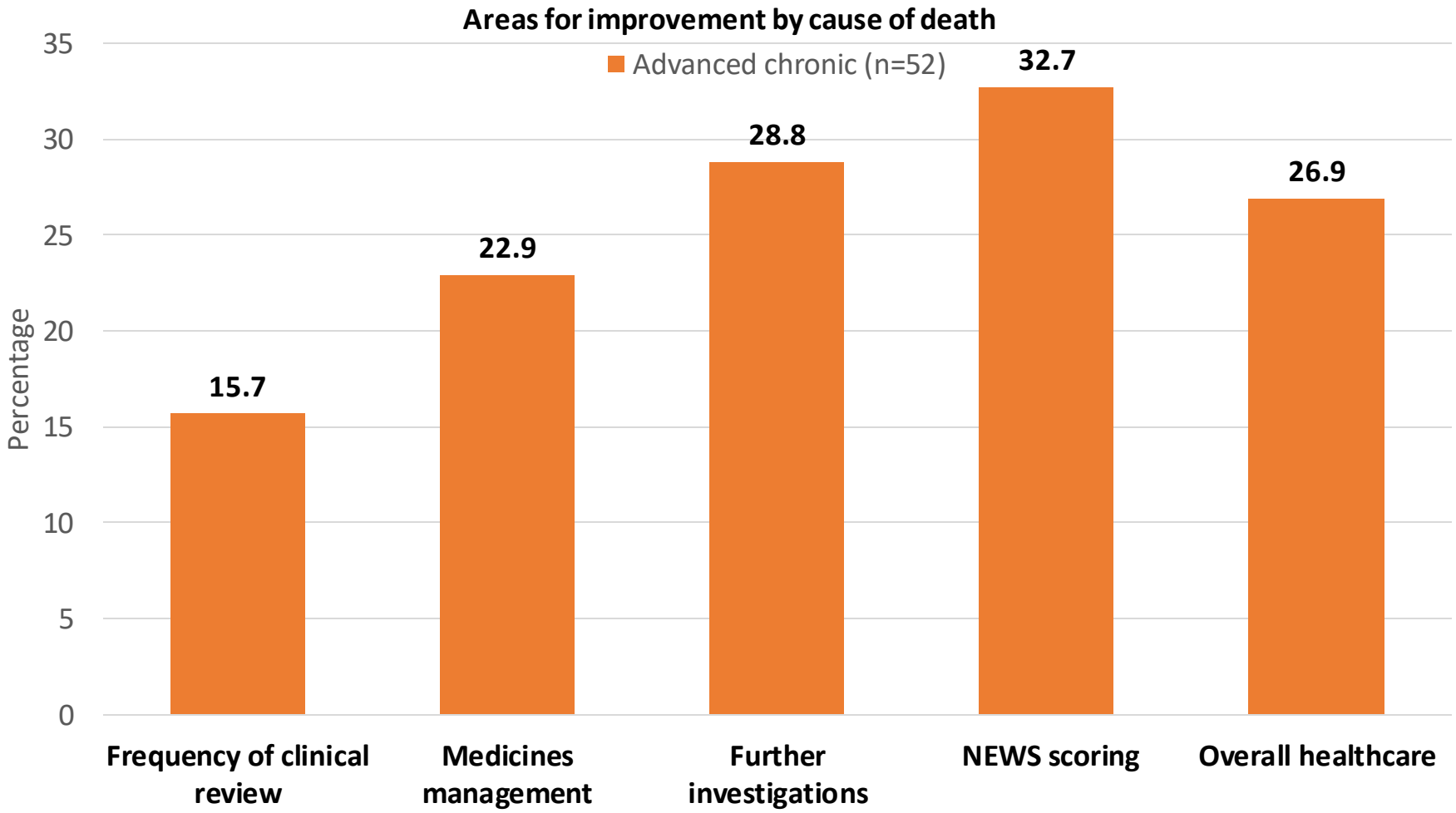
End of life care planning (Natural deaths)

Case history:

An elderly prisoner developed progressive and profound weight loss over a period of six months. The main focus of healthcare was on nutrition including MUST scoring. Eventually advanced metastatic cancer was diagnosed. No advance care plan was made following diagnosis and there was no documentation of the patient's wishes for end-of-life care.

The reviewers thought that there was an opportunity to make an earlier diagnosis. End of life care planning could also have been improved.

Advanced chronic disease



Age (years)
Mean 66.5
Median 70.5

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Medications

Was there room for improvement in the medicine(s) management for this patient?	Number of patients	%
Yes	60	27.8
No	156	72.2
Subtotal	**216**	
Unknown	16	
Not applicable	15	
Total	**247**	

Was it recorded in the case notes that any time-critical doses were missed?	Number of patients	%
Yes	30	25.4
No	88	74.6
Subtotal	**118**	
Unknown	6	
Total	**124**	

124 patients required time critical medications: Opiates, Bronchodilators, Diabetes, Antibiotics

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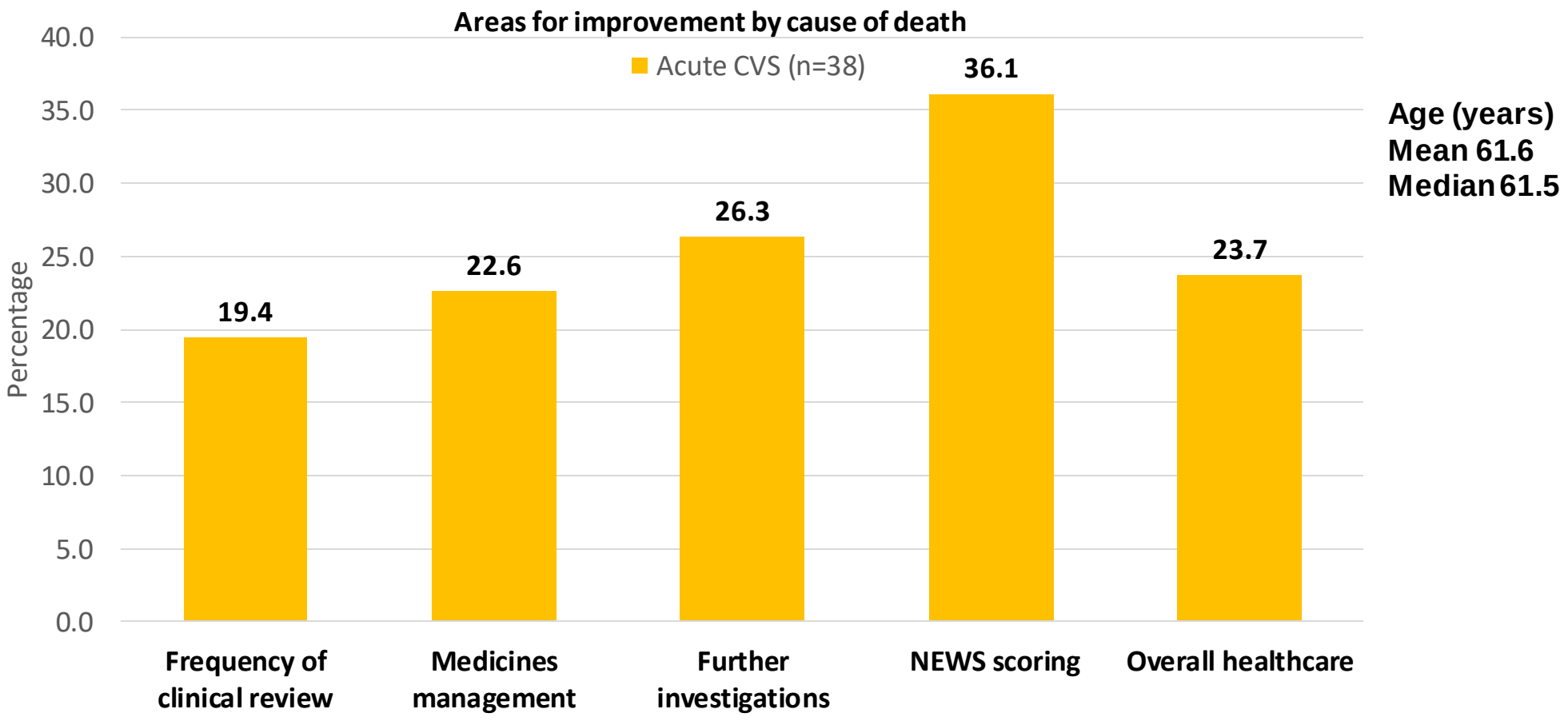
Acute CVS



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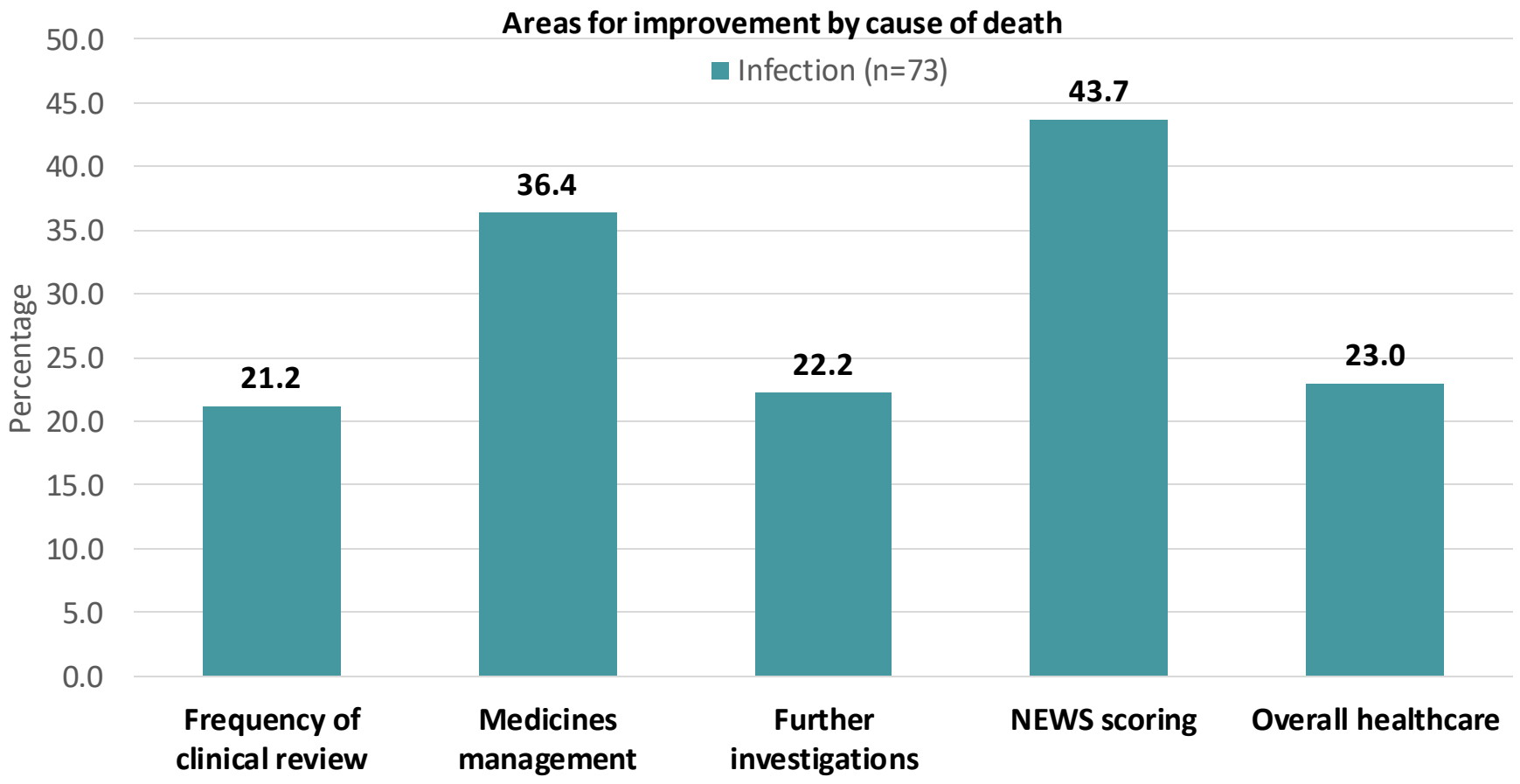
Infection



Age (years)
Mean 61.0
Median 64

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Deterioration

Is there evidence of deterioration in the patient's health before death?	Natural		Other non-natural		Total	
	Number of patients	%	Number of patients	%		%
Yes	158	82.3	10	21.3	168	70.3
No	34	17.7	37	78.7	71	29.7
Subtotal	**192**		**47**		**239**	
Unknown	6		2		8	
Total	**198**		**49**		**247**	

Was the deterioration managed appropriately?	Natural		Other non-natural		Total	
	Number of patients	%	Number of patients	%		%
Yes	101	65.6	4	44.4	105	64.4
No	53	34.4	5	55.6	58	35.6
Subtotal	**154**		**9**		**163**	
Unknown	4		1		5	
Total	**158**		**10**		**168**	

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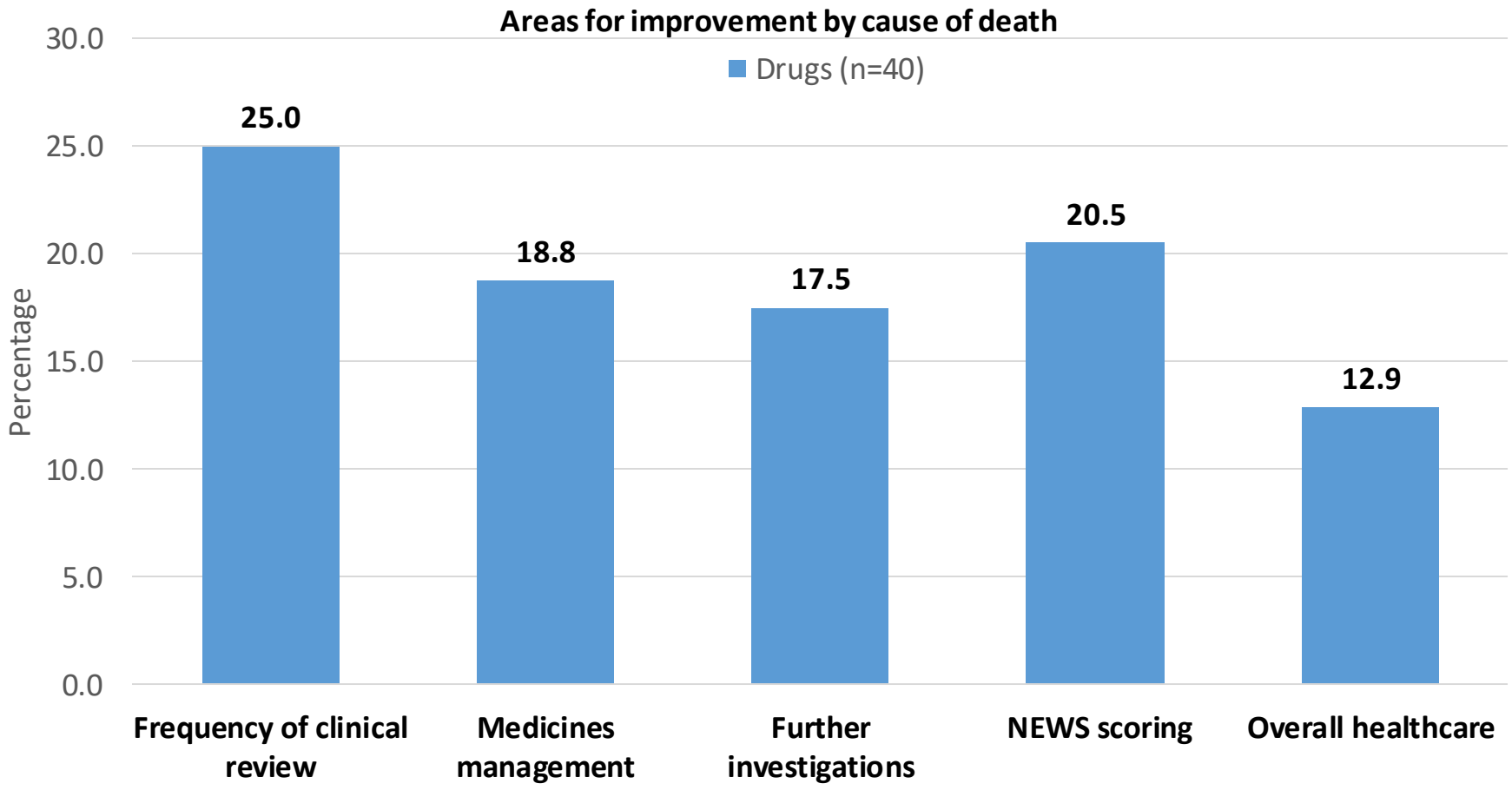
NEWS

	NEWS Scores used to assess		NEWS Scores used to monitor	
	Number of patients	**%**	**Number of patients**	**%**
Yes	135	55.8	96	40.5
No	107	44.2	141	59.5
Subtotal	**242**		**237**	
Unknown	5		10	
Total	**247**		**247**	

In your opinion, could the use of NEWS scoring have been improved for this patient?	**Number of patients**	**%**
Yes	73	30.7
No	165	69.3
Subtotal	**238**	
Unknown	9	
Total	**247**	

Drugs



Age (years)
Mean 40.5
Median 41.5

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Avoidable deaths

	Natural death		Other 'non-natural' death			
Was the death avoidable?	**Number of patients**	**%**	**Number of patients**	**%**	**Total**	**%**
Yes	23	13.3	23	67.6	46	22.2
No	150	86.7	11	32.4	161	77.8
Subtotal	**173**		**34**		**207**	
Unknown	25		15		40	
Total	**198**		**49**		**247**	

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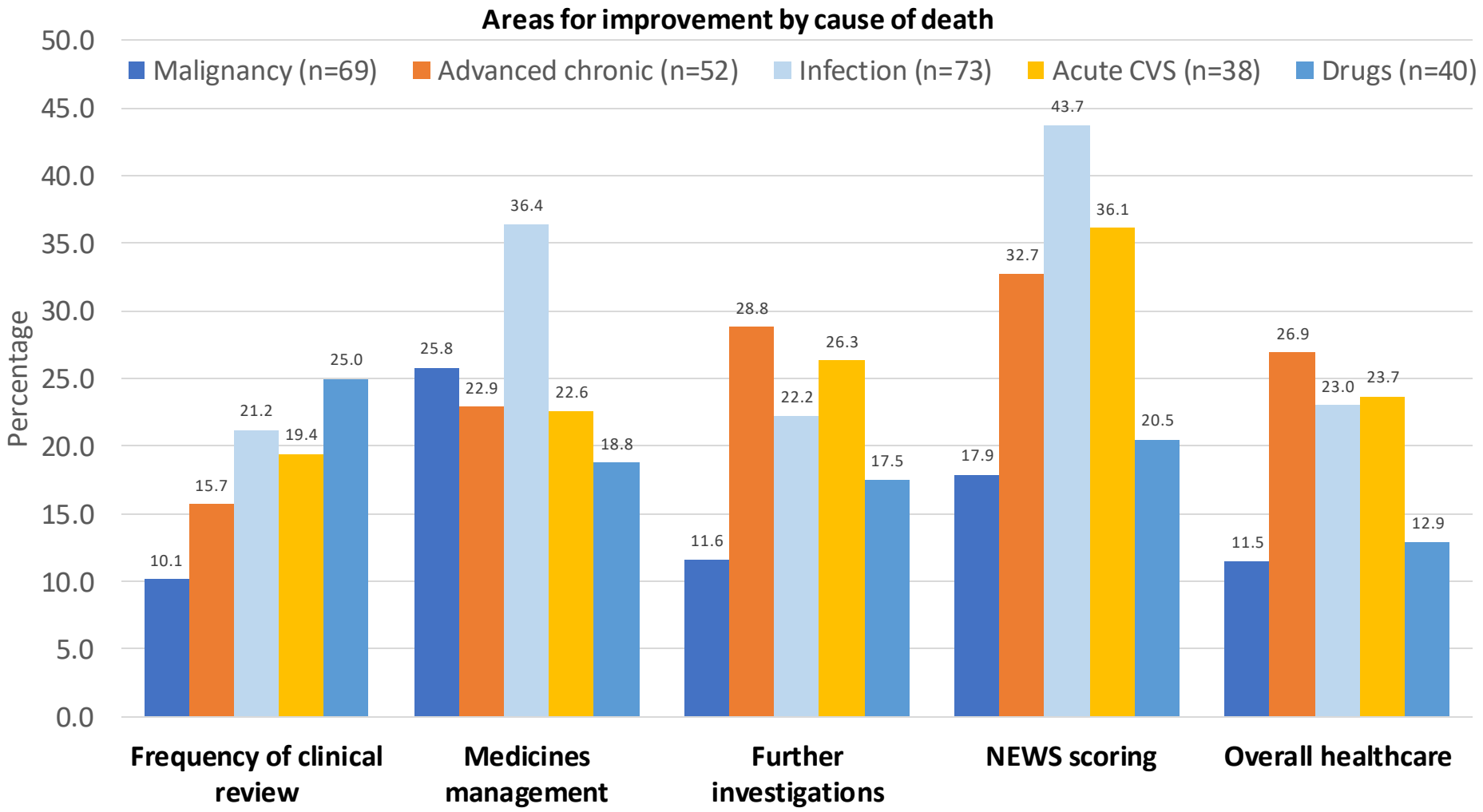
All deaths



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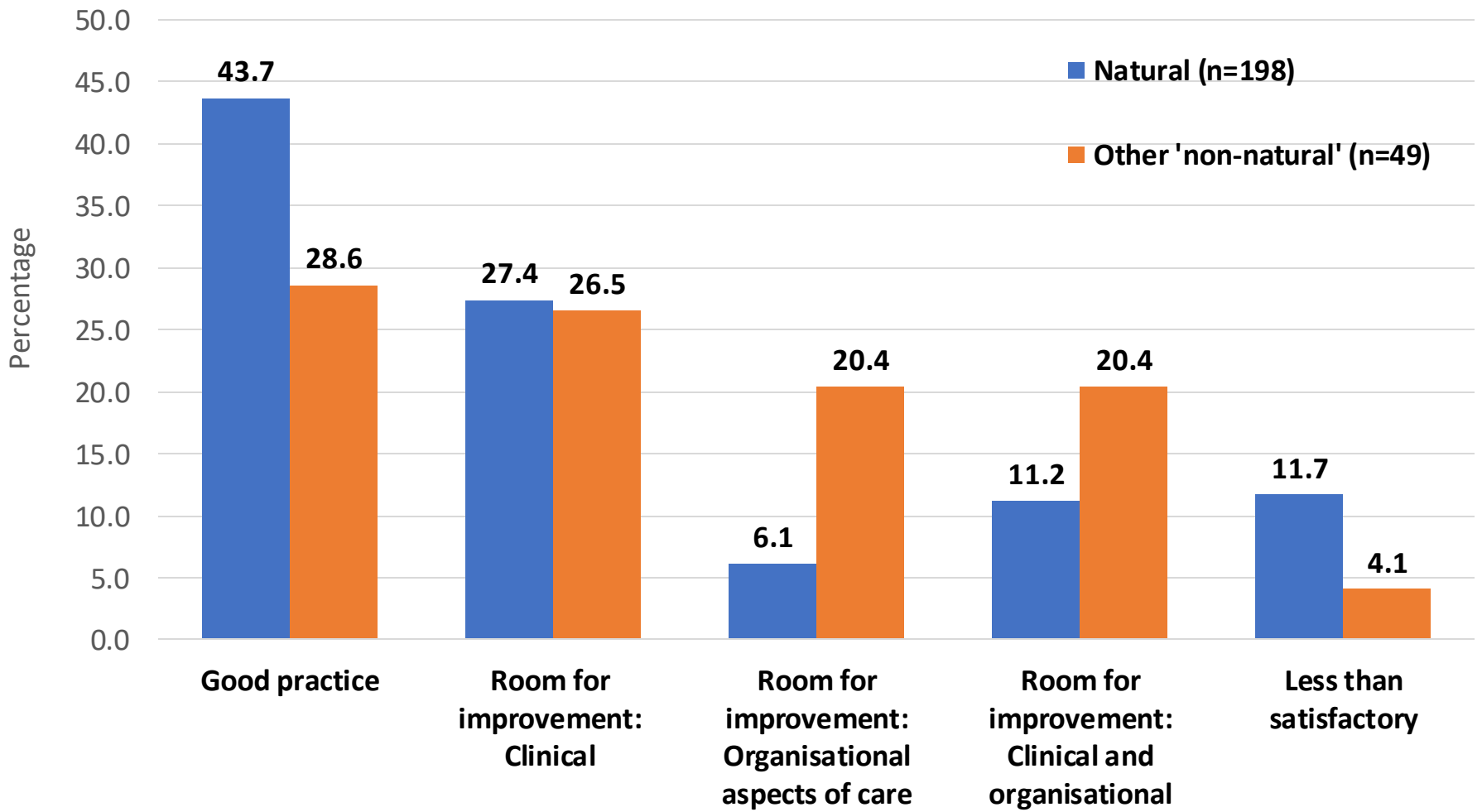
Overall care



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Not covered

- Organisational data
- NHSE clinical review
- PPO report
- Avoidability and prevention of future deaths
- Prison healthcare staff survey

Prison Healthcare staff survey

www.ncepod.org.uk

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Keynote Presentation

Nat Wright

Clinical Research Director - Spectrum CIC

Treatment for Substance Use in Northern Ireland Prisons:

findings from rapid review and consultation

NAT WRIGHT

RCGP 10TH HEALTH AND JUSTICE SUMMIT: BUILDING BRIDGES IN HEALTH AND JUSTICE

BELFAST *9TH–10TH OCTOBER*

Background: evolution of prison-based drug treatment systems

- On any given day - approximately 1,500 individuals (at the time of review but is currently approximately 1800) residing within the prison estate in Northern Ireland and have experienced significantly above average adverse childhood events during their formative years, thus placing them at risk of drug dependence, co-morbid severe enduring mental health problems, homelessness and wider social exclusion.
- Northern Ireland prison context - high remand population
- Regulation and Quality Improvement Authority (RQIA), *Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons* - October 2021 – highlighted a gap in service provision
- Parallels with the wider UK context of drug treatment in prisons where in last decade methadone provision has developed significantly
  - Underpinned by the Principle of Equivalence to reduce illicit heroin use, within prison crime, injecting and so aid wider recovery of the individual and reduce harm to wider society
  - "Equivalence" not "sameness" principle supported by a number of national and international declarations

Nat Wright: biographical details

Nat Wright trained as a GP and has over twenty-five years' experience of working with drug users in both community and prison settings. He has provided clinical leadership to the implementation of both local and national opioid maintenance programmes into prison settings. He has over twenty years' experience undertaking medicolegal work pertaining to issues of alleged failings in the standard of care offered to prisoners.

natwright@nhs.net

The Brief

The then Health and Social Care Board (which from 1 April 2022 became the Strategic Planning and Performance Group, Department of Health) commissioned Nat Wright to undertake a rapid review and consultation to understand current issues regarding demand and capacity in relation to OST and substance use issues within the prison system in Northern Ireland including the link to community addiction services. The prison system includes Maghaberry, Magilligan and Hydebank Wood Prisons.

Rapid Review

Given the relatively short timeframe for the project, the review questions and scope were focused to enable an efficient review of literature and data, without requiring the time or resources needed to undertake a full systematic review.

Setting the review within the context of both evidence base and guidelines for OST nationally and internationally, recommendations for service development are presented.

Stakeholder Consultation Exercise

Both face to face interviews and focus groups were conducted with leaders from the key stakeholders and included key personnel:

- Service Users
- Policy Leads
- Commissioners
- Clinical Leads
- Service Managers
- Prison Health Care Team Members
- Community Addiction Service Team Leaders
- Community and Voluntary Sector Representatives

Findings and Recommendations

Fall into a number of categories, which include:

- OST and Substance Use Services in Prison
- Transitions between Prison and the Community
- Links with Primary Care
- Workforce and Training

OST and Substance Use Services in Prison

1. Capacity needs to be built to facilitate Opioid Substitution Treatment (OST) initiation in prison, according to clinical need and without any significant waiting times, to support stability upon release from prison. Recruiting more specialist addiction nurses will support such capacity building.

2. Upon starting OST in prison, initiate a process of psychosocial assessment to include meeting need upon release from prison. This could be supported by formalised prison in-reach by the community and voluntary sector underpinned by contract provision.

3. Clarify the healthcare practitioner status of pharmacy technicians to enable them to administer prison-based methadone is common practice in other parts of the UK.

4. Consider that prescribing OST forms a requirement of training for every prison-based prescribing clinician and may be included in job descriptions.

5. Implement a process of peer clinical supervision between prison-based clinicians to foster support, competence and confidence in providing OST.

6. Provide training in the principles and practice of Cognitive Behavioural Therapy (CBT) to all staff providing support to prisoners (e.g. clinicians, key workers)

Transitions between Prison and the Community (1)

7. Ensure that prisoners receiving OST in prison have an appointment with either a community addiction service or homeless GP practice upon release (subject to recurrent funding for such a practice being made available), and that the appointment is given to the prisoner pre-release.

8. Enhance the offer of community addiction services to make some provision for open access/drop-in. Further telephone/video appointments could be offered to prisoners released homeless who are temporarily re-housed in a region that is distant to the community addiction service where they access OST, supported with the provision of link support workers to enable prisoners to access the full breadth of necessary health, housing and social care services upon release.

9. Support a pilot of electronic prescribing (EPS) of opioid maintenance medication to ensure ex-prisoners accessing telephone/video appointments do have access to OST.

10. Provide fast-track OST induction services for those resident in the community and referred from drug courts with a prison diversion community sentence, and consideration of associated impact on community pharmacy requirements to deliver any such service.

11. Develop and implement an integrated health, housing and social care crisis support service for people who are on remand and released from court unplanned at times of weekends and bank holidays.

Transitions between Prison and the Community (2)

12. Break the cycle between ex-prisoners accessing temporary unstable accommodation immediately post-release through funded enhanced pre-release planning to support uptake of permanent accommodation upon release.

13. For people who are within a cycle of repeated episodes of imprisonment offer buprenorphine depot treatment as it reduces the risk of treatment dropout when moving between community and custodial settings. It also reduces the burden of supervised dispensing on an already stretched community pharmacy network.

14. Scale-up access to Hepatitis C Virus (HCV) antiviral treatments through shared care arrangements with specialist hepatology services such that prison and community addictions teams, and also prison and community primary care teams, can prescribe antiviral treatments under specialist hepatologist supervisory arrangements.

15. Consider providing dedicated residential therapeutic communities for ex-offenders.

Links with Primary Care

16. Develop and implement a contractual framework that makes provision for the appointment of a salaried GP employed, if necessary, independently from a GP practice; such a postholder should have GP lead status for homeless healthcare provision, primary care and addictions treatment for homeless ex-prisoners and could also be supported to develop shared care and wider GP engagement with community addiction services.

17. Regularly audit primary care prescribing of opioids, gabapentinoids, benzodiazepines and any other drugs which can be readily diverted and used inappropriately as ‘currency’ within the prison population, and use results to set performance targets for reductions in prescribing such that the time released can be used to support repeat prescribing of OST for patient stabilised on such.

Workforce and Training

18. Provide training to all health, prison, social care, housing and probation staff regarding the multifaceted nature of drug dependence and that an integrated health, social care, housing and employment response is needed. Such training should be underpinned by training in values to challenge the stigma and discrimination experienced by many prisoners.

19. Provide advanced (RCGP part 2 certificate in substance misuse, or equivalent) training for all prison-based GPs, community GP leads, advanced nurse practitioners, nurse prescribers and pharmacy prescribers.

20. Encourage prison-based healthcare staff to undertake non-medical prescribing courses. However, build in a tie-in period if funding is provided to facilitate training completion (typically phased reduction of amount to be paid back over 2-4 years). As such prison-based clinicians with new prescribing qualifications are more likely to be retained to support provision of prison OST programmes.

21. Fund administrative support for the prison addiction service.

Conclusion

"In conclusion, whilst highlighting pockets of good practice in OST provision for both prisoners and ex-prisoners, the key narrative to emerge from this review was of a system with significant barriers regarding access and availability for vulnerable prisoner and ex-prisoner populations. Further, significant numbers of the clinical workforce, in particular primary care, appear to have inconsistent engagement with a shared care model when working with drug users, in part due to funding restrictions. However, this review has also highlighted improvements that can be made through cost-neutral re-organisation of current services rather than an additional resource requirement. One such example would be prison-based primary care prescribing services reducing the volume of analgesic medication to drug users, which would free up clinical time to provide OST.

However, having spoken to a wide variety of stakeholders representing prison and community service provider, policy, commissioner and the service user voice, the concluding reflection of the author is that where prisoners are fortunate to receive OST, the quality of such treatment is high. Such treatment is underpinned by robust clinical and strategic policy documents. Therefore, in simple terms, addressing the drug treatment needs of prisoners in Northern Ireland should entail a strategic focus upon quantity (in addition to the achieved quality) of treatment provision. The increase in availability needs to occur both in prison and upon release, with a particular emphasis upon supporting drug users make the transition from prison into the community, and so reduce the current significant risk of re-offending and re-imprisonment."

Headline Sponsor Plenary

camurus®

Mark Johnson

Founder - Lived Expert

MARK JOHNSON MBE

Essential Listening: Capturing the voices of lived experts to ensure equitable health for all

DISCLOSURES

I have received an honorarium from Camurus for this presentation

MY EXPERIENCE

20+ years in social innovation, coproduction and lived experience

Founded charities and social enterprises all led by the people they serve, including:

USER VOICE
ONLY OFFENDERS CAN STOP RE-OFFENDING

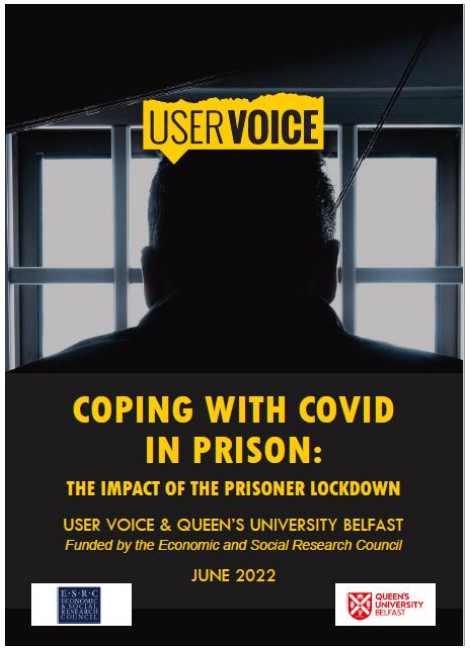
Can Do

LIVED EXPERT

COPRODUCING SERVICES

COUNCILS

4,000 elected Council members in **1/5 prisons** and **3/4 probation**



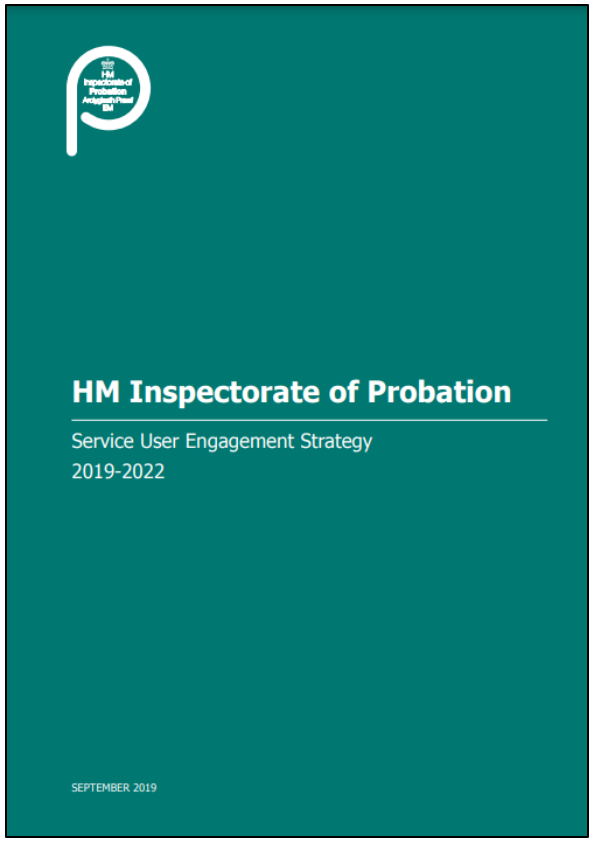
PEER RESEARCH

100 peer research projects with **20,000 participants**

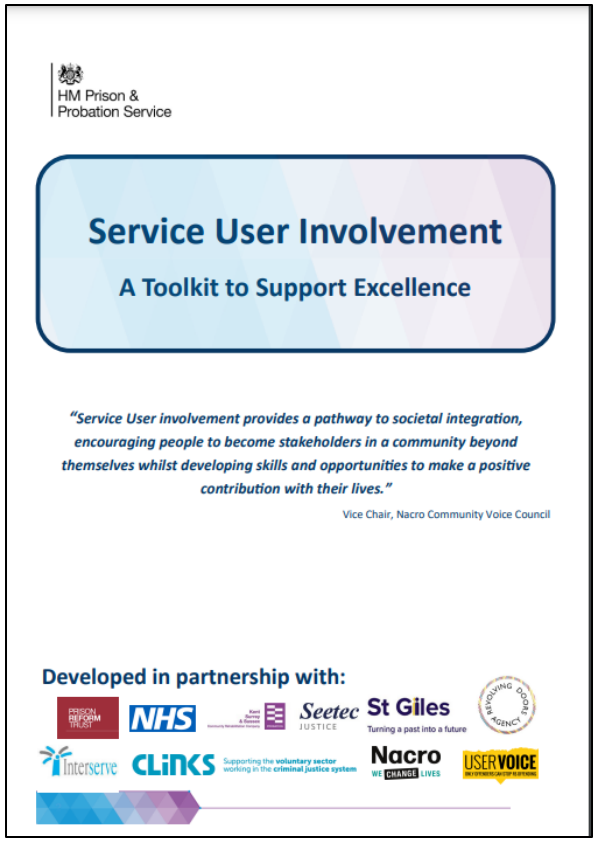
PEER COMMISSIONING

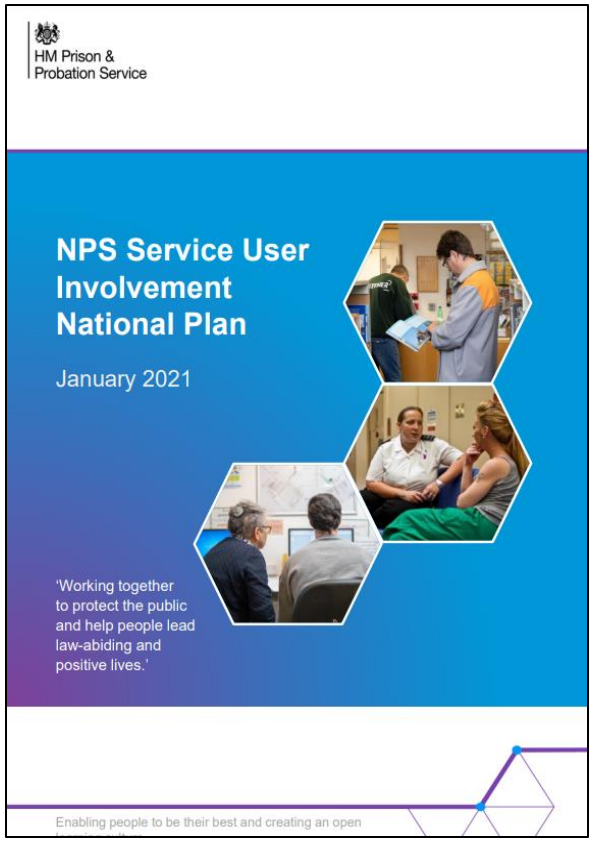
Peer Commissioners in procurement of healthcare in **40 prisons**

JOB DONE?


HM Inspectorate of Probation
Service User Engagement Strategy
2019-2022
SEPTEMBER 2019

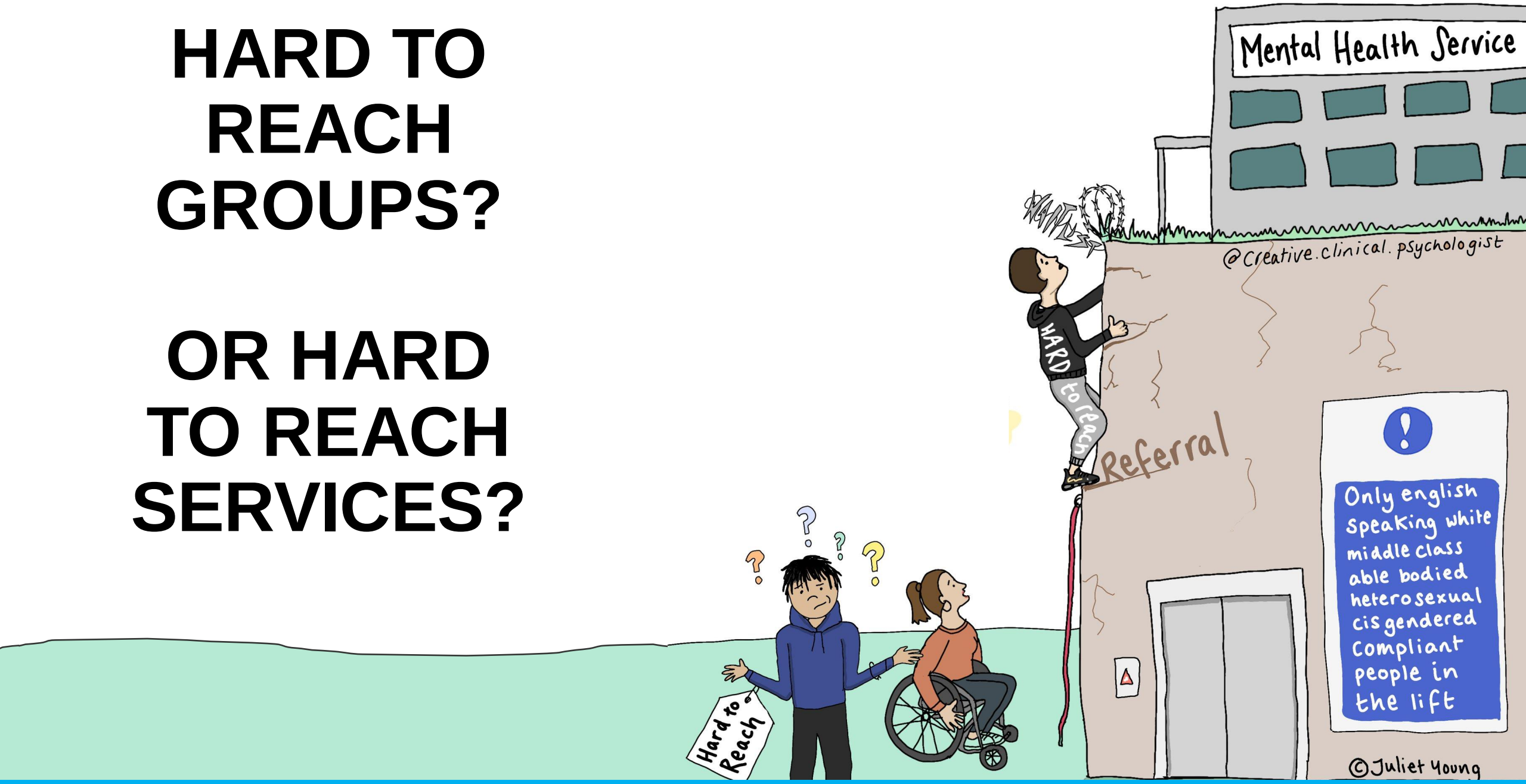

NHS England
Framework for patient and public participation in Health and Justice commissioning


HM Prison & Probation Service
Service User Involvement
A Toolkit to Support Excellence
"Service User involvement provides a pathway to societal integration, encouraging people to become stakeholders in a community beyond themselves whilst developing skills and opportunities to make a positive contribution with their lives."
Vice Chair, Nacro Community Voice Council
Developed in partnership with:


HM Prison & Probation Service
NPS Service User Involvement National Plan
January 2021
'Working together to protect the public and help people lead law-abiding and positive lives.'

HARD TO REACH GROUPS?

OR HARD TO REACH SERVICES?



AGENCY?

/ (ājənsē) /

Noun

The capacity to act independently and to make free choices. Human agency is the capacity for people to make choices and to impose those choices on the world. A person exhibits agency when they can act for themselves even in the face of social structures that oppress them.

Definition from The Alphabet of Social Justice by the SEAD Project

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Morning Break, Networking & Refreshments

Chairs Mid-Morning Address

Dr Eamonn O'Moore MD FFPH
Chief Director of National Health Protection
National Health Protection Service of Ireland

Headline Sponsor Plenary

Practice Plus Group

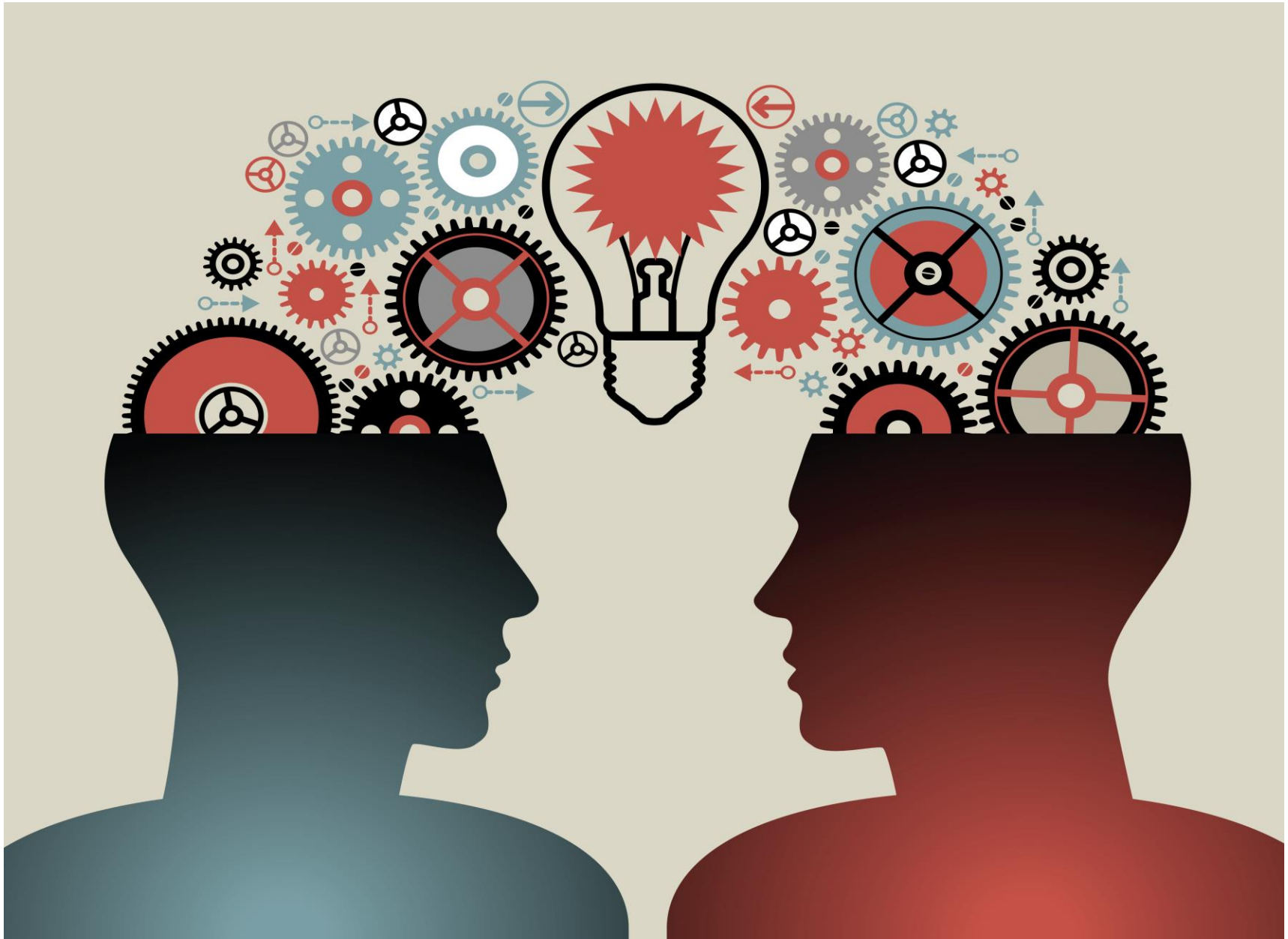
Dr Sarah Bromley
National Medical Director Health in Justice - Practice Plus Group

IRCs

Context, Challenges, Chances

Dr Sarah Bromley Oct 23

Practice
Plus
Group



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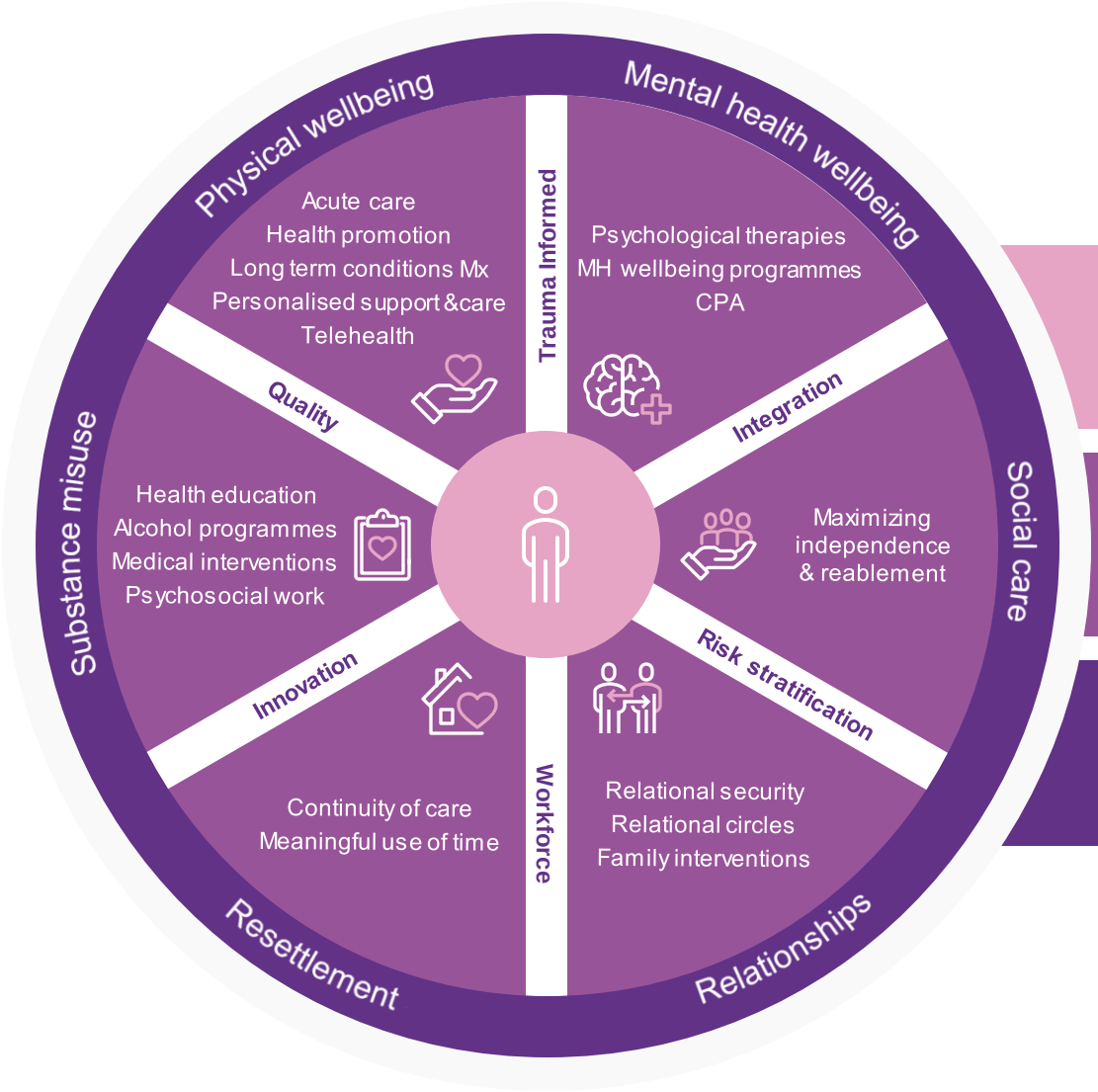
Context

PPG Approach to providing Healthcare in Secure Environments

Health and Wellbeing Approach



Centered on individual

Integrated

Holistic

Integrated Care Pathways

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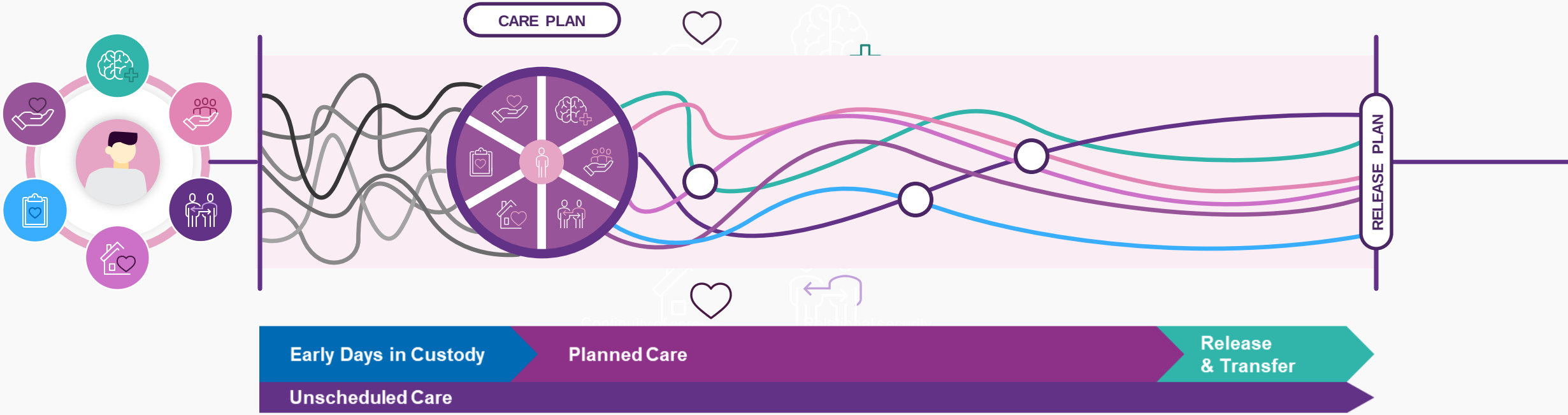

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Context

The Backdrop to Providing Healthcare in IRCs

Nov 2021

RNLI lifeboat crew blocked from going out to Channel by mob angry about refugees

September 2023

Practice Plus Group

Brook House Inquiry

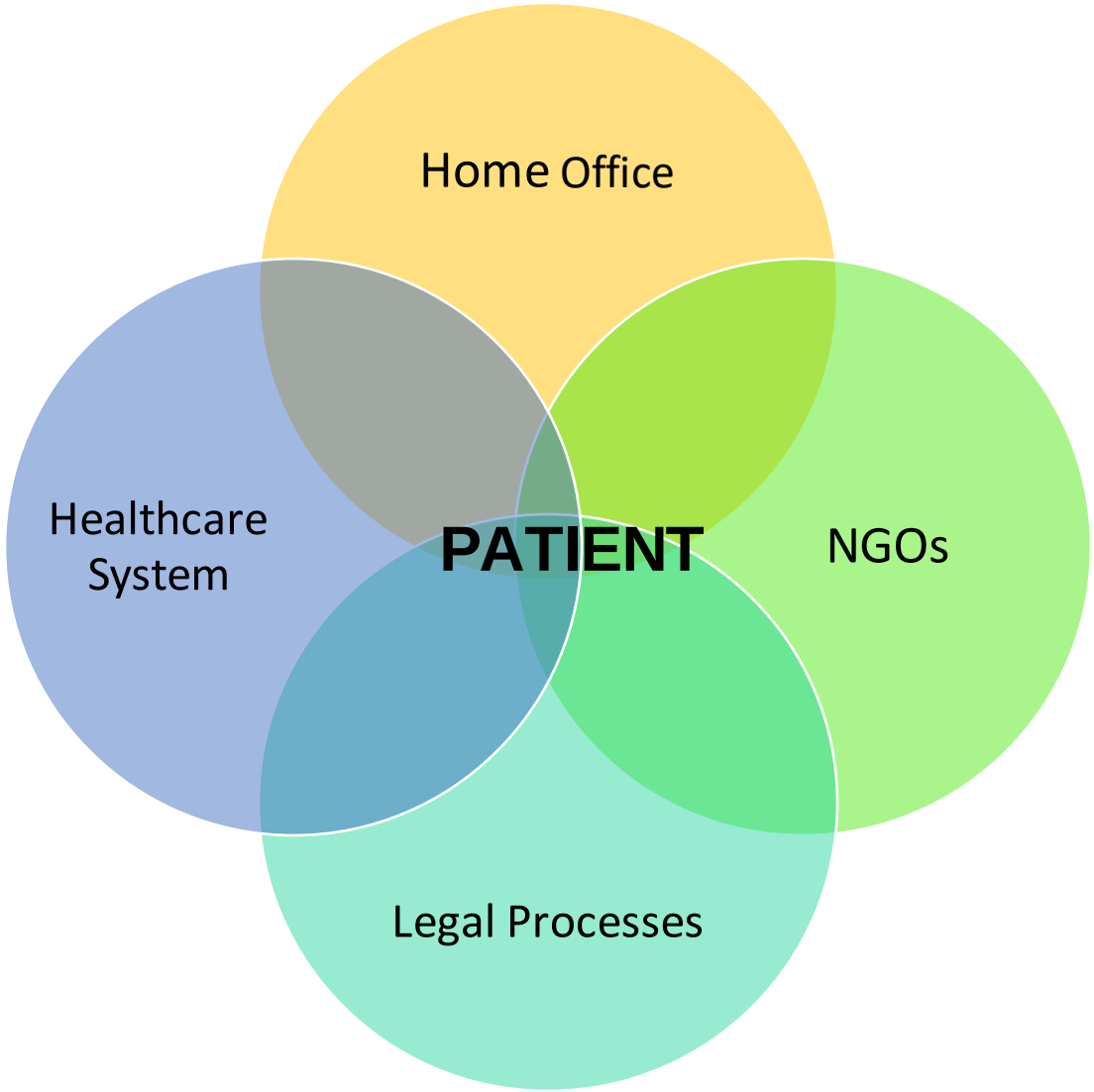
Mail Online

The 'dream' of multicultural Britain is dead: Suella Braverman warns West faces 'existential' threat from uncontrolled immigration as she says UK is living with consequences of people failing to 'integrate'

Challenges

What's so difficult about it?

Multiple Interested Parties



Rule 34

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"Every detained person shall be given a physical and mental examination by the medical practitioner … within 24 hours of his admission to the detention centre."

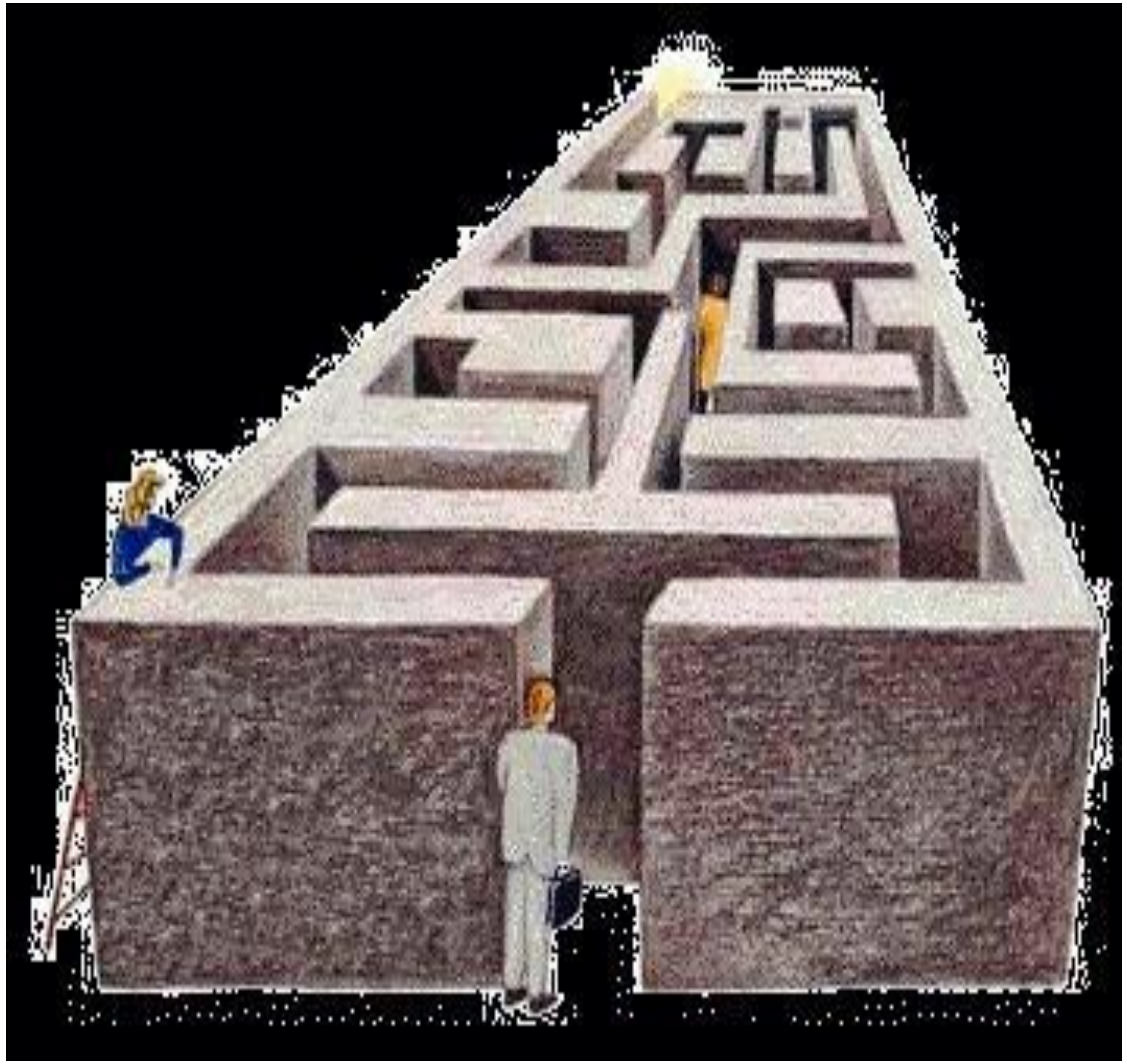
Rule 35 and Adult Safeguarding

"Immigration removal centre (IRC) doctors must report to Home Office caseworkers responsible for managing and reviewing that person's detention:

- *the likelihood of a detainee's* ***health being injuriously affected*** *by continued detention*
- *a suspicion that a detained person has* ***suicidal intentions***
- *concern that a detained person may have been a* ***victim of torture***"

"Protecting an adults right to live in safety, free from abuse and neglect"

Moral Maze



Meeting Population Health Needs for IRCs

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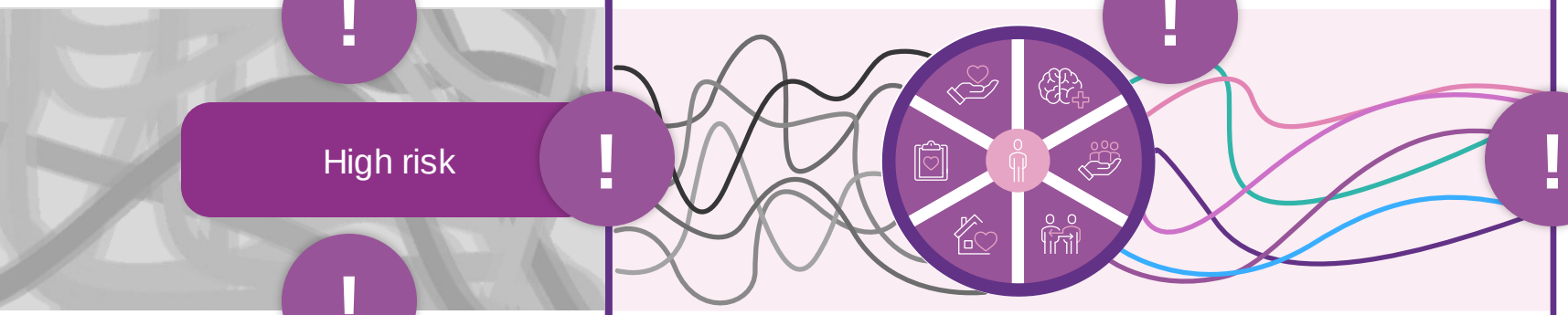
Multiple unmet health needs

High risk

High levels of trauma
First access to the service



Short stays

Managing continuity of care

High throughput requires:

- First 3-day risk management and holistic assessment
- Highly skilled clinicians
- Consistent handover of care

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Chances

What can we do and why should the prison healthcare system care?

(Exceptional Safety Assessment if high volume of short term holding patients)

First Night Screening

Complex

MDT Assessment & Rule 34

MH
SMS
RGN
GP

Overseen by GP

Complex Patients Pathway

Co-morbidity
Opioid Substitution Therapy
Secondary Care Requirements
Bedwatch or recent discharge
MH Step 3+
Women

Non-complex Patients Pathway

Single LTC
Step 1 & 2 MH
Imms/vacs, BBV screening
Health promotion
Sexual health
SMS psychosocial groups (low level)
Drop-in triage
Physio/optometry/podiatry
Travel vaccs

Day 14 - Secondary Assessment to identify unmet need and refer to appropriate pathway

Unscheduled Care Pathway (all patients)

Duty MH worker
Emergency response (paramedic/nurse)
Acute illness/injury

Clinical process

First night assessment

Acutely unwell

Hospital

Complex patient

No acute health issues

Day 1 MDT holistic Assessment & Rule 34

History of torture

Appropriate clinical pathway

Complex

Non-complex

MPCCC

Day 14 review

Deteriorating and/or Risk

MH Assessment

Clinical Assessment

Deteriorating and/or Risk

Discharge Planning

Rule 35/safeguarding

Complex case team
IS91RA Pt C
Book MDT/Rule 34 assessment

Rule 35 (1,2 or 3) assessment

Vulnerable adults Meeting

Rule 35 (1,2 or 3) assessment

ACDT/Constant Supervision

3rd party concerns

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Foreign National Prisoners

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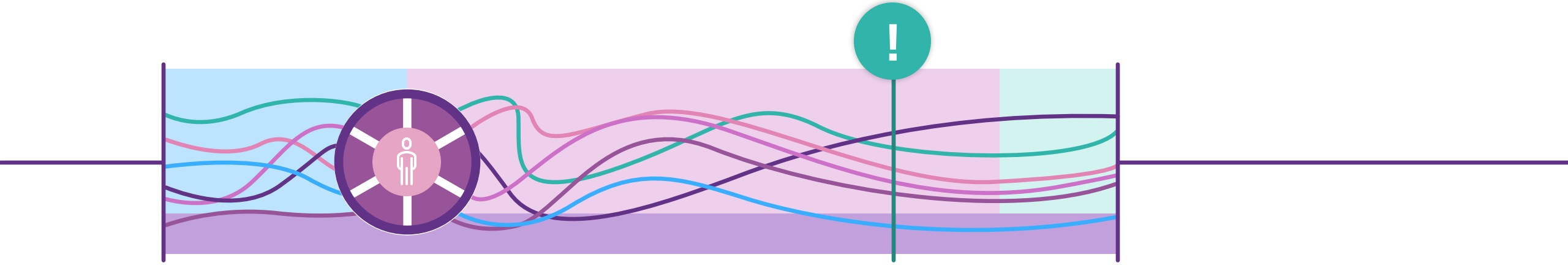
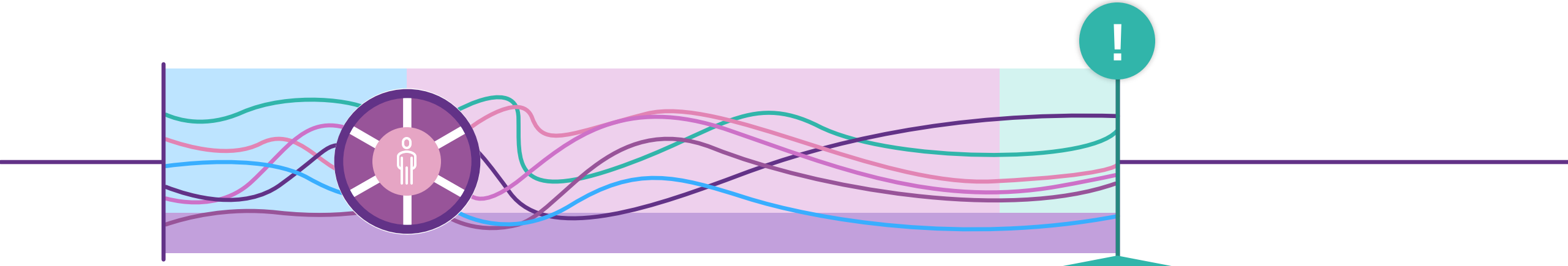
Status change to IS91 (detainee)



Foreign National Prisoners

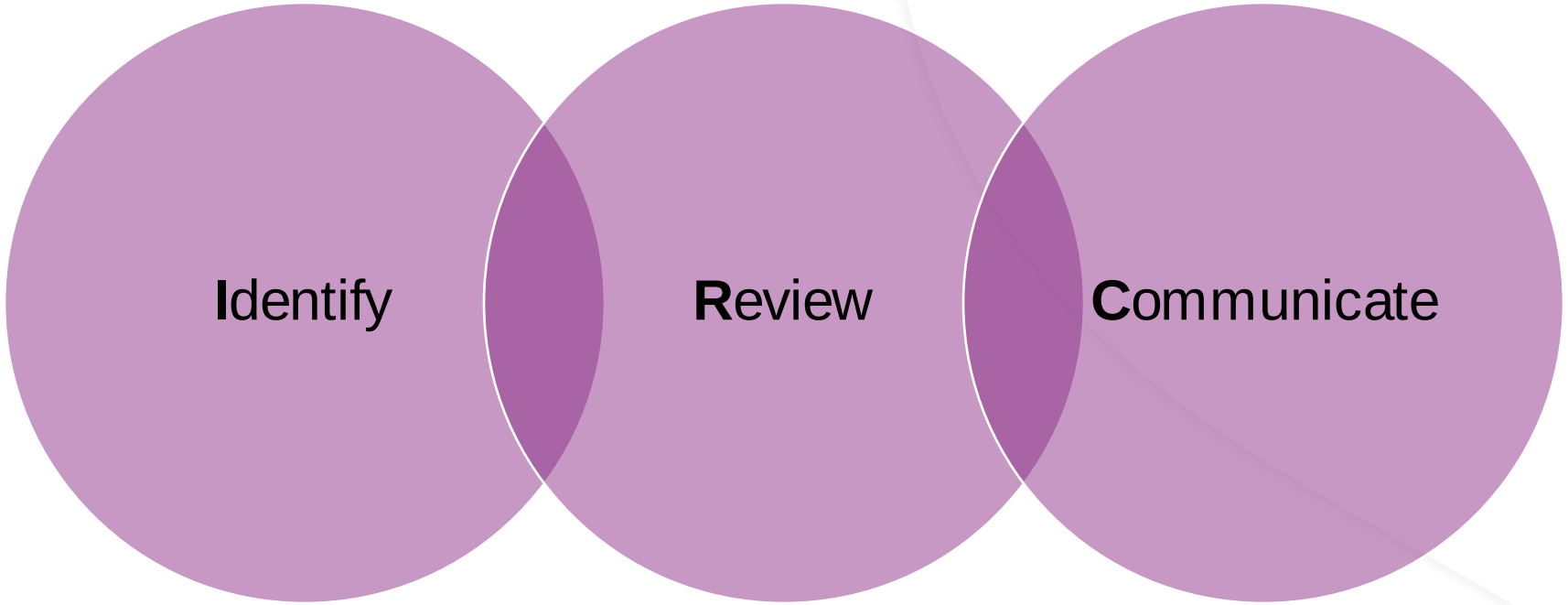
Practice Plus Group

Status change to IS91 (detainee)



- Identifying vulnerabilities
- Ensuring appropriate clinicians involved
- Clarifying deportation

Think IRC



Questions?

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BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RC GP

Keynote Presentation

Dr Michelle Addison

Associate Professor - Durham University

CONVENZIS

Mental health ‘problems’ as an unfolding dimension of social harm generated by stigma

Dr Michelle Addison, Associate Professor
Durham University, Michelle.Addison@durham.ac.uk

Professor Monique Lhussier, Northumbria University

Structure of Talk

- Context
- Outline of study
- Theory and concepts
- Findings
- Reflections

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Context

- World Health Organisation (WHO) regards mental health and wellbeing as a global priority
  - WHO describe mental health as *'a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community'*
- Lived experience of mental health is intersectional & impacted by social and environmental factors, significantly exacerbated by inequalities
  - ONS: 1 in 6 adults in England & Wales experienced moderate to severe depressive symptoms (Attwell et, al. 2022)
  - ONS: Prevalence of moderate to severe depression higher amongst marginalised and vulnerabilsed group (Attwell, et, al. 2022)
- Lancet commission on ending stigma and discrimination in Mental Health (Thornicroft et, al. 2022)

Wellcome Trust Study: ‘Health inequalities amongst people who use drugs in northeast England’

- Seed corn award – Wellcome Trust
- Semi-structured interviews with people who use drugs
  - Snowball & purposive sampling
  - Primary drug class A & B: Heroin / Crack Cocaine / Cocaine / Amphetamine
  - Age range: 20-49 years old
  - n-24: 11 men / 12 women / 1 Transgender
  - Predominantly White British – northeast England
  - Frequent & dependent usage; past & present

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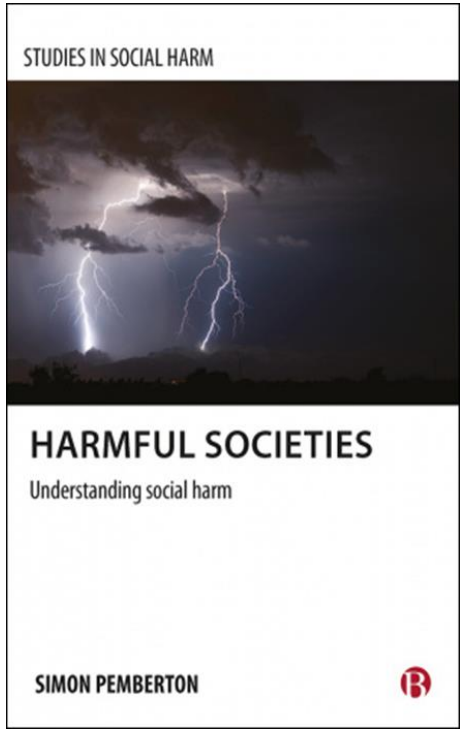
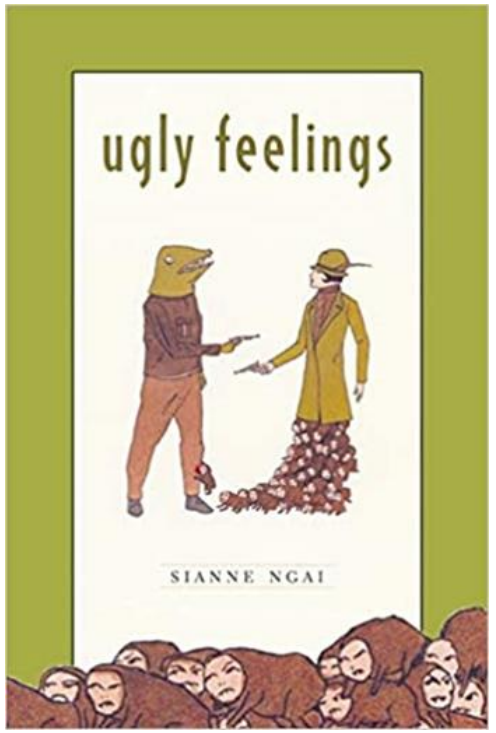
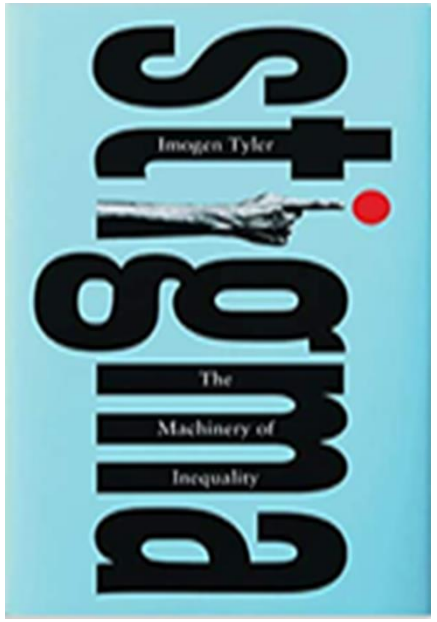
Theory & Concepts

- Mechanisms of stigma and machinery of inequality (Tyler 2020)
- Social Harm – psychological/emotional, physical, sexual, financial, relational, autonomy (Pemberton, 2016)
- Social Harm – damaging and pervasive amongst disadvantaged people (Dorling et, al. 2005)
- ‘Ugly feelings’ are difficult to discuss – almost unintelligible at times but felt ‘under the skin’
- Social relations between people (Bourdieu, 1984)







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Pre-existing mental health conditions

I mean, if you're not feeling mentally well, you can't work, you can't live a normal life because your emotions are all tied up. You don't know whether you're coming or going. [Jack, 43 yrs]

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Public Stigma

I walk down the street the other night and a couple of lads called me a **smack head** because I didn't have a lighter on me to give them a light for a fag. And it wasn't that they knew, they didn't know, it's just that's something that people randomly can't get, and it's classed as something that's **degrading.** So, like they call you that to **put you down.** So, when the more people do that, the more starts getting here. And the more you start thinking right, *well that's what I am*. [emphasis from participant] [Samantha, 36 yrs]

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What is stigma?

Personal & Structural

‘Stigma has *meaning* and becomes apparent through its effect on people.’

(Addison, 2022)

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Addison, M. (2022) *‘They don’t even class me as a human being’:* Understanding Stigma as a Social Harm that Widens Inequality, *The Sociological Review Special Issue*

Relational Stigma

It was always, “There’s something wrong with this kid”. So, my experience of mental health interventions at that age had been very, very negative and very **accusatory and shaming**. [Haven, 30 yrs]

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Internalised Stigma

…it makes you mentally and emotionally and spiritually not well. It just deadens anything that's healthy really, any healthy thoughts, feeling anything, emotionally well about yourself and I think that's what it strips away from you [Karla, 49 yrs]

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Stigma is harmful to mental health

I'm mentally ill with my emotions and depression and anxiety and panic attacks and all that and I get depressed […] and then people pass comment like as they do, and they don't realise **how damaging that is**. That's put me in… it's kind of **imprisoned me**. It took my confidence away from us and I didn't want… I don't want anything to do with people anymore. [Jack, 43yrs]

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Stigma is harmful to mental health

I mean sometimes it can make people feel really low and depressed. I mean they deal with the habit already and everything else and problems at home or whatever and then you've got the one place where you go to get that same thing each day and you know… you've got somebody looking at you like you're a piece of s**t. [Kev, 41 yrs]

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Living with stigma

…in terms of seeking psychological help, I'd say I just feel like I went round in circles for years with the NHS. I didn't really get anywhere with them, you're out waiting at doctor's rooms and Crisis, crying my eyes out and they've got three and a half minutes to speak to you, if that, once they've typed your information into the system and left themselves time to write notes. I just never really thought, in fact, **I still don't really feel that the care is there publicly** [Andy, 29 yrs]

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Reflections: Stigma is harmful to mental health

What does stigma look like?

Stigma enacted in multiple complex ways: structural (public, systems, policy), internalised stigma ('ugly feelings'), relational (symbolic value, worth, judgement)

- Stigmatisation 'normalised' as everyday symbolic violence towards marginalised groups = **dehumanises people**
- Impacts a person's sense of self-worth and is harmful to mental health
- **Stigma generates multiple complex social harms** – emotional, physical, financial, (see also NHS Alliance: Stigma Kills campaign) and **impacts health & social inequality**

Isolation, deteriorating mental health, barriers to accessing support, changes in drug use, self-harm, suicidal ideation, prison sentences, survival crimes, reduced social capital, estrangement from family/children

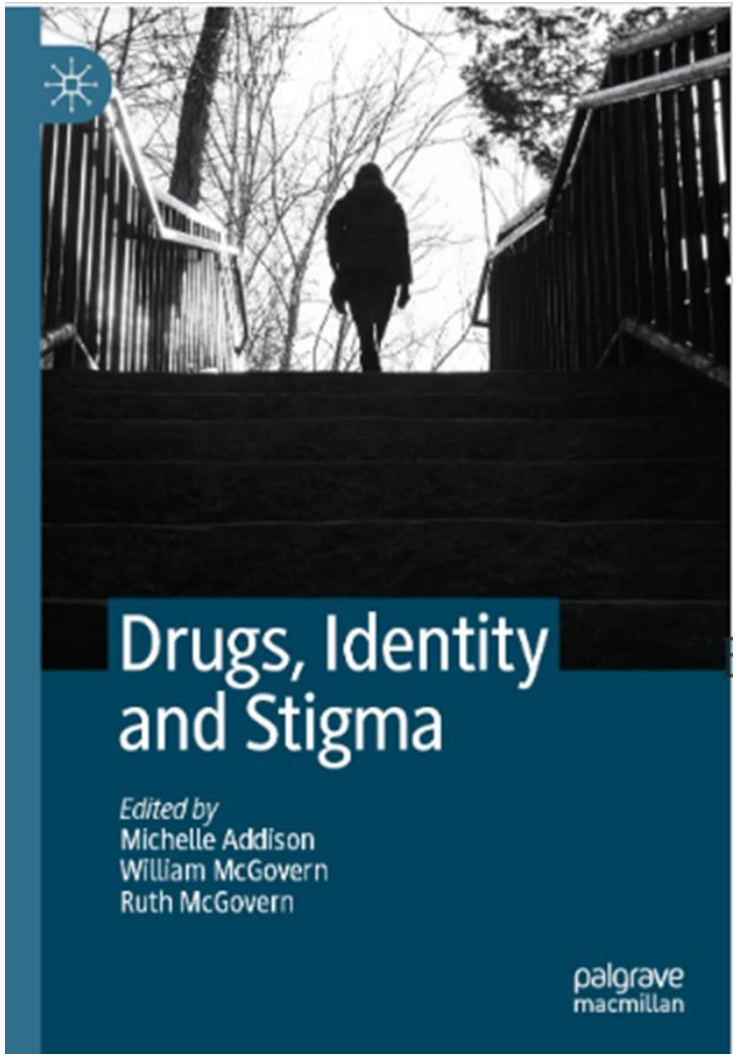
Palgrave Edited Collection

Addison, M. McGovern, W. and McGovern R. (eds) (2022) *Drugs, Identity and Stigma*, Palgrave Macmillan

- How does stigma get '*under the skin*'?
- How is it negotiated, resisted and absorbed by people who use drugs?

Book chapter (Forthcoming, 2024)

- **Addison, M.** and Lhussier, M. (2024) 'If I wasn't on drugs or I didn't take anything, I wouldn't be here': Mental health 'problems' as an unfolding dimension of social harm generated by stigma relations' in Weston, S. and Trebilcock, J. (eds.) *Mental Health, Crime and Justice*, Palgrave Macmillan



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Thank you

Dr Michelle Addison & Professor Monique Lhussier

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Keynote Presentation

Professor Dame Carol Black

Principal of Newnham College Cambridge and Expert Adviser on Health and Work - NHS England and Public Health England

10th Health & Justice Summit

Building Bridges in Health and Justice

Titanic Belfast, 9 October 2023

Challenges for Treatment and Recovery of Drug Dependent People in the Secure Estate

Dame Carol Black

Independent Adviser to Government on combatting misuse of drugs

Review of drugs 2019-2021

Two exclusions from my remit:

- changes to the law
- treatment of drug-dependent people in prison.

I was asked to look at diversion from prison, and continuity of care after prison.

I discovered when doing the Review that the community and secure estate are closely related, the quality, variety and therapeutic endeavours in one affect the other, and people cycle between them.

I am now filling in that gap.

Usage and prison

In 2019 :

- around 3 million people in England and Wales took drugs;
- around 300,000 users of heroin and/or crack cocaine were driving nearly half of all serious acquisitive crimes and homicides;
- more than a third of the prison population were there for drug-related crime.

We know that

engagement in good-quality treatment reduces crime

Prisons

- In principle the prison system presents a huge opportunity for positive intervention.
- On a given day in 2019 c. 20,000 people, or nearly 1 in 4 prisoners, were detained because of offending related to drug use, as opposed to being involved in supply.
- Over a year this is 50,000 people, generally cycling in and out of prison, on short sentences, largely for theft.
- Prison provides accommodation and three meals per day, and the person is ever present and available.
- This provides opportunity for treatment, recovery, and engagement with meaningful activity.

Prison – a missed opportunity?
HMI Prisons annual report 2022-23

Table 5: Purposeful activity outcomes in establishments holding adult and young adult men

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	0	0	6	8
Training prisons	1	0	9	11
Open prisons	0	0	1	0
High secure prisons	0	0	1	0
All men's prisons	**1**	**0**	**17**	**19**

Table 7: Rehabilitation and release planning outcomes in establishments holding adult and young adult men

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	1	7	6	0
Training prisons	0	6	11	4
Open prisons	0	1	0	0
High secure prisons	0	1	0	0
All men's prisons	**1**	**15**	**17**	**4**

Some people will continue to receive a custodial sentence, or spend time on remand. This could be an opportunity to intervene, but for too many that is not seized.

HMI Report shows that people in prison are not getting purposeful activity, and rehabilitation and release-planning outcomes are mostly not good enough.

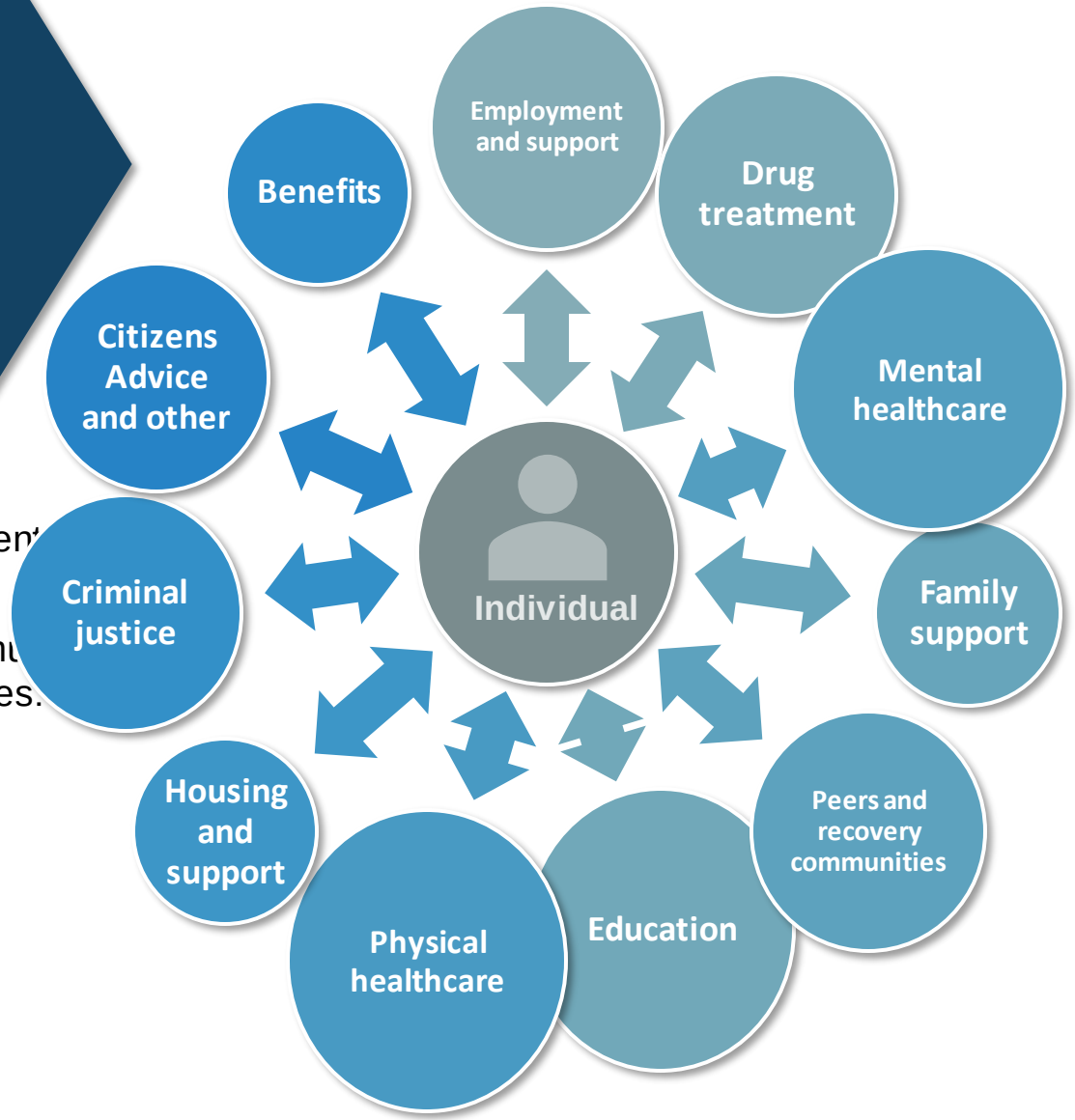
Things that troubled me in 2019

- Addiction not considered a chronic health condition.
- Stigma and ostracisation
- Commissioning, Accountability and Leadership
- Mental Health and Trauma services
- Recovery
- Co-morbidities; drug deaths
- Young people
- Housing
- Employment and skills
- Workforce
- The ‘hamster wheel’ of prison: poor diversion & aftercare.

Most of these could apply to prison

To reduce health harms, and to help people achieve and sustain recovery, and live safely and well in society, a wide range of services need to work together.

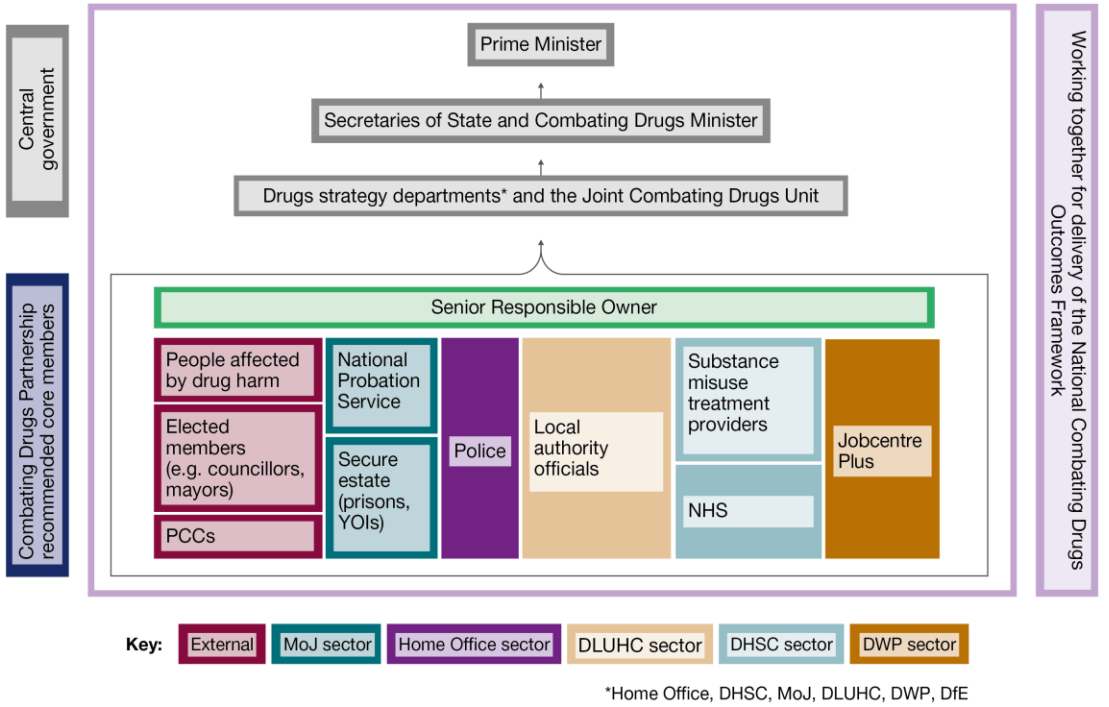
- This can only happen if there is strong government leadership and investment
- The following Government Departments must work effectively together to provide services:
  - Home Office
  - Dept of Health and Social Care
  - Dept for Work and Pensions
  - DLUHC
  - Ministry of Justice
  - Department for Education



Strong local structures and processes are also needed.

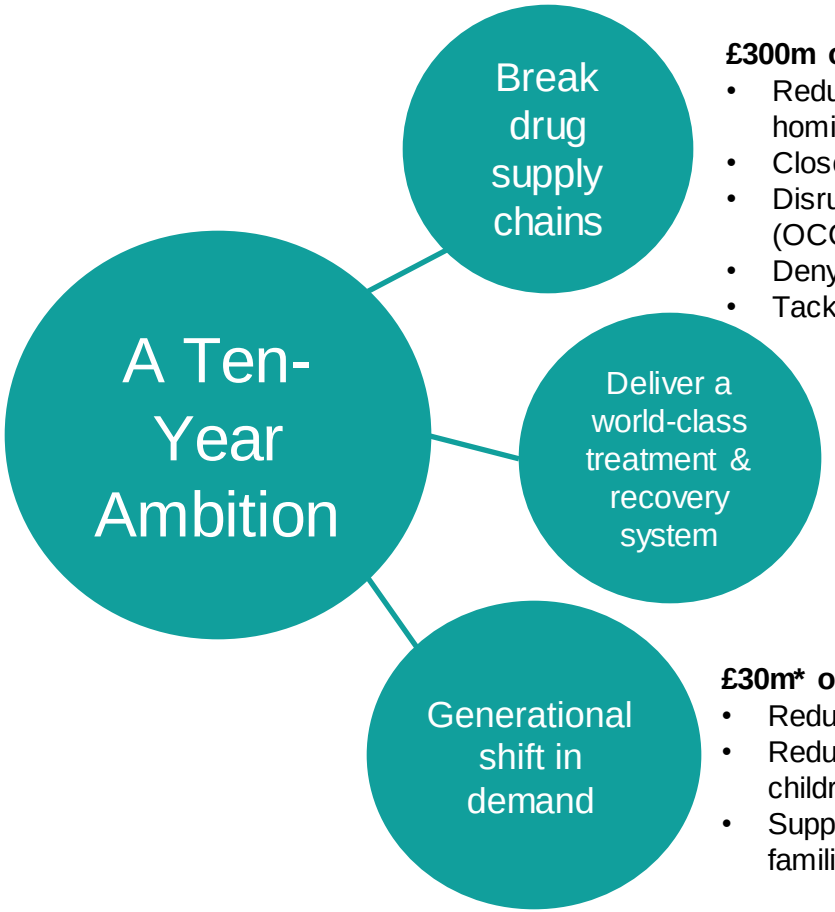
Structure: Central Unit and Local Partnerships

- Successful delivery requires a central unit with ministerial leadership and coordination **across the full range of local partners…**
- …. a whole-system approach.
- 104 multi-agency **Combating Drugs Partnerships** have been created covering all areas in England.
- **Senior Responsible Officers** (SRO) have a direct line to government and are the first point of contact to understand local performance, held to account by the Drugs Minister and JCDU, against the National Combating Drugs Outcomes Framework.
- Departments will retain oversight of their delivery partners and specific programmes.
- A **new blueprint** for local accountability.



Also important are educational institutions, V-Cs, and regional OHID

A whole-system response



£300m over 3 years to:

- Reduce drug-related crime and homicide
- Close more County Lines
- Disrupt Organised Crime Group (OCG) activity
- Deny more criminal assets
- Tackle drug supply in prisons

£2.8bn over 3 years to:

- Prevent drug misuse deaths
- Improve quality and capacity of treatment and recovery services
- Rebuilding the workforce

£30m* over 3 years to:

- Reduce overall drug use
- Reduce number of school children using drugs
- Support young people and families most at risk

*This is the uplift i.e. the investment in new programmes directly on reducing drug use

Outcomes expected by 2024/25:

- Prevented 1,000 deaths
- Delivered 54,500 new high quality treatment places
- Contributed to prevention of 750,000 crimes
- Closed 2,000 more County Lines
- 6,400 major and moderate OCG disruptions (a 20% increase)

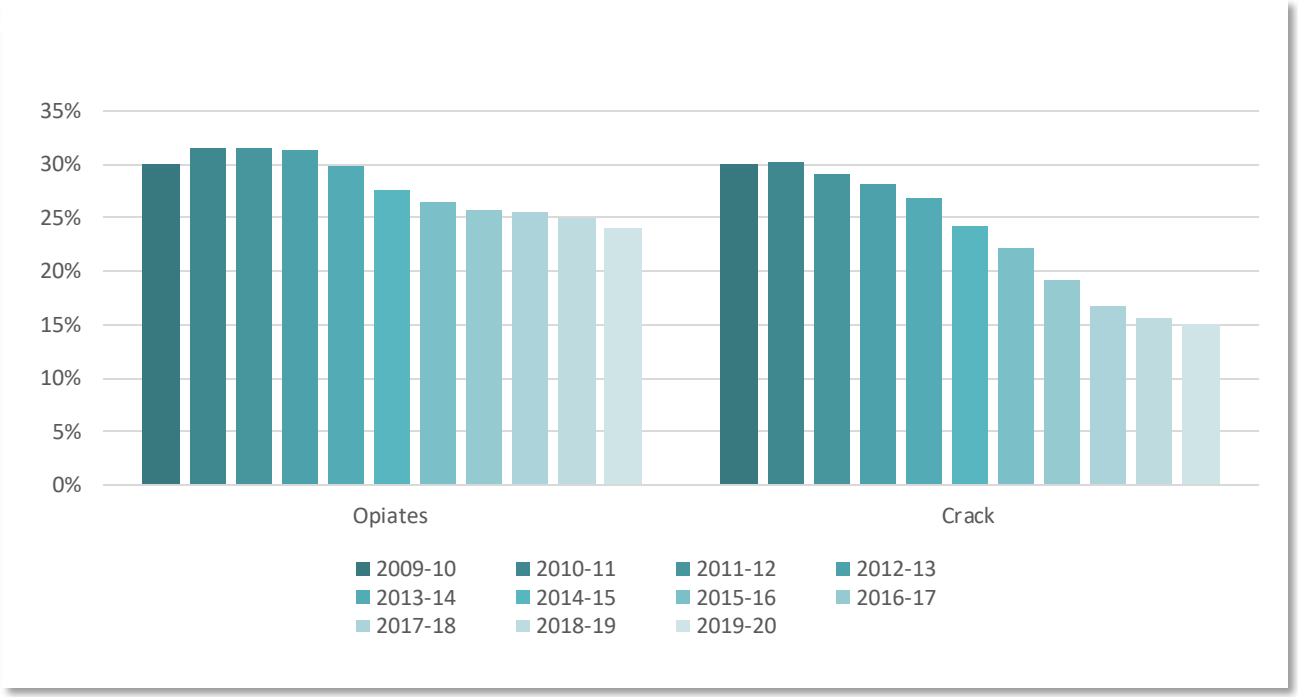
By 2031, an ambition to:

- reduce overall drug use towards a historic 30-year low.

As a more cost-effective alternative to short prison sentences ….

… more people should be diverted into drug treatment and recovery services, when appropriate.

% referrals from the criminal justice system:



Referrals to treatment from criminal justice, and community sentences with Drug or Rehabilitation Requirements, have both fallen substantially over 7 years.

The Review recommends

As to diversion into treatment:

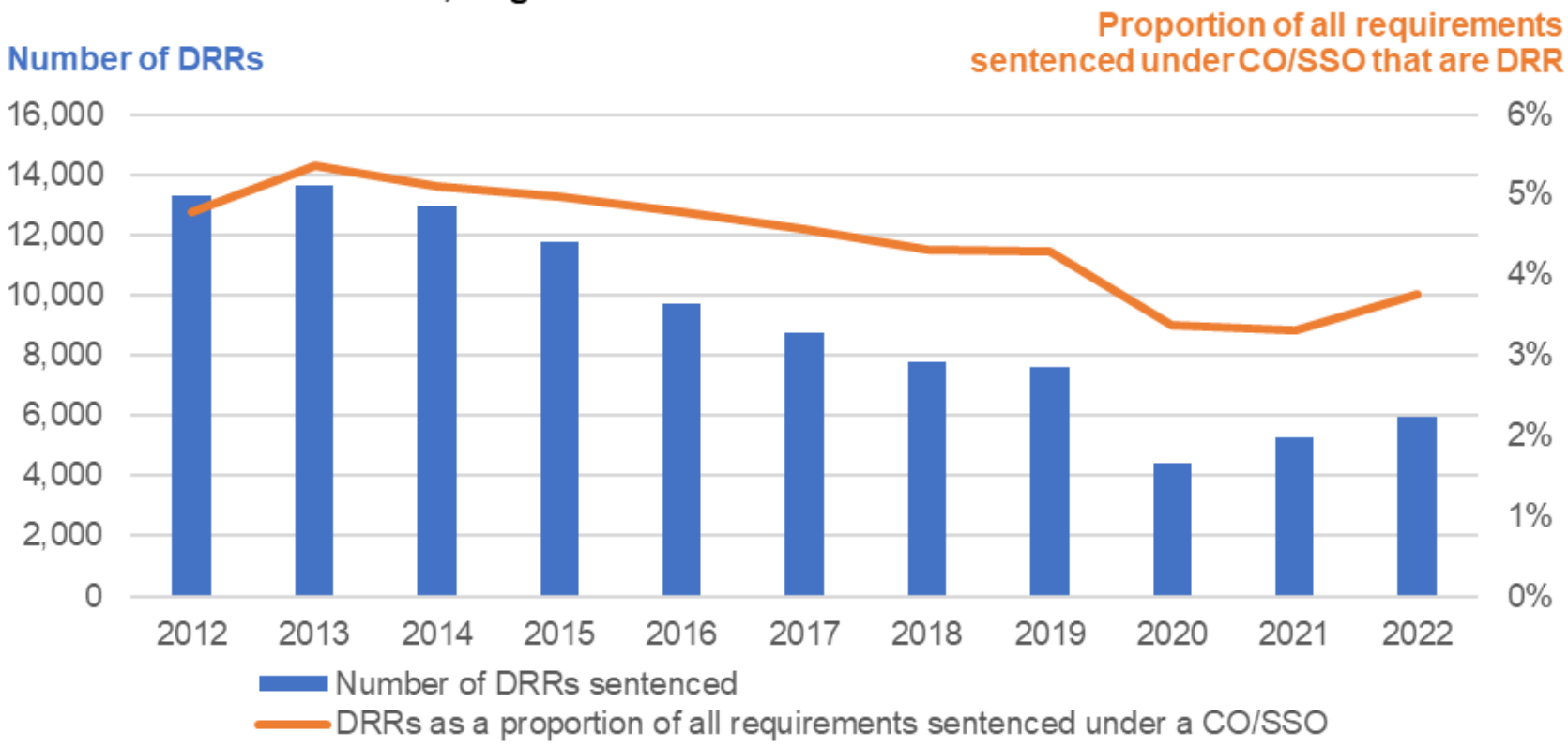
- MoJ, HO, DHSC, NHSE and OHID ensure improved treatment pathways from CJ settings and more diversion into treatment from CJ systems.
- DHSC and NHS England extend the CSTR (Community Sentence Treatment Requirements) programme nationwide by 2025.
- Transparency and accountability of drug services inside prisons be improved.

As to aftercare, as only a third of those who need treatment after release from prison receive it:

- All leaving prison have identification, bank account and access to DWP support
- The new health and justice co-ordinators cover all English probation areas.

Drug Rehabilitation Requirements (DRR)

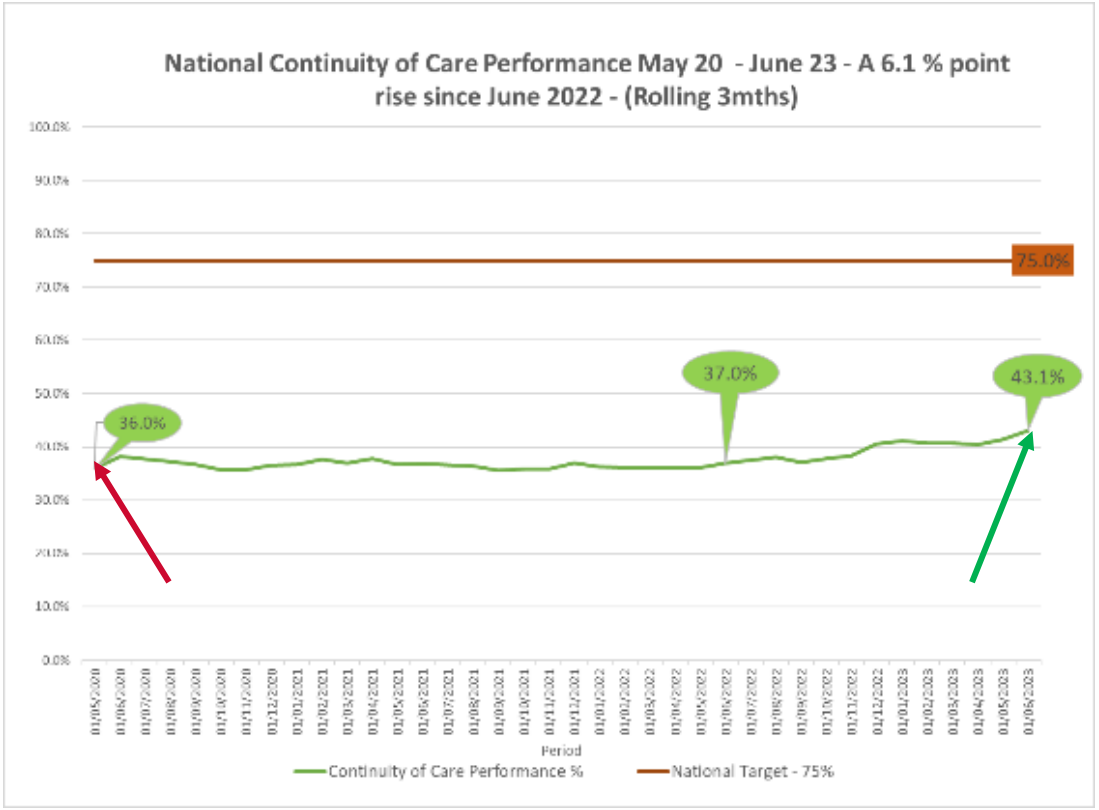
Number of DRRs sentenced, and DRRs as a proportion of all requirements sentenced under CO/SSO, England and Wales



Source: Ministry of Justice, Offender Management Statistics quarterly – October-December 2022

National continuity-of-care performance is improving

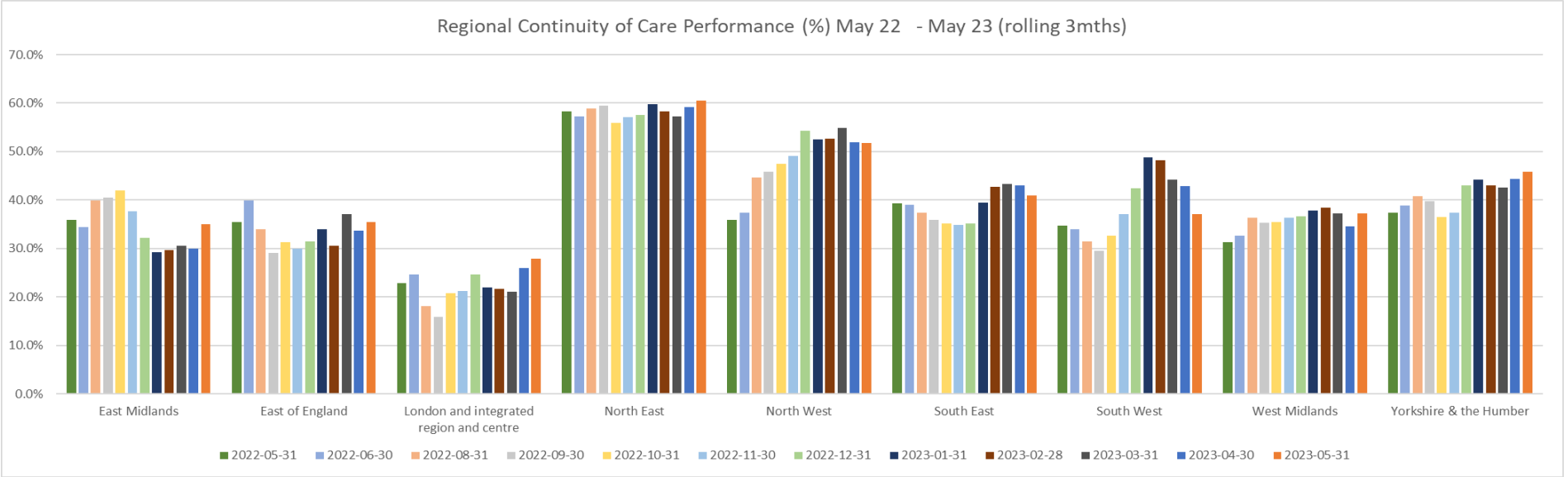
An improving outlook – up 6.1% from June 22



Also:

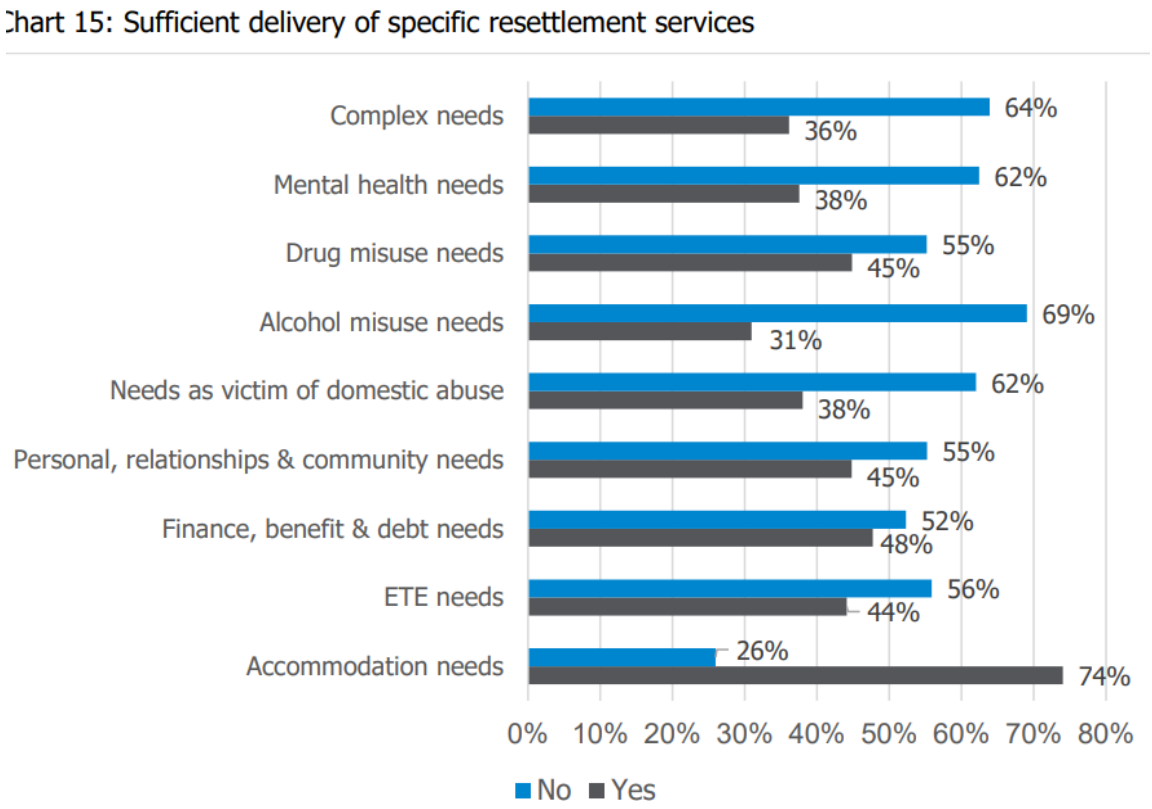
Information from OHID shows more referrals from prison to community treatment, and greater numbers starting treatment (May 2020 to June 2023).

… but regional data show a North-South divide



Continuity of Care Performance	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire & the Humber	England
Baseline May 22	35.8%	35.5%	22.8%	58.4%	35.8%	39.3%	34.8%	31.3%	37.4%	36.2%
Latest Data (May 23)	35.1%	35.5%	27.9%	60.6%	51.8%	41.0%	37.1%	37.2%	45.8%	41.4%
Change since baseline	-0.7%	0.0%	5.1%	2.2%	16.0%	1.7%	2.3%	5.9%	8.4%	5.2%

Challenges for achieving good continuity of care – HMI Probation annual report



OHID lessons learned:

- Poor communication / information sharing between prison healthcare and community treatment services causes clients to be missed.
- Some regions e.g. London, struggle with co-ordinating communications with a complex network of separately-commissioned treatment systems receiving referrals from a widely dispersed prison population.
- **Prisons that draw population from their local communities (e.g. North East) have an inherent advantage, of ability to develop closer working relationships with key local treatment providers.**

From Harm to Hope: progress in the criminal justice system

- **Drug Testing on Arrest** – over 35 police forces are now establishing or delivering Drug Testing on Arrest with improved data collection (4,064 referrals to treatment were reported between June 2022 and February 2023, enabling access to support to address drug misuse).

- **Increasing police-led referrals into treatment** – over the next two years the lead on drugs for the National Police Chiefs' Council, supported by HO and DHSC, will develop a national plan.

- **Project Adder** (Jan 21 – Mar 23) achieved 2,749 Organised Crime Group Disruptions, 9,208 Out of Court Disposals to divert people into treatment/recovery, plus 7,672 naloxone kits in the community, and c.5,000 people benefited from ADDER-funded interventions in drug treatment.

From Harm to Hope: progress in the criminal justice system

- **Offenders' treatment engagement and continuity of care** – local authorities have recruited 476 additional criminal justice workers and are looking at how DRRs can be used more effectively.

- **Prisons –** recruiting 50 drug-strategy leads to bring together heath and security in all male category B and C, and all women's prisons, expanding Incentivised Substance-Free Wings – up to 100 by March 2024 - and engaging prisoners with community treatment pre-release via video calling, notification of releases, and recruiting Health & Justice Partnership Coordinators

Intensive Supervision Courts

- Pilots at Liverpool and Teesside Crown Courts (and for female offenders in Birmingham) to divert offenders from short custodial sentences into enhanced community-based sentences (Scotland established such courts in the early 2000s).

- Frequent random testing, increased supervision, regular court reviews.

- Dedicated judge at the centre of sentencing, rehabilitation and compliance, alongside a multi-disciplinary team

- Pilots to run for18 months, robustly evaluated for impact and value for money.

- Working to ensure more offenders engage in high-quality treatment and to improve continuity of care for leavers.

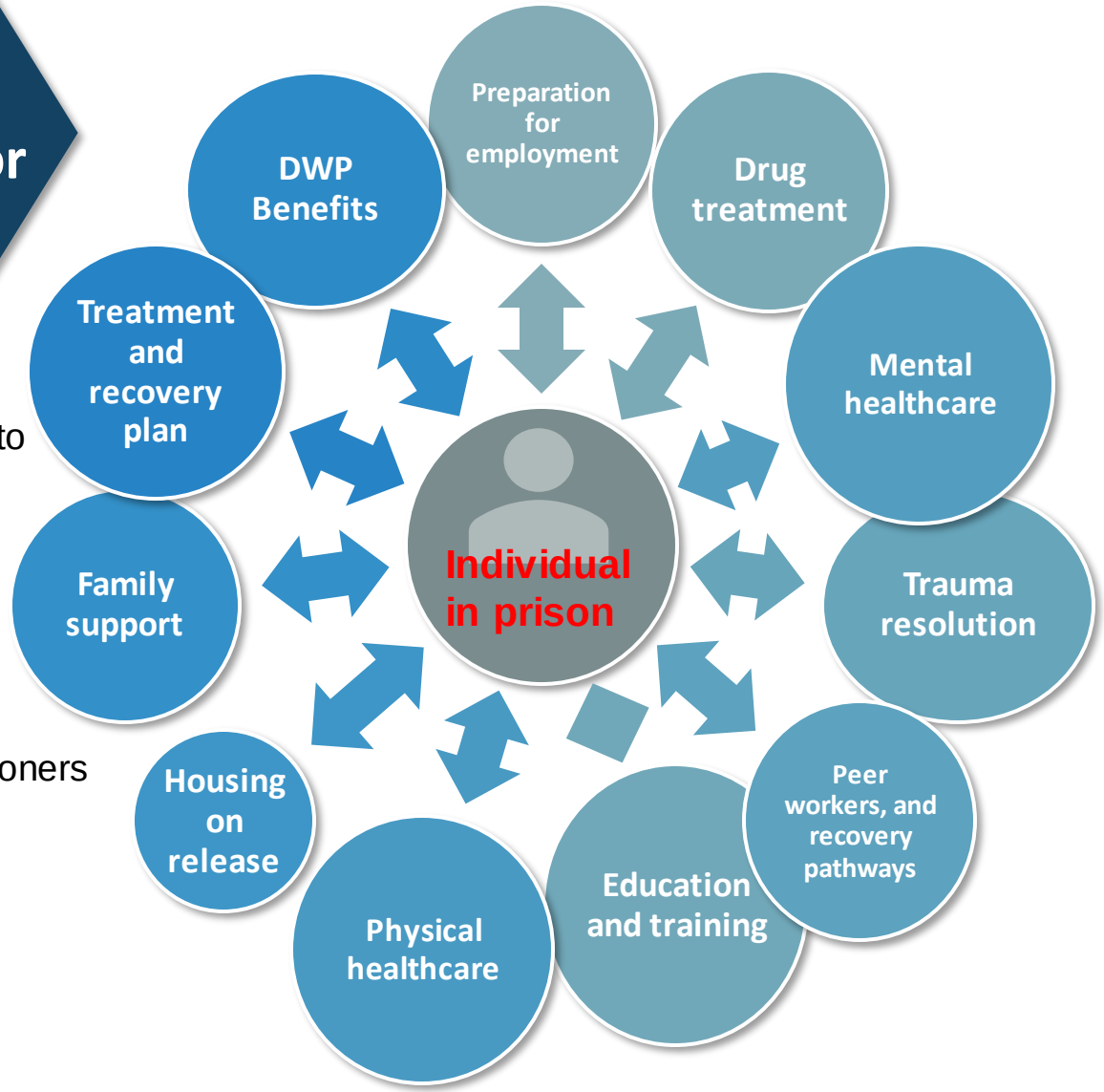
My approach to achieving treatment and recovery for prisoners

The following must work effectively together to provide services:

- judiciary
- HMPPS
- prison officers
- probation officers

- NHSE, national teams, commissioners
- DWP

- substance misuse service
- MH and trauma service
- housing services.



10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Health and Justice UK Summit Committee

Dr Eamonn O'Moore MD FFPH
Chief Director of National Health Protection
National Health Protection Service of Ireland

Lunch, Networking & Refreshments

Seminars

Close of Day 1 – See Tomorrow's Agenda Here:

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Day 2

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RC GP

See today's Agenda here:

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Chairs Opening Address

Kate Davies CBE
National Director for Armed Forces, Health and Justice and Sexual Assault Services - NHS England

Health and Justice Summit: Building bridges in Health and Justice

October 2023

Kate Davies CBE
Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England

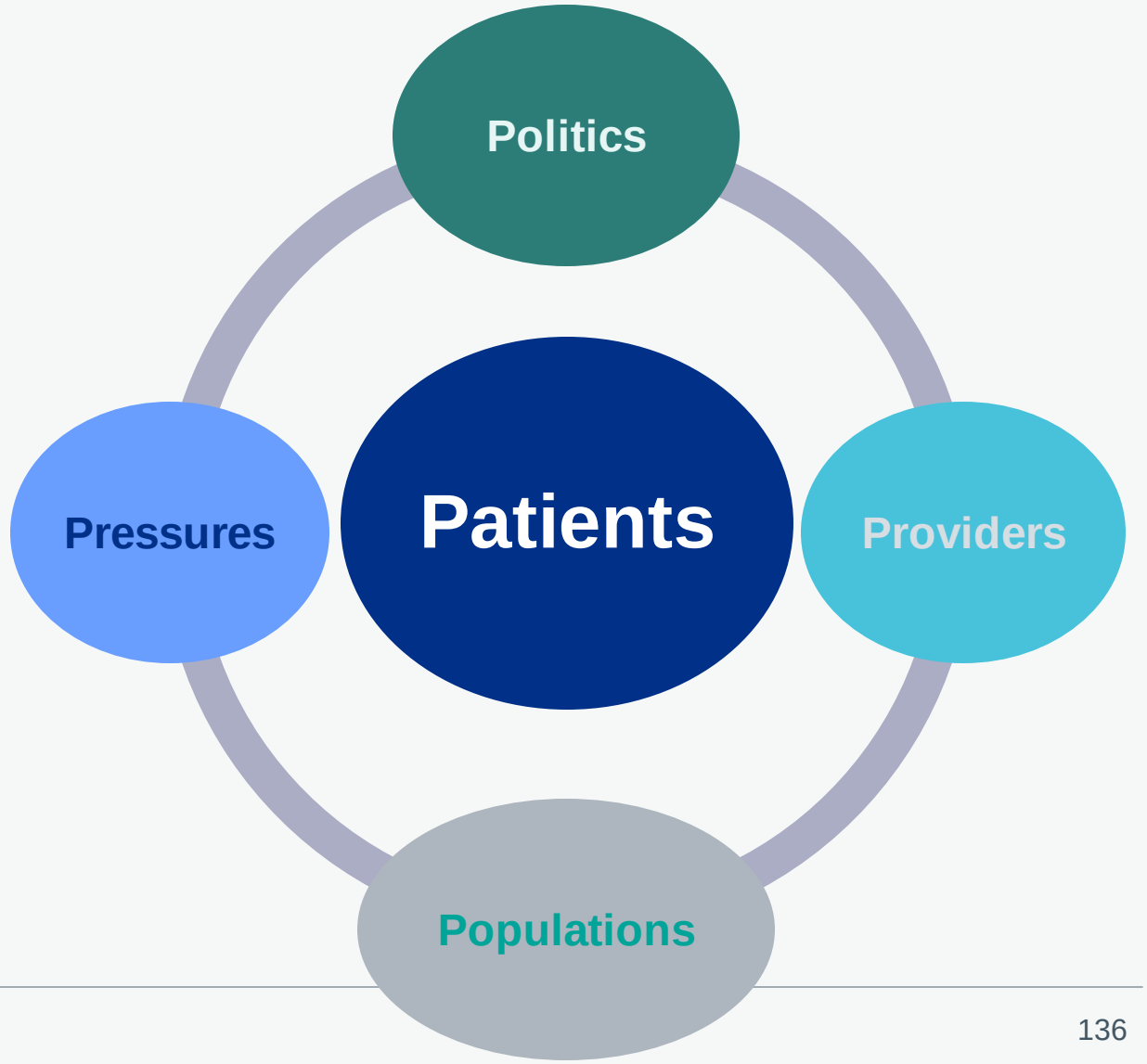
Health and justice: what's happening?

What is coming over the wall?

What is going out of the gate?

What is under the radar?

Health and justice environment



Co-production

The voice of lived experience is loud and clear in health and justice (H&J)

- Patient and public voice
- Lived experience network
- Service user representation through the third sector
- Centring the lived experience voice throughout service design

Together we have achieved so much

to improve access to equitable healthcare

Strategy and workforce

H&J Clinical Reference Group (CRG)	Well established CRG with refreshed membership	In line with NHS England transformation agenda	3 year work programme across key areas	Aims: reduce inequalities, reoffending, improve continuity of care and transitions
Funding	Funding for prisons has increased circa 9% over the last 3 years			
Inclusive workforce	2 year inclusive workforce programme to support regions tackle unprecedented workforce demands	Focus on promoting health and justice clinical roles and supporting recruitment of individuals with lived experience		

Children and young people secure estate (CYPSE)

Framework for integrated care vanguards	12 vanguards have started to receive referrals	Total of 3,348 referrals since April 22 (3148 accepted)	Framework for Integrated Care in the Community response to long term plan
Healthcare standards for CYP in secure settings	Refreshed this year	NHS England core outcome based specifications benchmarked by these standards, have also been refreshed and are due for publication.	

Together we have achieved so much

to improve access to equitable healthcare

Non-custodial

Courts healthcare and prison custody	Enhanced peripatetic service now available in most criminal court cells	Bi-annual review of prison healthcare national service specification nearly complete	
RECONNECT	82% coverage across England	Investment has risen from £1.0m to £7.2m over the last 3 years, with further investment due in 2023	Embedded peer support
Mental Health Treatment Requirements (MHTRs)	80% coverage of primary care MHTR programme across England's population	Programme on track for 100% coverage by summer 2024	
Liaison and Diversion	Delivering specialised pathways of care for several different cohorts, including women, children and young people and veterans	Embedded peer support	
Sexual assault services commissioning	Enhanced mental health pathfinders continue to be rolled out across regions	Aim for at least one site per region by the end of 2024	

Together we have achieved so much

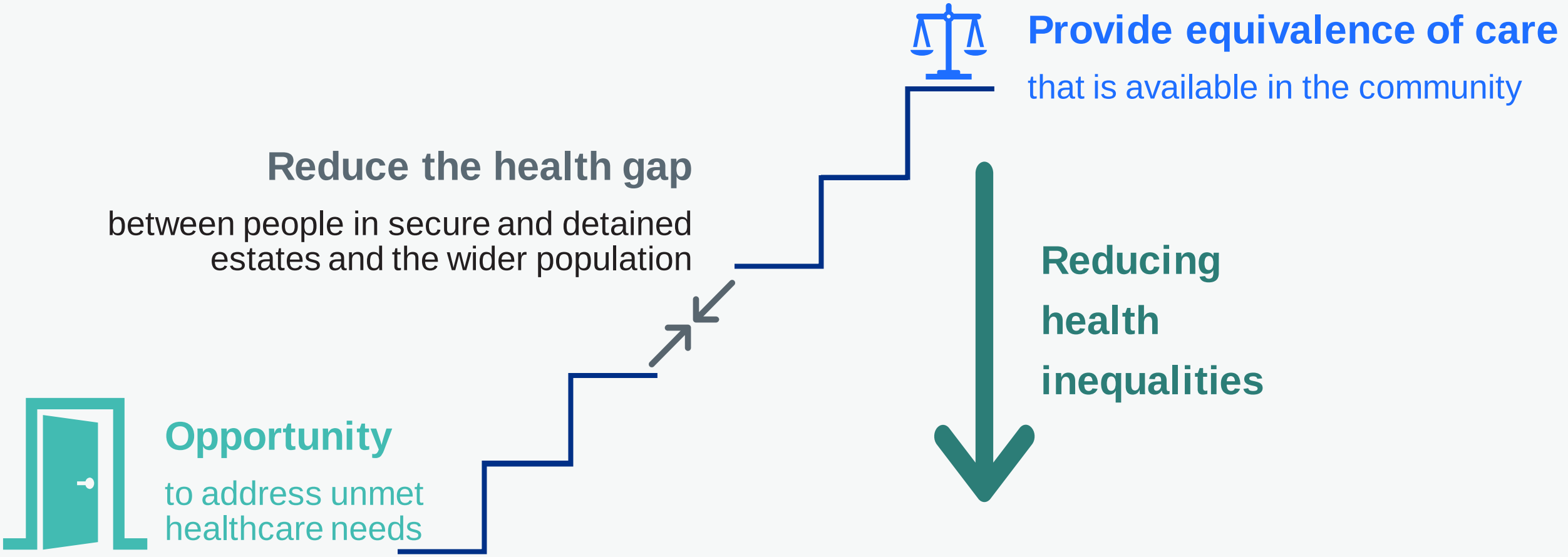
to improve access to equitable healthcare

Custodial

New Prisons - Prison Expansion Programme (NPPE)	Government funding £4bn+ creating 22,000 additional prison places by mid to late-2020s	Equitable, population health-based approach to the programme working with Government	Ensuring healthcare facilities within new prison builds are fit for purpose and meet NHS regulations
Immigration removal centres (IRCs)	Expansion of IRC estate requires additional planning	Working with colleagues across the NHS including primary care to plan and manage care for those arriving on small boats	**Operation Safeguard** impacting on IRC population
Medicine and vaccines	Autumn COVID vaccination programme underway and aligns with the community programme	COVID treatments for high risk detained people continue to be accessed via ICB-led services	Work to enable buprenorphine within recovery pathways and other opioid substitute options by March 2024
Substance misuse	Work progressing since October 2022, supported by an additional £21m	**Priority 1:** Need to improve early screening	**Priority 2:** Targeted support for those with complex needs	**Priority 3:** Improve continuity of care and alignment with RECONNECT for people leaving prisons
Mental health (MH) and neurodiversity (ND)	Prison programmes have benefitted from £7m additional funding	For MH, ND and trauma informed care pathways	To support the workforce meet the needs of these pathways/cohorts	To support meeting recommendations of Centre for Mental Health report

Health and justice workforce – a hidden asset

Levelling up: providing quality to deliver equitable care



Best practice

Coproduction

Retained

Respected partners

Evidence based

Resilient

Thank You

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Keynote Presentation

Dr Frances Caldwell
Specialist Forensic Psychologist - Forensic CAMHS NI – South Eastern HSCT

Dr Phil Anderson
Consultant Forensic Psychiatrist
Forensic Child and Adolescent Mental Health Service for Northern Ireland [FCAMHSNI], South Eastern HSCT

South Eastern Health and Social Care Trust

A Profile of Referrals Made to the Forensic Child and Adolescent Mental Health Service for NI (FCAMHSNI) – A Five Year Cohort

DR PHIL ANDERSON – CONSULTANT PSYCHIATRIST FCAMHSNI (SE TRUST)

DR FRANCES CALDWELL - FORENSIC PSYCHOLOGIST FCAMHSNI (SE TRUST)

DR COLM WALSH – QUEENS UNIVERSITY BELFAST

Introductions to FCAMHSNI

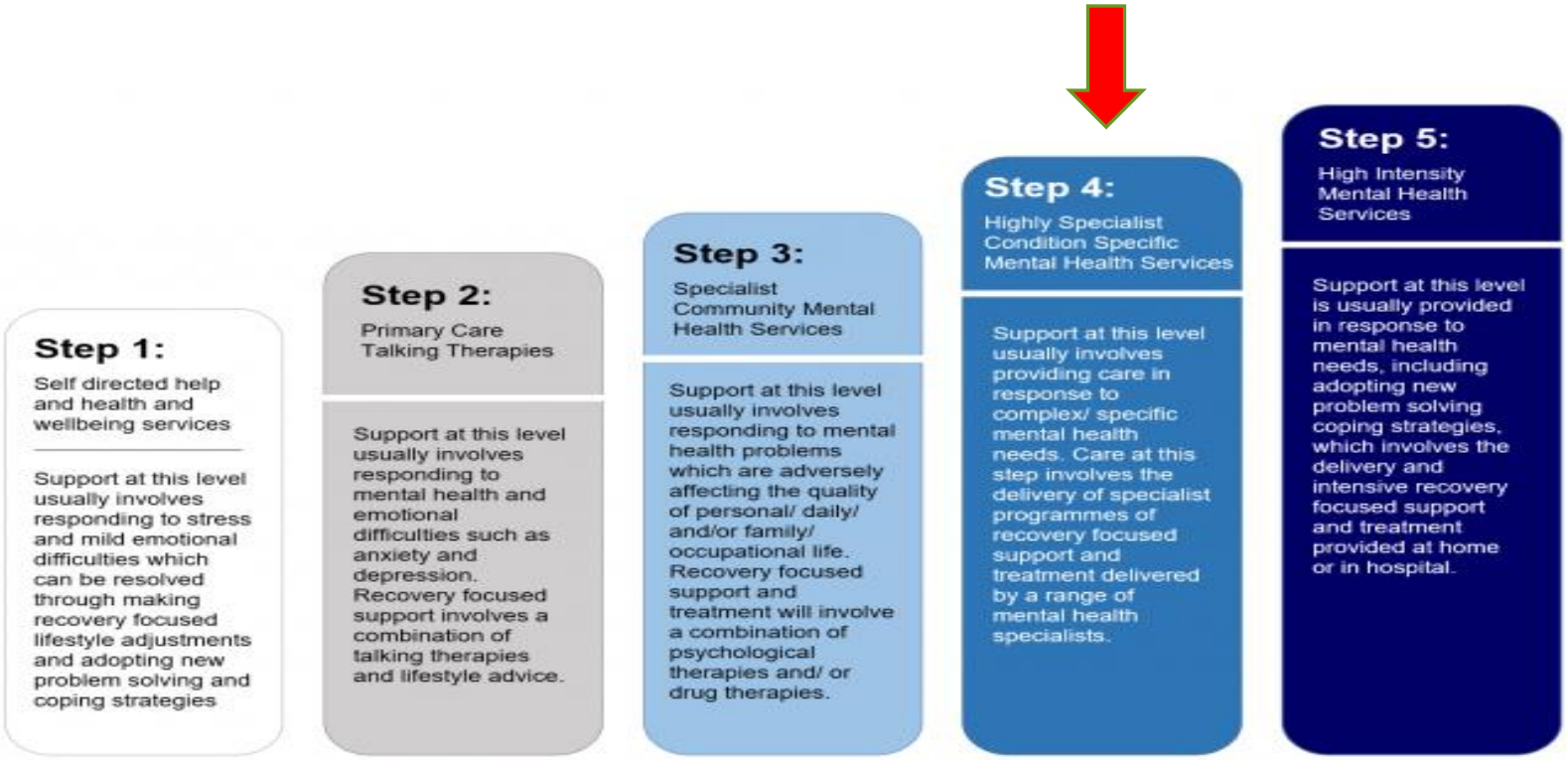
FCAMHSNI is a regional service (ie covers all 5 HSCT's)

Managed by South Eastern HSCT and based in Newtownards, County Down,

We are a specialist [tier 4] CAMHS service who provide liaison, consultation, risk assessment and risk management support to services caring for young persons presenting with complex needs and high risk behaviours

MDT made up of psychiatry, psychology, (forensic practitioner, operational management in recruitment) and admin

Regional CAMHS Stepped Care Model



Referral Criteria

Complex needs

Significant risk of harm to others (violence / sexual / fire setting or other relevant risk)

Under 18 and living in NI

Gatekeeping role for secure CAMHS referrals

Background

Prevalence of Complex Needs and ACEs

- A young person with complex needs has two or more needs affecting their mental, emotional, social or physical well-being. Such needs typically interact, are severe and difficult to manage.
- Young persons in contact with the youth justice system and secure care have significantly higher levels of complex needs than their peers, including; developmental trauma, mental health difficulties, intellectual disability, neurodiversity and substance misuse (Dent, 2013)
- This population are recognised to have needs are often mis-or-undiagnosed and not well understood. Thus interventions to address the high risk behaviours must understand and address complex needs as part of improving outcomes [Khan, 2010]
- Extensive research has found an association between experiences of ACEs, attachment issues and offending behaviour in both adults and young people - eg 77% of YP known to Youth Justice reported 4 or more ACES (Malvaso et al, 2022)

70/30 CAMPAIGN: EMPOWERING COMMUNITIES TO PROTECT OUR CHILDREN

Adverse Childhood Experiences

Traumatic events that can have negative, lasting effects on health and wellbeing

People with 6+ ACEs can die

20 yrs

earlier than those who have none

1/8 of the population have more than 4 ACEs

www.70-30.org.uk
@7030Campaign

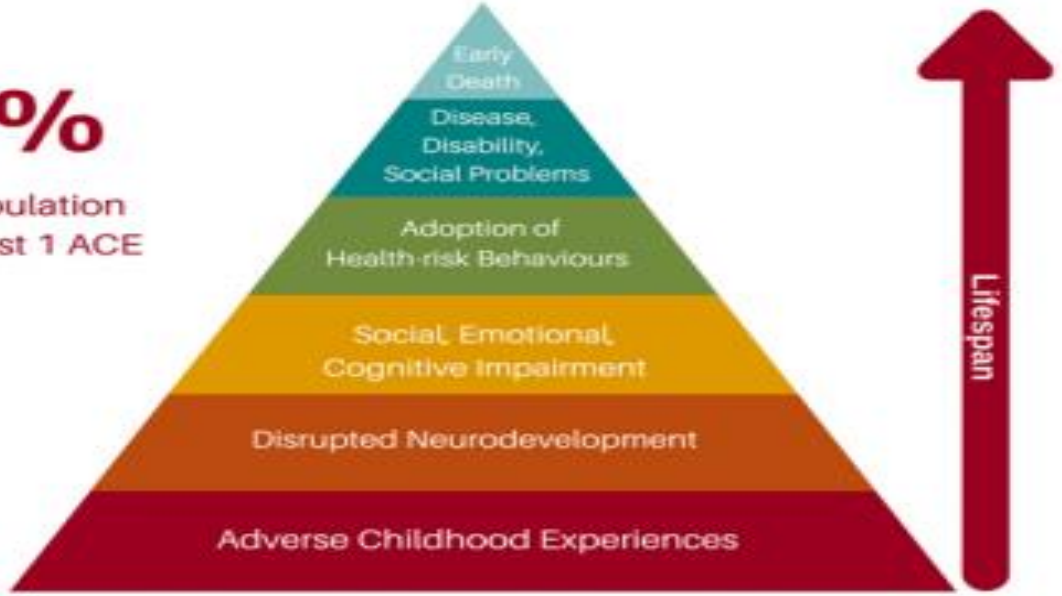
4 or more ACEs

- **3x** the levels of lung disease and adult smoking
- **11x** the level of intravenous drug abuse
- **14x** the number of suicide attempts
- **4x** as likely to have begun intercourse by age 15
- **4.5x** more likely to develop depression
- **2x** the level of liver disease

> **Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today**
>
> Dr. Robert Block, the former President of the American Academy of Pediatrics

67%

of the population have at least 1 ACE



Belfast Telegraph Pg 24

Thursday March 3 2022

Concern as 200 young offenders are referred for mental health care

Executive urged to roll out policies to tackle offending

By Andrew Madden

MORE than 200 young offenders in Northern Ireland have been referred to mental health services in the last three years, new figures show.

The Youth Justice Agency (YJA) runs the Woodlands Juvenile Justice Centre, which provides custodial facilities for children and young people referred by the court system. It has the capacity to house 48 boys and girls between the ages of 10 and 17 in custody.

Woodlands Child and Adolescent Mental Health Services (CAMHS) is a dedicated multi-disciplinary service provided by the South Eastern Trust, with specialist provisions in psychiatry, nursing and psychology.

In the last three years there were 206 referrals to Woodlands CAMHS: 78 over the course of the 2018/19 financial year; 68 in 2019/20; and 60 in 2020/21.

Back in March 2019, a senior mental health practitioner was appointed in the Southern Health Trust area and in October 2021 a similar arrangement was extended to the Western Trust area.

Established on a pilot basis, the role of these practitioners is "deliver direct services to children, help link children to other CAMHS services, provide consultation to YJA staff, and to help YJA staff to develop their knowledge, skills and confidence in dealing with the mental health needs of children", according to Justice Minister Naomi Long.

Since their inception until the end of December 2021, a total of 175 referrals have been made to both of these services.

Woodlands is in the constituency served by Green Party MLA Rachel Woods, a member of Stormont's Justice Committee, who said the figures are "deeply concerning but not surprising".

"Young people's poor mental health is a serious issue in our society.

"The five-party Executive has much to do to ensure that mental health support is adequately funded," she said.

"The Executive parties should be doing more to roll out policies proven to reduce youth offending, such as investing in youth services and tackling deprivation.

"Northern Ireland has one of the lowest ages of criminal responsibility in Europe.

"It's not right that children as young as 10 can be brought before the courts and held as fully responsible for their actions as if they were an adult.

"In 2016 the UN Committee on the Rights of the Child recommended that Northern Ireland should raise the minimum age of criminal responsibility in accordance with acceptable international standards.

"It's time for Ministers to take ready action to reduce youth offending, and ensure that all young people have access to properly-funded mental health support."

The news comes after Stormont's Justice Committee was told that plans for Youth Justice Agency mental health teams to work with children and teenagers here are to be phased out. Chief executive Stephen Martin said the decision was made due to budget cuts.

"I hoped we would be able to continue rolling out that service, but with the budget cuts, I do not think that will be possible," he said. "With careful management of resources and regular prioritisation, we can live within the proposed budget in the first year. From year two, however, the cuts will start to bite.

"That work prevents re-offending, but it is not required by statute, and we will need to reduce it as budget cuts bite, particularly from year two on."

A minibus arriving at Woodlands Juvenile Justice Centre

Neurodiversity

It is widely recognised that there is a very high prevalence of neurodiversity amongst young persons involved with secure care and justice settings

- Research has indicated that incidence rates of speech and language disorders can be as high as 60 - 90%. The prevalence rates range from 1% to 7% in the general population [Hughes, 2012]
- ASD incidence rate in youth custody is 15%. This compares with reported rates of between 0.6 and 1.2% in the general population [Hughes, 2012]
- 25% of young persons who offend have low IQs of less than 70 [Newman, 2016]

CONTEXT - NHS England FCAMHS Review and Wales FACTS review

LANE ET AL, (2023) STUDY OF 13 FCAMHS SERVICES IN ENGLAND

- 1406 referrals
- 26% of referrals led to direct case input in terms of assessment or therapeutic intervention
- 50.9% had experienced/witnessed multiple traumatic events
- 30% were looked after children
- 26.5% diagnosis of autism
- 28% ADHD

KABELIC ET AL (2022) – 5 YEAR COHORT STUDY OF REGIONAL FORENSIC ADOLESCENT CONSULTATION AND TREATMENT SERVICE [FACTS] IN WALES

- 80 Referrals
- Referrals exclusively had indirect consultative case input
- 44% had experienced/witnessed 4 or more traumatic events
- 69% were with birth family, 10% in other family arrangements, 30% in social care accommodation
- 26% diagnosis of autism
- 44% diagnosis of ADHD

Aims

- The primary aim of the current study is to address the regional gaps in how the needs of those accessing FCAMHSNI are understood

- Specifically, this study will provide a regional picture of service activity and the characteristics of young persons accessing FCAMHSNI

- A secondary aim is to organise and present data that is comparable on a national and international level.

Method

- Data analysed was taken from a standardised referral form as well as from the clinical consultations and assessment for referrals from April 2018 – April 2023
- Data includes details regarding the referral source, the reason/s for referral, current and previous engagement with clinical services, known mental health difficulties and any diagnoses, and a range of demographic details (e.g., gender, age, educational status and social care status).
- Where data was captured but specific variables were missing, these were coded as 'unknown'
- All young people accepted as meeting the FCAMHSNI referral criteria, whether for direct or indirect support were eligible for inclusion. Clinical data was screened and anonymised before being shared with the lead researcher
- Exploratory analyses include chi-square tests of independence, one-way Anova, and t-tests for independent groups to understand differences between groups

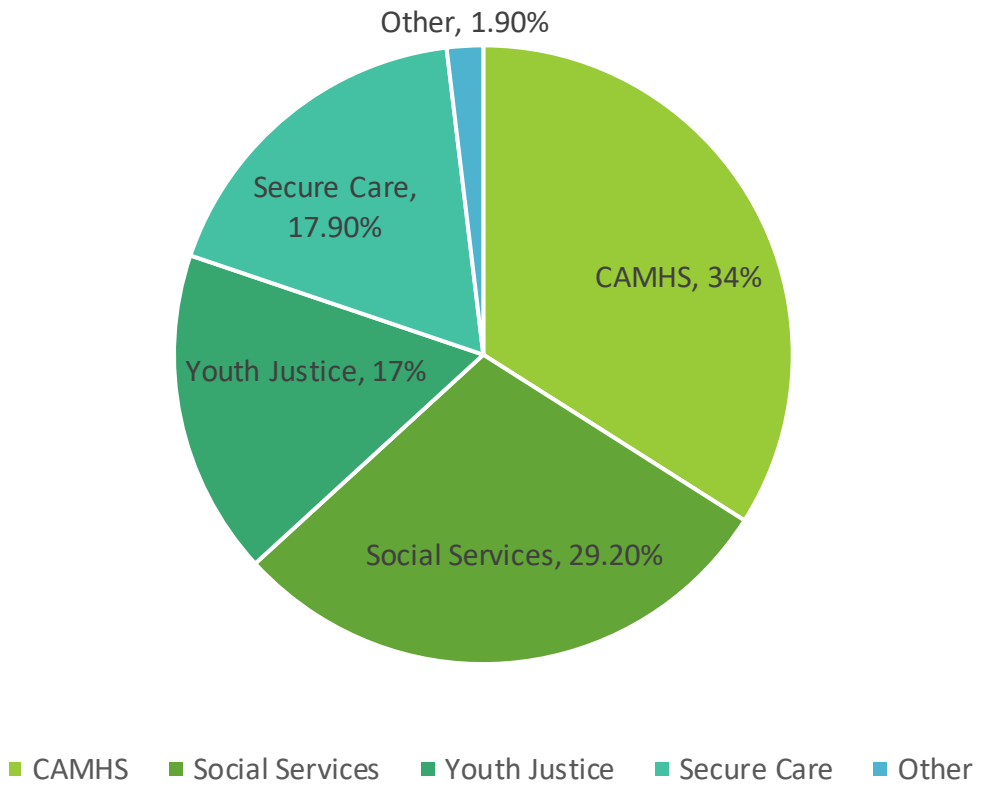
Results

- n = 107 from 5 years of referrals [April 2018 – April 2023]
- Mean age 15.1 years old and ranged between 8 and 17 years old
- Majority of cases were male (81.1%, n=86), compared with less than one-in-five who were female (18.9%, n=20)
- 89.6% self-identified as ‘white’, 5.7% who identified as ‘Irish Traveller’ and 4.6% who identified as either Black, Mixed Ethnicity or Other Ethnic Group

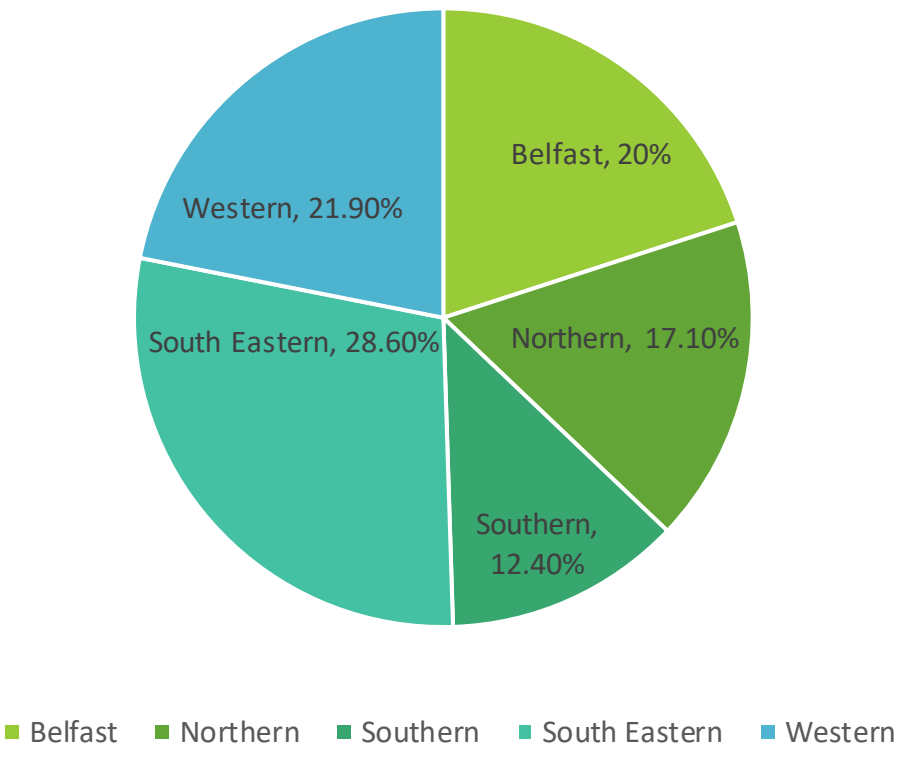
Results

- 61% were Looked After Children (LAC)
- 61.3% were involved with the Youth Justice Agency
- Missing data but majority come from Catholic/Nationalist backgrounds (15.9%) and Protestant/Unionist backgrounds (8.4%). However, 75% missing data
- 25% not in education or training

Referring Services



Referrals by HSCT



Presentations

- Overall 79% had a diagnosed mental health condition
- 20% had diagnosis of ASD
- 48% had diagnosis of ADHD
- 4.4% had a diagnosis of Foetal Alcohol Spectrum Disorder [FASD]
- 18% had diagnosis of Intellectual Disability

Traumatic Early Life Experiences

- Almost all of the sample are known to have experienced at least one traumatic early life experience (95.2%). This compares with 37% who are known to be exposed to at least one adverse event in the general youth population (Bunting, 2020)

- The association between known CSE issues and mental health comorbidity was statistically significant $X^2(1, N=104)=5.89, p=.015$) indicating greater mental health difficulties for victims of sexual exploitation

Risk of harm to others

	FCAMHSNI	NHS England FCAMHS	FACTS Wales
Violence and Aggression	48 (62.3%)	1125 (80%)	60 (75%)
Multiple Offences	10 (13%)	522 (37.1%)	Not Given
Harmful Sexual Behaviour	3 (3.9%)	424 (30%)	41 (51%)
Fire Setting	5 (6.5%)	147 (10.5%)	20 (25%)
Other	1 (1.3%)	Not Given	Not Given
Second Opinion in a Complex Case	10 (13%)	434 (30.9%)	Not Given

Discussion points

- Disproportionately high numbers of young people from the Irish Travelling community (5.7%) were referred to FCAMHSNI comparative to the relative Irish Traveller population, which was estimated at 0.14% in the 2021 Census (Equality Commission for NI, 2021).
- The majority of young people being referred to FCAMHSNI come from Catholic or Nationalist backgrounds (15.9%), as opposed to Protestant or Unionist backgrounds (8.4%).
- There were gaps in available data, however these findings mirror outcomes from previous studies–a majority of young people referred to the Youth Justice Agency come from Catholic backgrounds, and that the majority of young people who are sent to custody are from Catholic backgrounds. (McAlister, McNamee, Corr & Butler., 2022)
- FCAMHSNI and NHS England data found around a quarter of young people referred were not in education, employment or training
- Almost all of the sample are known to have experienced at least one potentially traumatic event (95.2%) – comparatively higher than NHS England findings (64.2%)

NI Context

- NI has experienced significant adversity, conflict and violence over last 50 years not seen elsewhere in UK or Ireland
- Communities are still segregated and many communities are still recovering and impacted by sectarianism, paramilitarism and connected violent crime
- NI has relatively higher levels of social deprivation than those found in England, Scotland and Wales (Bywaters, 2018]
- It would be of future interest to compile data on specific experiences of young people in NI which may differ from trends in terms of violence exposure or exploitation elsewhere; such as considering community threats such as paramilitarism, through which vulnerable young people may be easily exploited, harmed or exposed to organised crime or violence
- There is certain transgenerational trauma which continues to impact young people today, as a result of parental and grand-parental experiences in the conflict. There is therefore arguably an additional layer to the complexities of our young people.

Future Planning

- Promotion of FCAMHSNI through regional clinic model – beginning in end of 2023 to address differences in numbers of referrals coming from different Trust areas

- Highlights complexities and vulnerabilities of our YP – reinforces need for a highly trained, specialist community based, multidisciplinary team to support management of YP

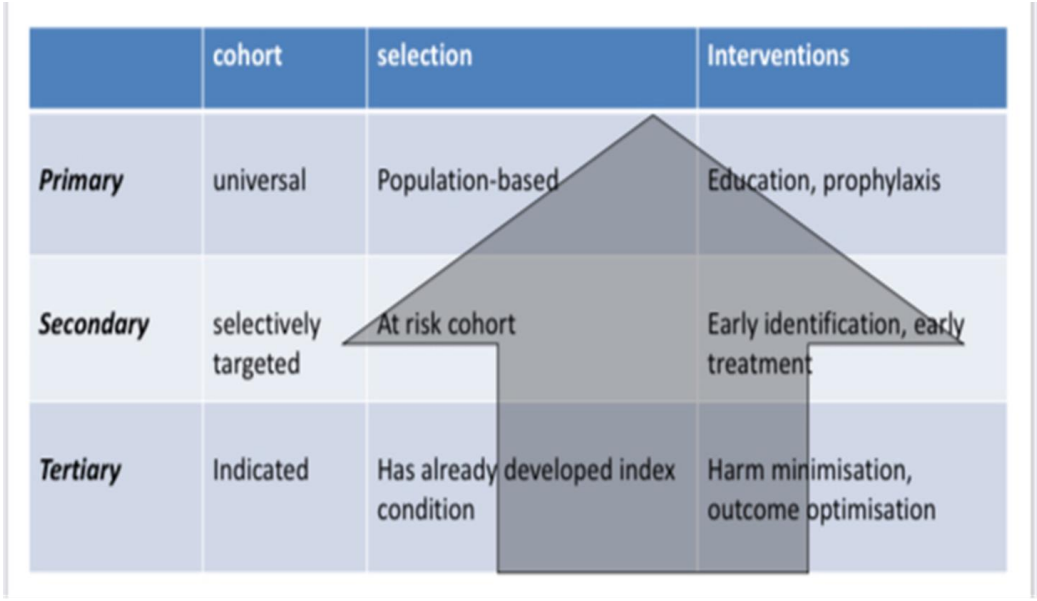
- 26% of NHS England referrals led to direct case input. FCAMHSNI direct case input is currently limited due to resources and service operates largely on a consultative model. Plan for review of this and development of more direct assessment /intervention work to align with NHS England.

Public Health Approach

England, Scotland and Wales have a stratified Public Health Approach to addressing youth violence

NI does not currently have such an approach

This evaluation supports the needs for such an approach and reflects the needs and risks of our young people as being potentially higher and more complex



	cohort	selection	Interventions
Primary	universal	Population-based	Education, prophylaxis
Secondary	selectively targeted	At risk cohort	Early identification, early treatment
Tertiary	Indicated	Has already developed index condition	Harm minimisation, outcome optimisation

Public Health Approach

Most effective way to reduce problem behaviours is to work with families whose children are at the highest risk, at the earliest point possible [Khan, 2010]

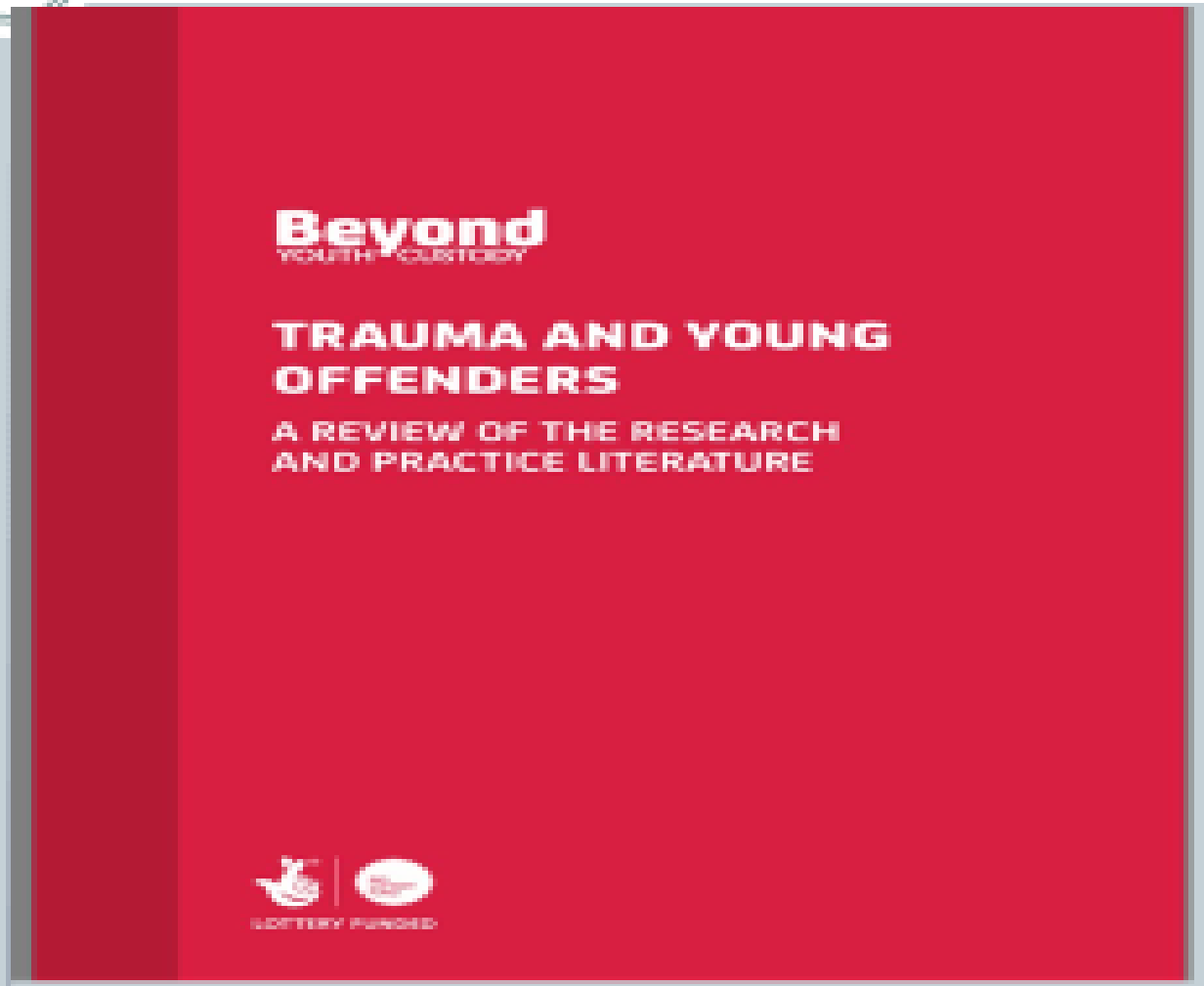
Poor parenting and family dysfunction explains up to 40% of problematic behaviour in children, indicating a need to focus predominantly on strengthening parenting skills and on building the child's resilience [Khan, 2010]

Interventions specifically aimed at reducing problem behaviours. Parent training for parents of primary school children [Scott, 2005] and MST for older adolescents [Fonaghy, 2018]

There is clear evidence of the potential long-term costs efficiencies of early intervention, with costs estimated at £70,000 per head. [Hughes, 2012]

‘If we started thinking about offending as a trauma-spectrum condition, then…

people might start being viewed as victims of past injustice, rather than just perpetrators’



Thank you!

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RC GP

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Keynote Presentation

Vanessa Fowler
Deputy Director of Specialised Mental Health, Learning Disability/ASD and Health & Justice

Emma Sweet
Lived Experience Lead for the Womens Review

Mahala McGuffie
Head of Better Outcomes for Women in Custody - HMPPS Women's Directorate

HM Prison & Probation Service

NHS England

The National Women's Prisons Health and Social Care Review – an early preview

October 2023

“Women are and have different issues to men in prison.

Some of us are mothers, carers, home makers, sisters, girlfriends, daughters. Social expectations of women are different.

When we make a mistake - shame, guilt and embarrassment is piled on us because we are women, because we 'should' know better.

These feelings can make us feel so belittled that reaching out for help can be difficult. It is important services understand this better.”

For today

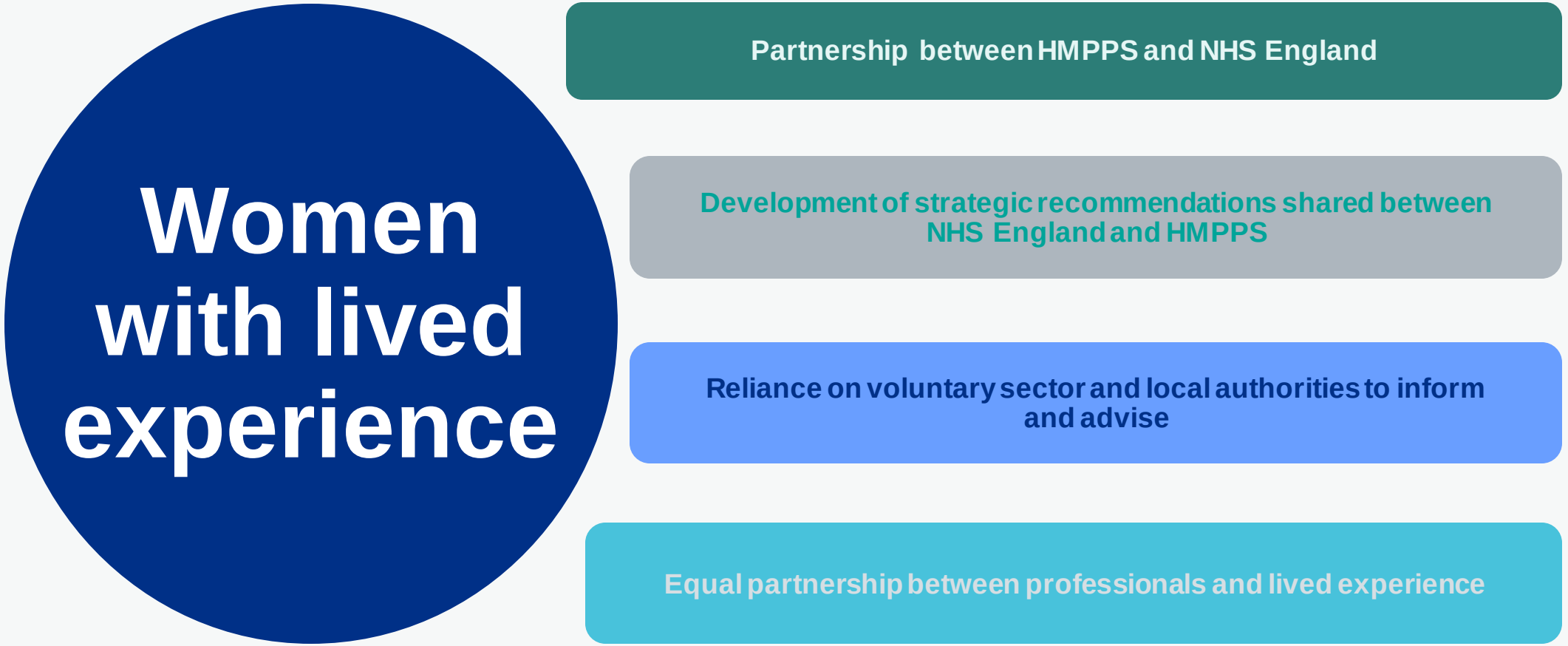
A preview of the national review

Commissioned by NHS England in partnership with His Majesty's Prison and Probation Service (HMPPS)

Aims:

- To further improve health and social care outcomes and experience for all women in prison in England and upon their release
- Reduce health and social care inequalities
- Ensure equity of access
- To help improve the commissioning of health services and quality of care for women

Core approach



How?

Established a Women's Review Board – Independent Chair and a dedicated programme manager

Seven task and finish groups:

Early days in custody, resettlement, health and social care needs assessment, clinical models, performance and quality, prison perinatal care, substance misuse, fabric and environment (from where health and social care are delivered)

Production of 13 detailed chapters as outputs from the task and finish groups

A lived experience steering group to guide the lived experience element of the review – over 2,250 contributions from women with a feedback loop

Stakeholder engagement events, eg north region and south region events with dedicated events for social care professionals, voluntary sector providers, pharmacists and prison governors

Bespoke literature review that included a review of all existing health needs assessments, data analysis, inspection outcomes and related strategy and policy documents

Main findings

8 main findings and strategic recommendations

Main finding 1:

Health and social care services across the 12 prisons are inconsistent and not always gender specific or sensitive to women with protected characteristics. The prison environment is experienced as unfit for purpose by many women and health and social care providers.

"I went to four different prisons throughout and each healthcare doesn't have consistency, so it's all very different. Either they would deal with things very quickly or it can get delayed, so there should be consistency throughout prisons. My main concern was about my medication."

Strategic recommendation 1:

Health and social care services for women in prison should be underpinned by an approach that is gender specific, gender compliant, considerate of protected characteristics, personalised, accessible, equitable, and consistent between all womens prisons. Fabric improvements across the womens estate should be made as needed.

Overarching themes

Partnerships and Governance

HM Prison & Probation Service

NHS England

Communication

"I was going to get an abortion – I didn't know about MBUs. A few weeks in, healthcare came over and said we needed to get me ready for an MBU Board. I was like "OMG, can I keep my baby?!"

"It's a shock when they say, you can't have that (medication), no one really takes the time to explain, it's just stopped – the withdrawal can be hard."

"I didn't understand what the doctor meant. He tried to put me on these tablets, but didn't tell me what they were for, so I stopped taking them."

Workforce

"St Giles family worker/support have been amazing with me. I can't thank the ladies enough."

"The chaplaincy are the ones who provided me the most support. I'll be forever grateful for them."

"The staff here are good, healthcare work hard and try their best. You feel looked after and that people care."

"I'm lucky, my key worker is brilliant and has helped me get a job to get me out of my cell and always has time for me. Gym staff give as much support as they can."

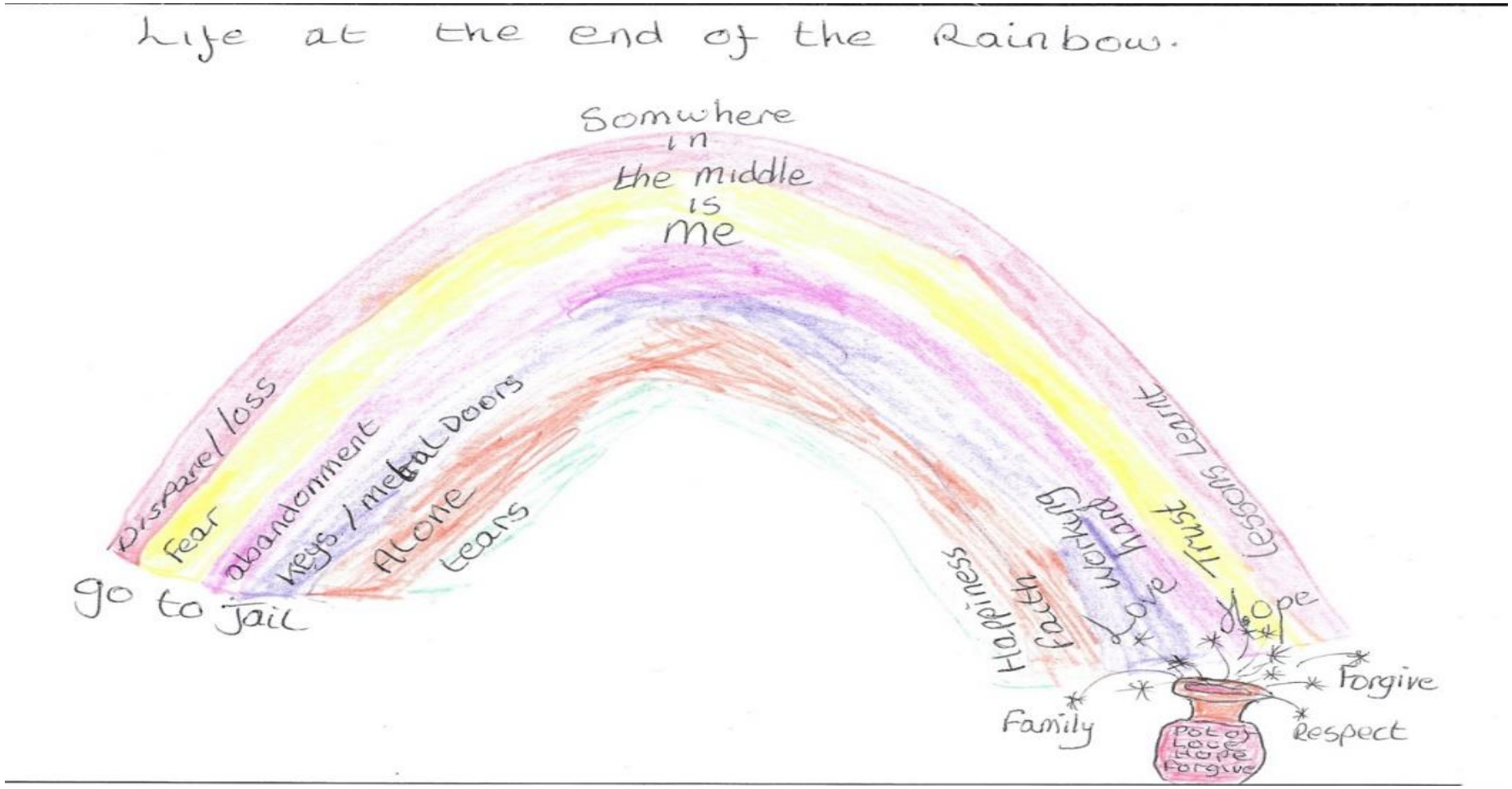
Next steps and implementation

1. A new national Women's Health, Social Care and Justice Partnership Board will be established. The board will oversee the delivery of the 8 strategic recommendations made in the report and accepted by NHS England and HMPPS. Underpinned by a comprehensive programme of work that will be delivered over the next three years.

2. A commitment to co-design and co-production with women with lived experience will be a hallmark of the delivery of the recommendations of the women's review. This is an important legacy for future commissioning strategies and partnership working.

3. The new Board will also set out clear governance and assurance processes, including lived experience. This will include arrangements for the new Women's Prisons Learning Network and the National Social Care Implementation Group.

4. A bespoke, enhanced health and social care model for the women's estate will be developed during 2024/25. This will be reflected in a new service specification for healthcare in women's prisons, which will seek to further improve the quality of care for women in prison.



Picture by a woman from HMP Drake Hall

Thank You

10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RCGP

CONVENZIS

Keynote Presentation

Sarah Hume
Principal Psychologist - Irish Prison Service

Enda Kelly
National Nurse Manager - Irish Prison Service

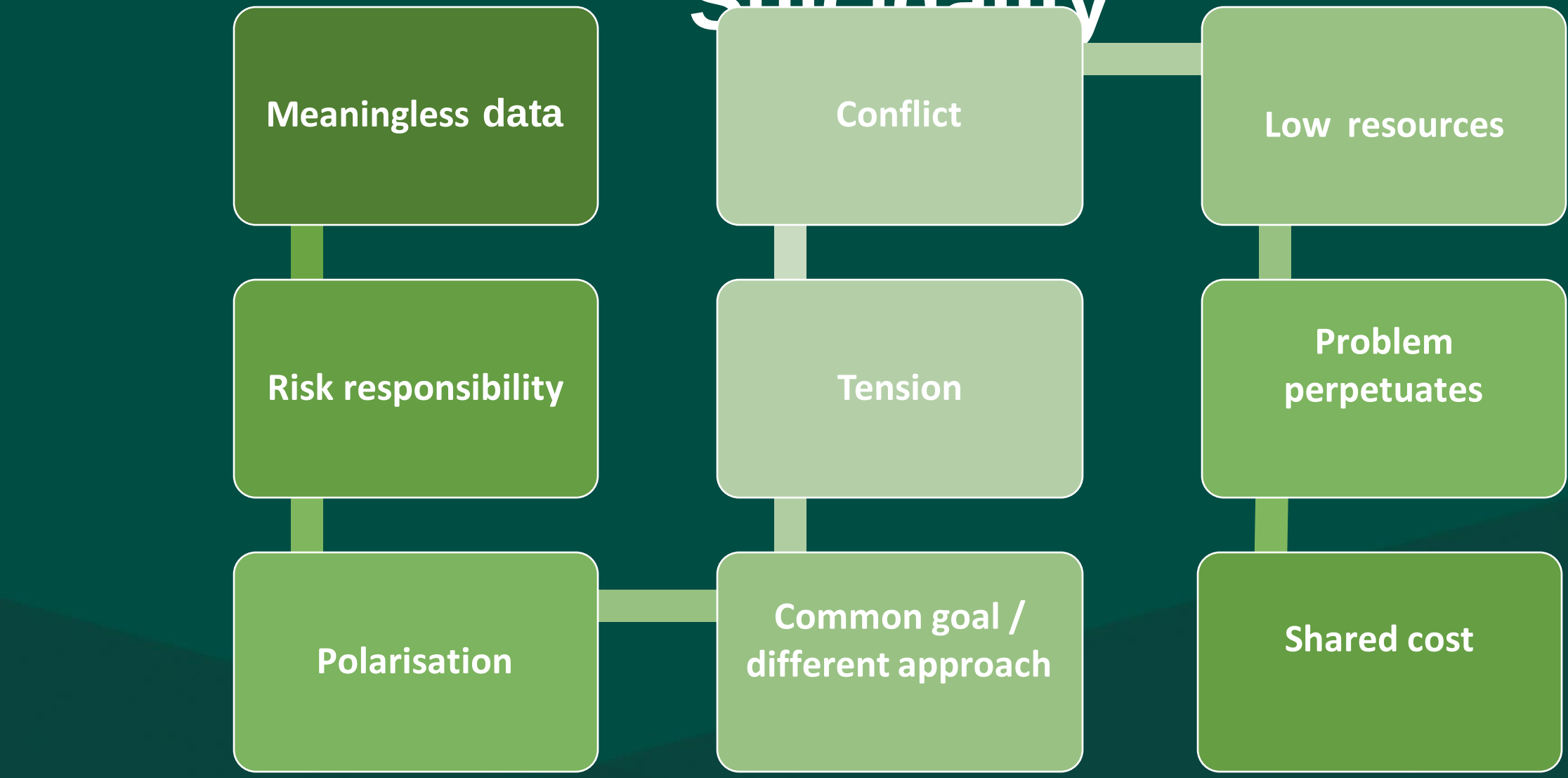
Seirbhís Phríosúin
na hÉireann
Irish Prison Service

10th Annual Health & Justice Summit
Belfast, Oct 2023

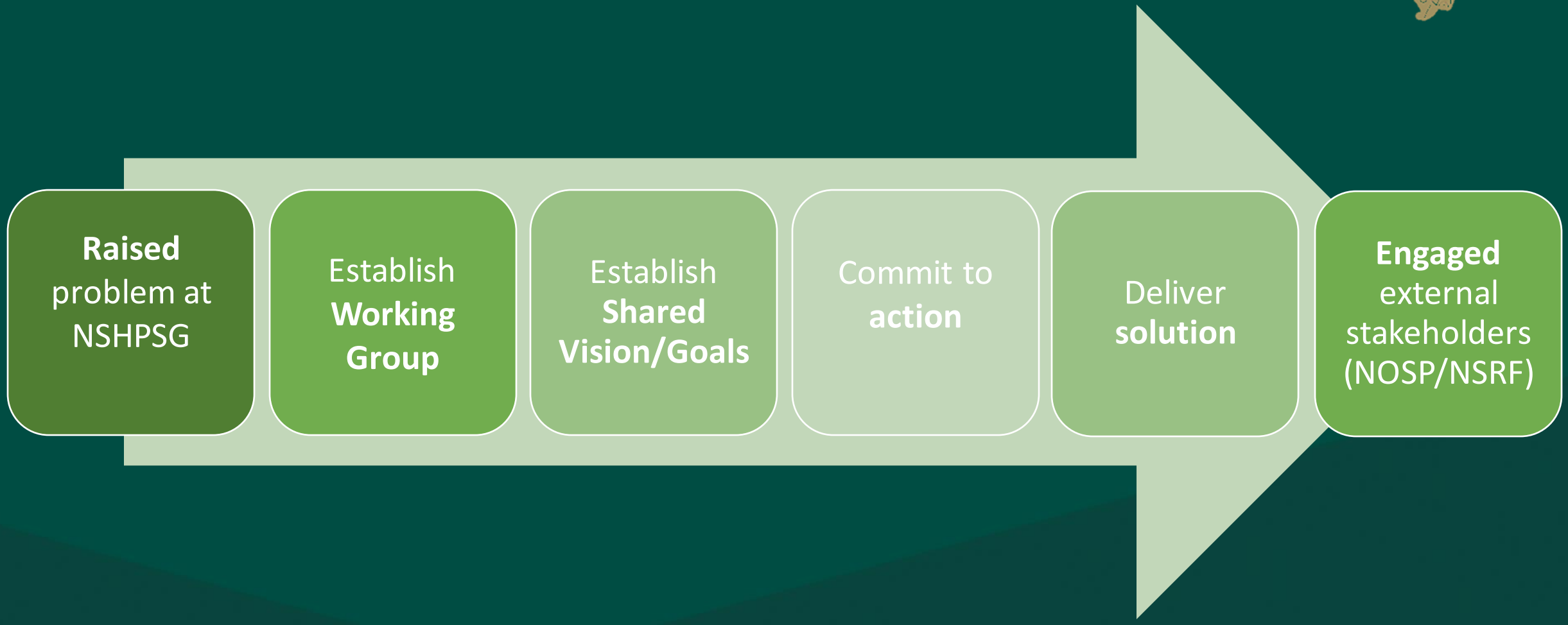
From Protectionism to Progress

Enda Kelly, National Nurse Manager, Irish Prison Service
Sarah Hume, Acting Head of Psychology, Irish Prison Service

The Prompt for Change: Self Harm & Suicidality



Where did we start?



IRISH PRISON SERVICE

SADA

Self-harm Assessment & Data Analysis

Prison		Accommodation	
Prisoner #		Cell Type	
Age		Sentence Length	
Gender		Trimester	
Method of Self Harm		Legal Status	
Date/Time of Incident		Most Serious Offence	
Location of Incident		Monitoring Level	
Previous history in Community		Previous history in custody	
Alone/In Company		Regime Level	

Brief description of Incident

Please categorise incident as either of the following:	**Deliberate act of self injury without conscious intent to die.**		**Incident involved a conscious intent to die**

SEVERITY

INTENT TO HARM	No treatment required.	No treatment required.	Minimal intervention/minor dressing.	Local wound management.	Outpatient/A&E treatment.	Hospital/ Intensive Care	Loss Of Life
	High level of intent - Evidence of high level of thoughts, ideation, premeditation and planning.						
	Medium level of intent – Some level of thoughts, premeditation, planning.						
	No/low intent – No planning or premeditation. Impulsive act.						

Code		Contributory Factor	Primary	Secondary	Please Describe
ENVIRONMENTAL	E1	Legal issues (e.g. pending charges, court case, recently convicted, 1st time in custody, unexpected custody).			
	E2	Shortage of staff and/or staffing issues (causing stress/tension/chaos).			
	E3	Reduced access to regime (causing isolation/lack of stimulation).			
	E4	Type of accommodation or cell type.			
PROCEDURAL	P1	Recently placed in SOC/on special observation.			
	P2	Protection issues (e.g. Rule 62/63).			
	P3	Transfer issues (transfer, denied transfer, moved to CSC).			
	P4	Recent P19, reduction in incentivized regime.			
	P5	Recent barrier handling/designated VDP/additional staff/disruptive or oppositional behavior.			
	P6	Denied visit/placed on screened visits.			
	P7	Denied TR/remission or breached TR.			
	P8	To orchestrate access to contraband/other instrumental gain.			
	P9	Pre-release concerns.			
RELATIONAL	R1	Relationship difficulties with other prisoners (e.g. being victimized/bullied, under threat, conflict, peer pressure).			
	R2	Relationship difficulties with staff.			
	R4	Relationship issues with significant others (e.g. friends/family)/ reduction in family or access to community support(s).			
	R5	Bullying/threatening/victimizing others.			
BEREAVEMENT /LOSS	B1	Death or anniversary of death of someone close.			
	B2	Adjustment issues (e.g. loss of freedom, identity, and stigma).			
	B3	Loss of family or intimate relationship.			
	B4	Loss of possession or object.			
	B5	Transfer or release of supportive family member/friend/associate.			
	B6	Child custody/access issues.			
MEDICAL	M1	Medication issues (e.g. non-compliance, admin issues, drug seeking).			
	M2	New diagnosis or worsening symptoms.			
	M3	Chronic pain.			
	M4	Terminal illness.			
MENTAL HEALTH	MH1	Mental health (e.g. mood disorder, anxiety, PTSD, eating disorder, psychosis, personality disorder, hopelessness/low mood etc). ** Where MH1 is identified, further information should be supplied:*			
	MH2	Substance use/addiction.			
	MH3	Poor coping/difficulties managing emotions.			
	MH4	Impulsivity.			

What was the outcome?

Typology

Contributory Factors

History

Intent

Severity

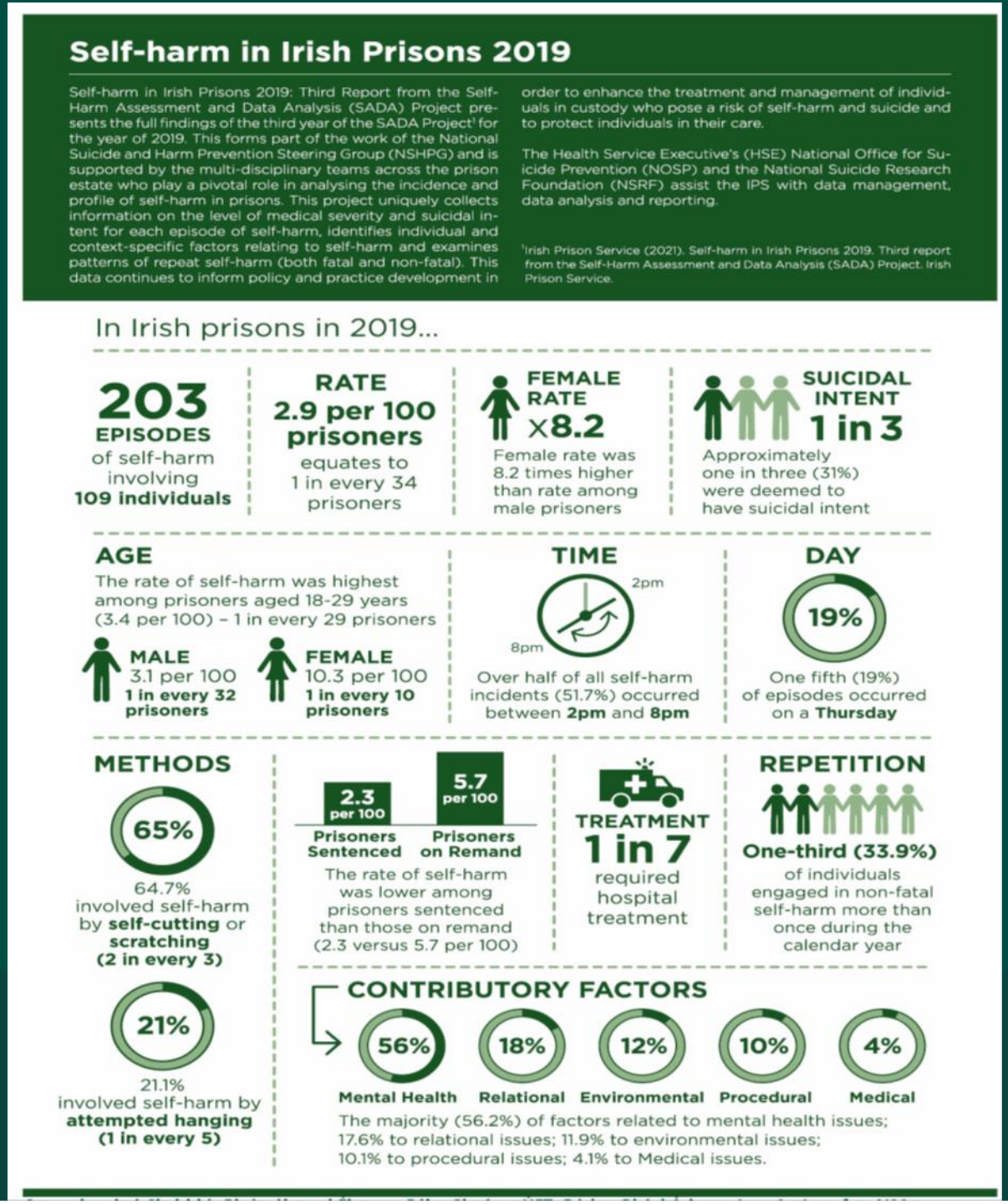
When, where

Quarterly review of data

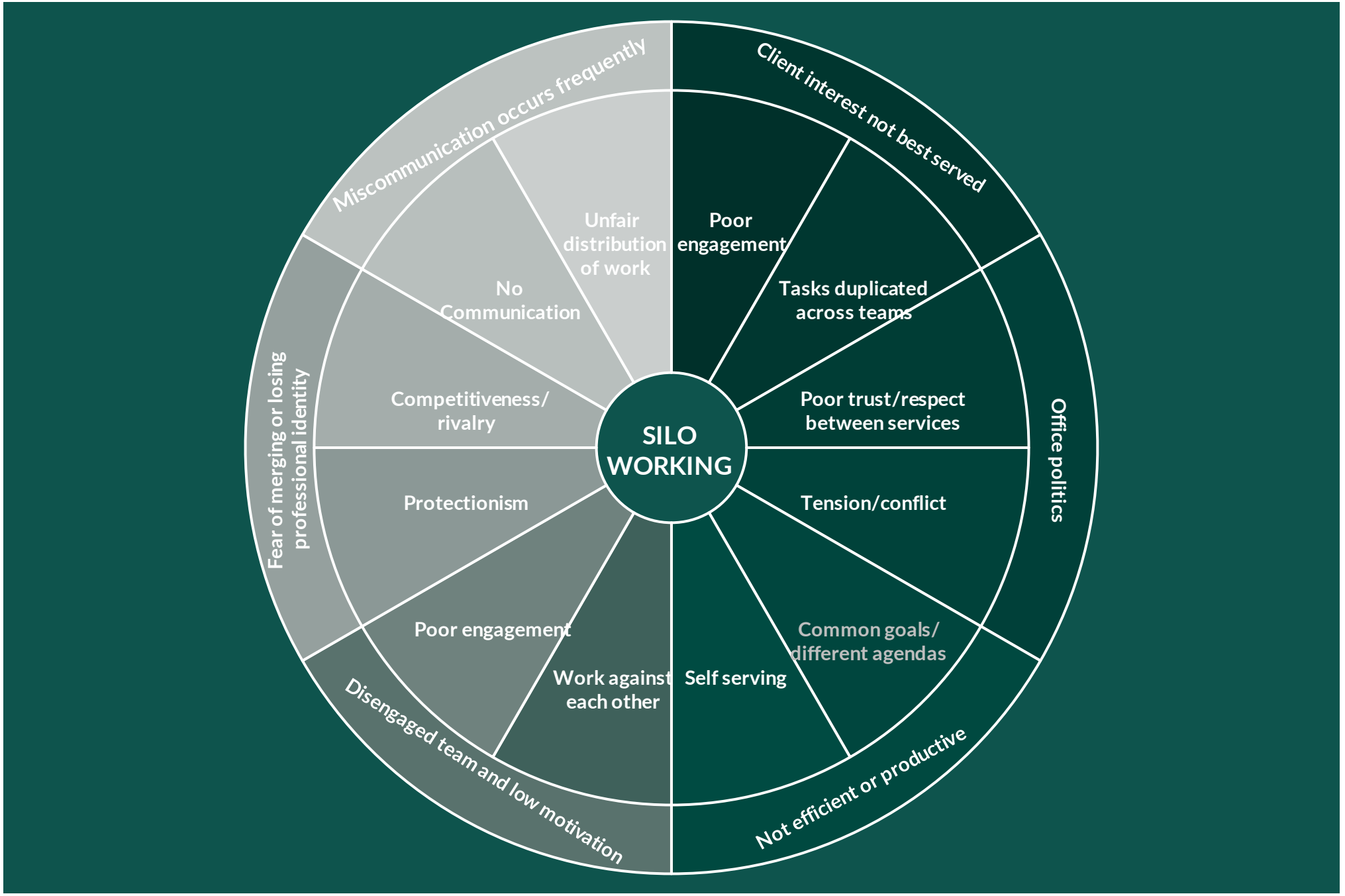
Infographics

Annual report

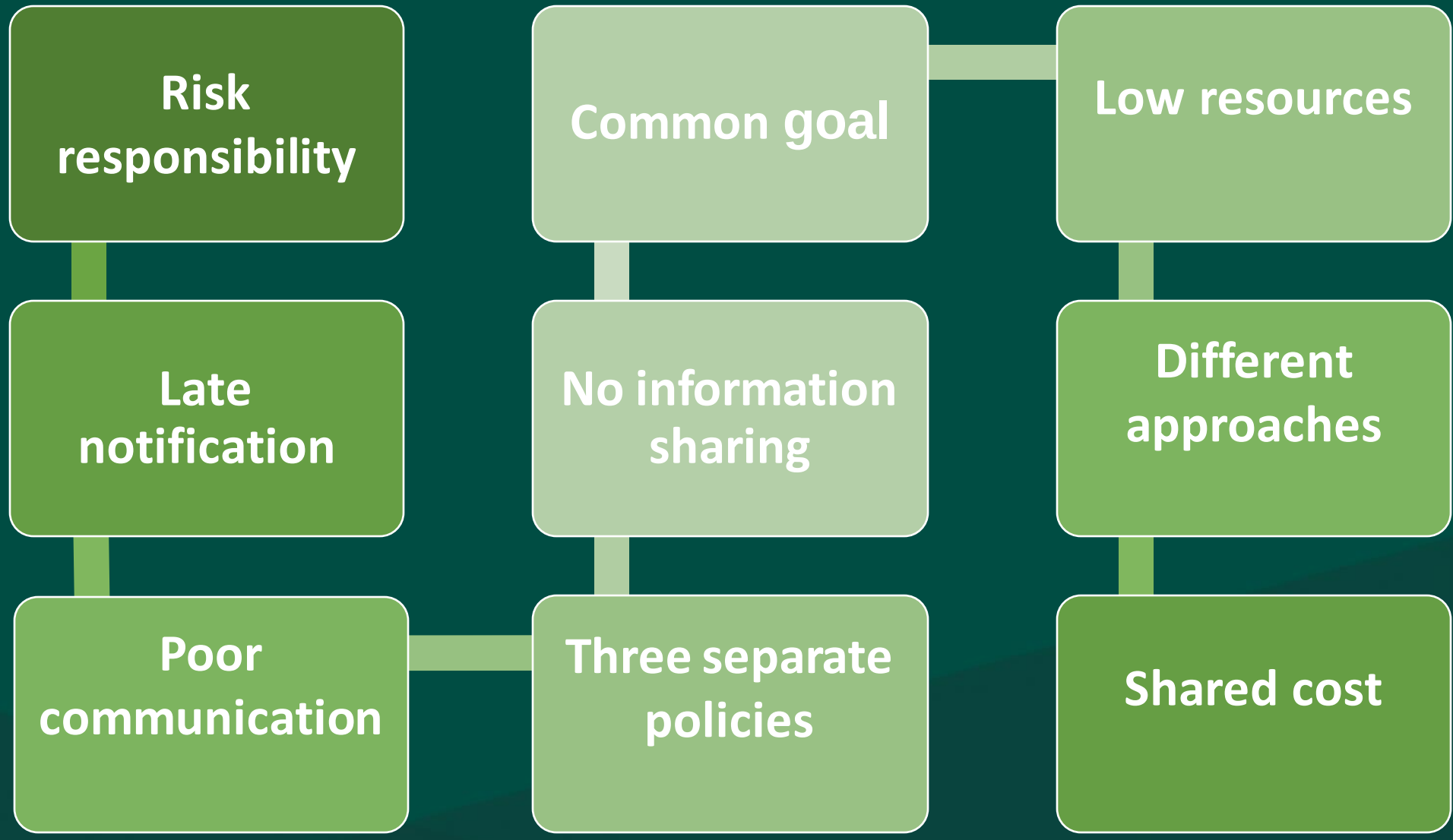
Research



https://www.nsrf.ie/strategic-research-clusters/the-self-harm-assessment-and-data-analysis-sada-project/


SILO WORKING
Miscommunication occurs frequently
Unfair distribution of work
No Communication
Competitiveness/ rivalry
Fear of merging or losing professional identity
Protectionism
Poor engagement
Disengaged team and low motivation
Work against each other
Self serving
Not efficient or productive
Common goals/ different agendas
Tension/conflict
Office politics
Poor trust/respect between services
Tasks duplicated across teams
Poor engagement
Client interest not best served

Food and/or Fluid refusal



Ways we overcame challenges:

Maximise Resource

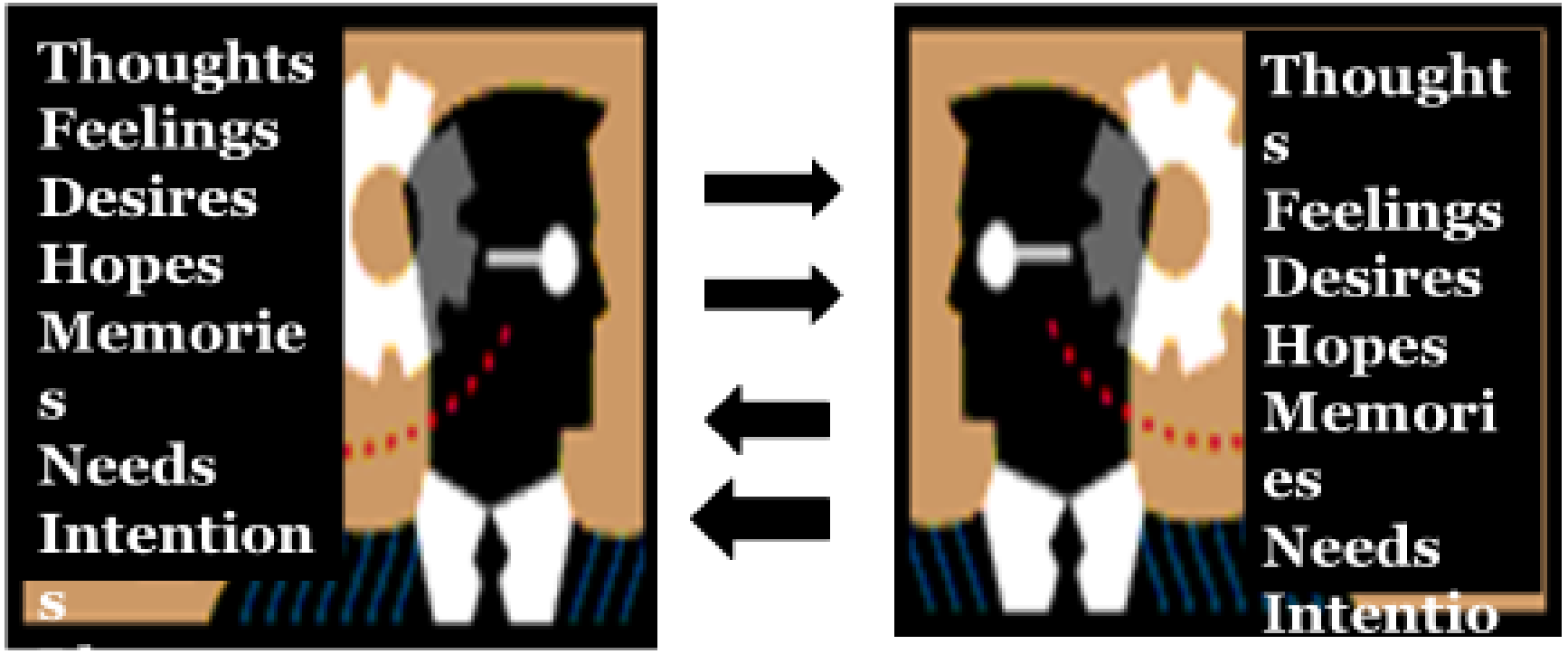
- One weekly multi-agency meeting
- Share the load
- External stakeholders
- Information sharing
- Shared formulation & approach
- Joint policies

Engagement

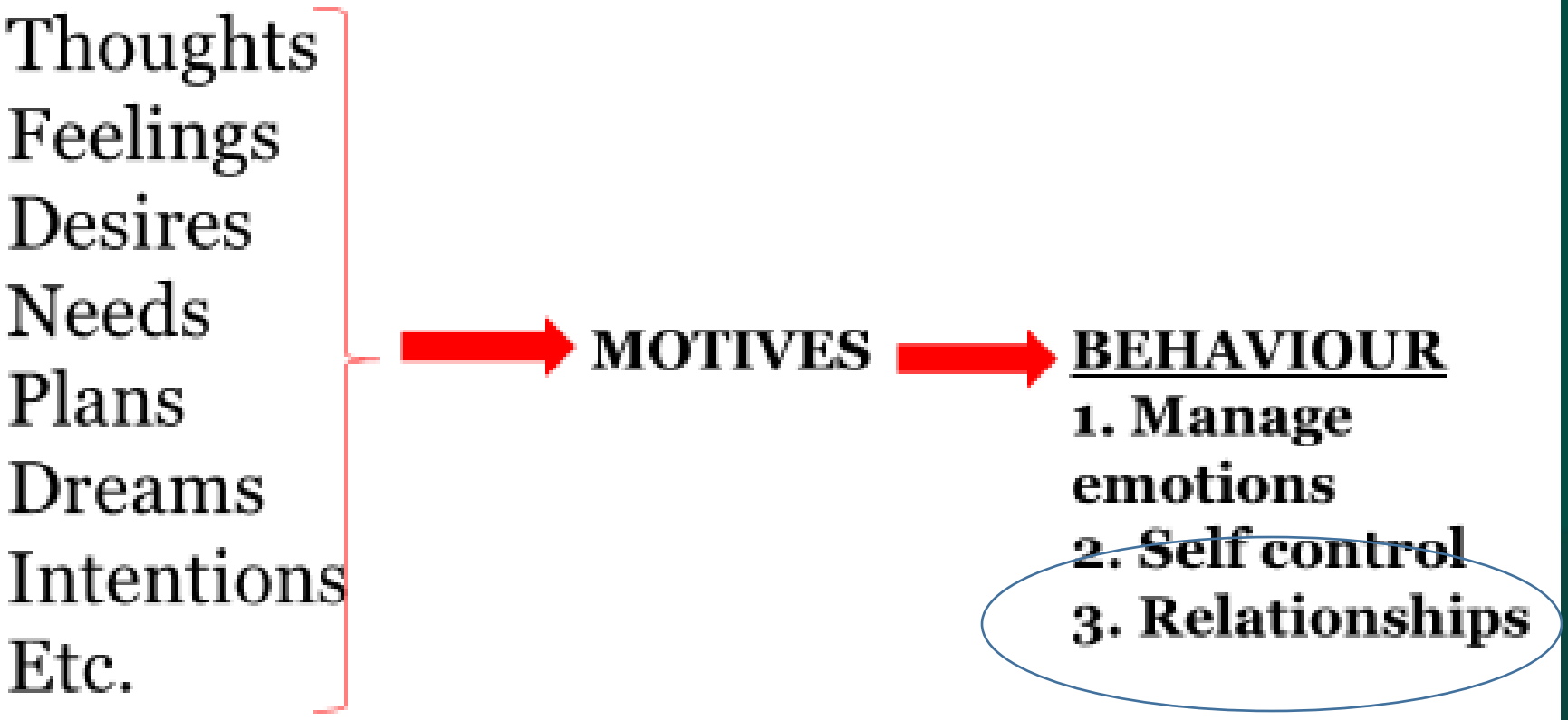
- Upward feedback & ongoing review
- Reinforce high value
- Improve contact between managers
- Early involvement of all services
- Joint decision making

Good Mentalisation!

What is Mentalizing?: A meeting of minds



Why is mentalizing important?



Common Unmentalized Cognitions (Other)

He/she wants to control me / take over

This is him/her being superior or knows better

He/she is empire building

People promise things but don't do them

He/she is only trying to exert power and control

Others want to exploit me / me to do all the work

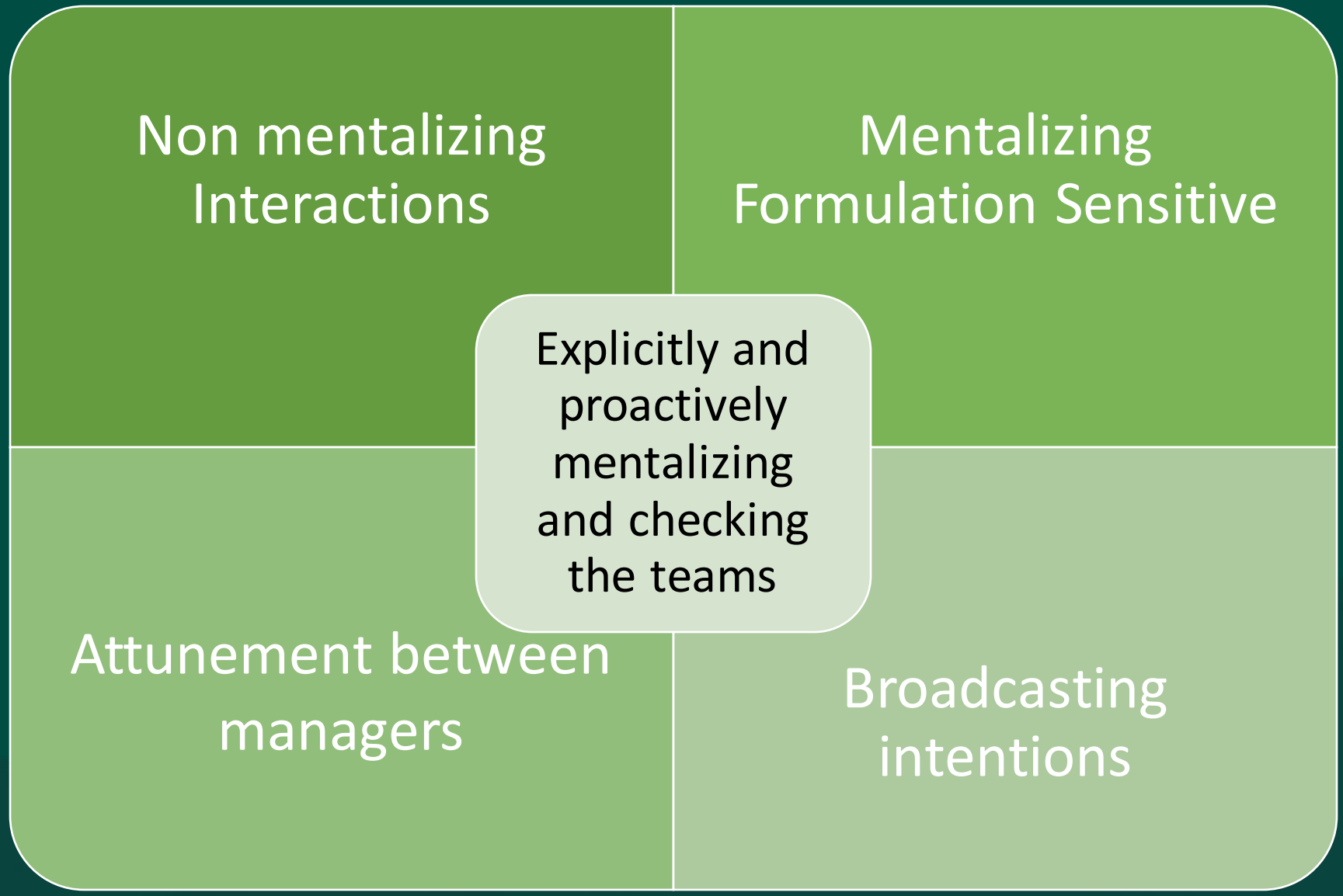
He / she is passing the buck

He/she thinks I am lazy or don't care about the clients/patients

He/she doesn't value my opinion

He/she is blaming me

Mentalisation in action:



Lessons learnt:

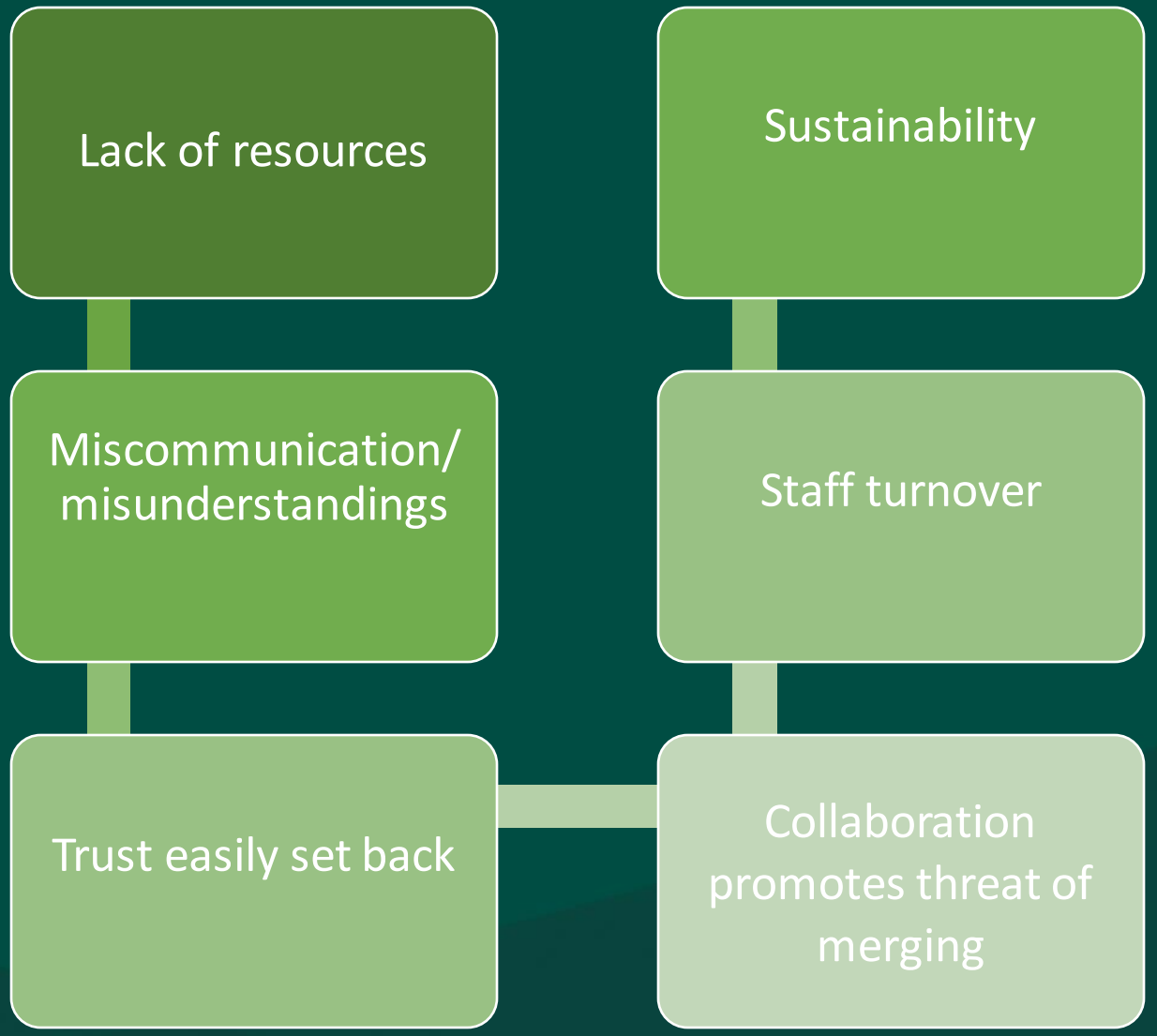
Involvement of ‘front line’ staff at outset

Plan for sustainability

Engaged earlier with external agencies

Informal ‘non threatening’ contact between teams

Ongoing Challenges:



Seirbhís Phríosúin
na hÉireann
Irish Prison Service

Thank you for listening

Any Questions?

10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Ethypharm

CONVENZIS

Headline Sponsor Plenary: Ethypharm

Samantha Evans
Recovery Worker - DRW
Inclusion NHS

Mark Grantham
Drug Strategy Lead - HMP Featherstone
HMPPS (His Majesty's Prison and Probation Service)

Kayleigh Evans-James
Deputy Head of Healthcare HMP Featherstone - Practice Plus Group

Health in Justice

HMP Featherstone

Drug Recovery Wing – The Junction

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/ or search for MHRA Yellow Card in the Google Play or Apple App Store.
Adverse events should also be reported to Martindale Pharma, an Ethypharm Group Company. Tel: 01277 266 600. e-mail: drugsafety.uk@ethypharm.com

Prescribing information can be found at the end of the presentation

UK-GP-105b
Date of preparation: Sept 23

Presenters:

Kayleigh Evans-James, Deputy Head of Healthcare for Practice Plus Group

Mark Grantham, Drug Strategy Lead and Local DRW Project Lead for HMPPS

Sam Evans, DRW Recovery Lead for Inclusion

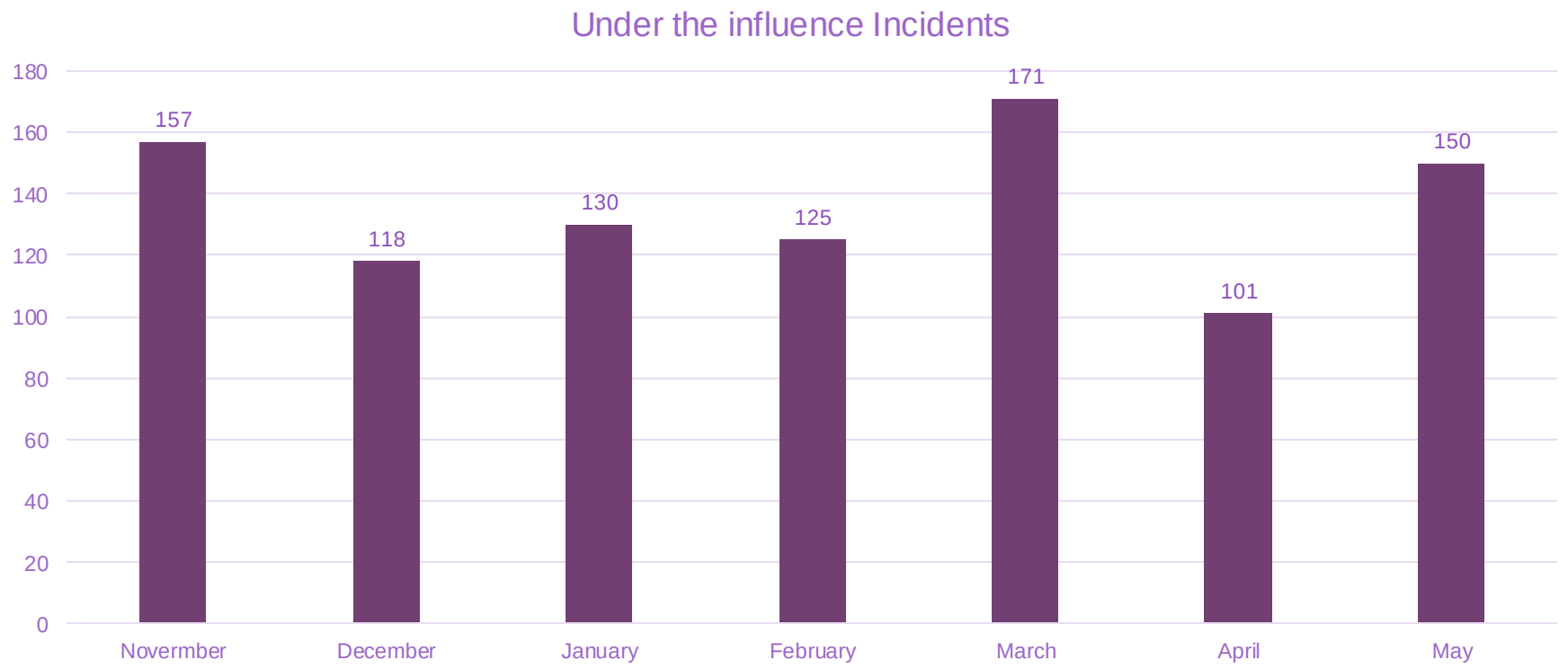
Practice Plus Group

Declaration of Interest

The symposium was funded by Ethypharm as part of their sponsorship package for the event. The speakers have received an honorarium for their time. Ethypharm has had no input into the content of the presentation but has been given the opportunity to review its contents.

HMP Featherstone – Background - KEJ

PS stats – how the prison was / challenges / staffing



Service impact

- High number of Code Blues
- Use of Naloxone at a code blue
- Refresher training for Naloxone / opiate overdose?
- Psychosocial / Mental Health demand
- Staff morale

Abstinence-DRW Concept and Ethos

In line with the Governments 10 year 'Harm to Hope' plan to tackle drugs, HMP Featherstone was one of 6 prisons in the country successful in its bid to deliver an Abstinence-Drug Recovery Wing.

This was a significant project for the prison and did come with additional resources such as staff, a budget of £50,000 to improve or modify the environment and additional Psychosocial Recovery Workers funded by NHS England.

The unit is designed to support prisoners in recovery, to maintain abstinence. Primarily focussing on those that have detoxed from OST but also currently supporting a secondary cohort of prisoners who are in recovery and maintaining abstinence from all substances.

There is a specific entry criteria and all the prisoners must sign a contract whereby they agree to be drug tested twice per month. In order to support the community any breaches of the contract would lead to a multi-disciplinary review of the individual's suitability for the unit.

The ambition and framework for the unit is built around 8 key components..

8 Components of the DRW

- Strong Leadership- to steer the direction of the unit
- Good Management- to oversee and support daily practice
- Empowered and actively involved prisoners.
- Competent, supportive and actively involved staff.
- Promoting safety and security.
- Enhancing care and wellbeing.
- Enabling environments with a strong rehabilitative culture.
- Strengthening continuity of care.

Building a Recovery Culture and Cultivating Community on the DRW

The power of community in recovery is well documented and has been a key focus throughout the project to date.

By bringing like-minded prisoners together and educating staff we have taken great steps to nurture a strong sense of recovery culture and community amongst the men on the unit.

This has been achieved through community forums, structured group work sessions, enrichment activities such as games days, celebrations and competitions. We have nominated community reps and mentors in place who deliver sessions to their peers and offer support to men arriving on the unit.

At every step of the journey, we sought to engage the prisoners, including consulting with them on how the £50,000 should be spent to support a recovery culture. But also, and importantly, the naming of the unit- which is now called **The Junction.**

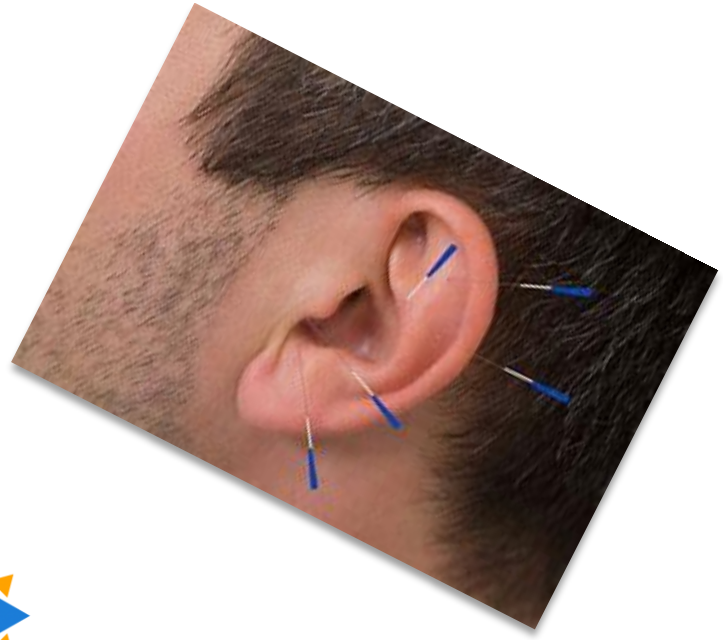
Partnership working

The key to our success for the DRW is co-production

- HMPPS, Practice Plus Group and Inclusion
- Project group attendance
- DRW business case for staffing

Inclusion – Psychosocial support - Sam

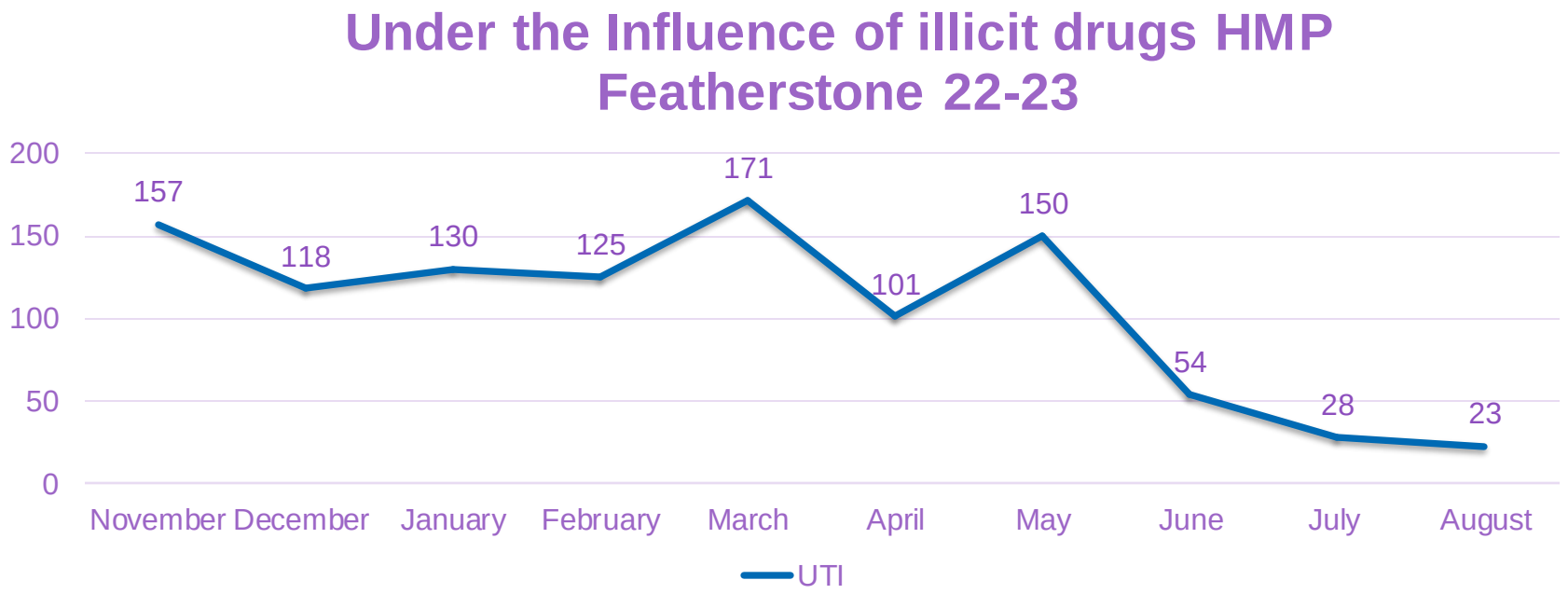
- Sam's role on the DRW
- Delivering structured interventions
- The DRW community



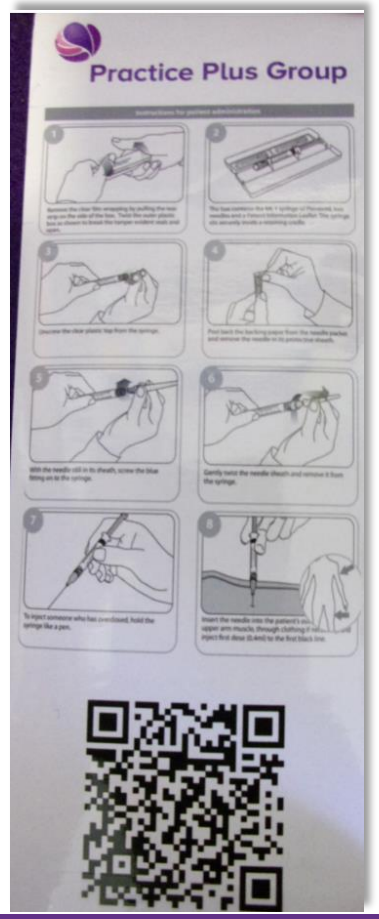
Peer support - Sam

- The importance of peer support on the DRW
- Building networks with community support and having key speakers come in

Successful stories and outcomes – Mark and Sam



Our Naloxone mission - KEJ




RECOGNIZE THOSE GONE UNSEEN
ALCOHOL OVERDOSE
DEPRESSANT OVERDOSE
STIMULANTS

Thank you

Practice Plus Group

Prescribing Information for Prenoxad (naloxone hydrochloride) 1mg/ml Solution for Injection in a prefilled syringe
Please refer to the Summary of Product Characteristics (SmPC) before prescribing.

Presentation: A sterile, clear and colourless liquid in a 2ml prefilled syringe, each 1 ml of solution contains 1 mg of naloxone hydrochloride. **Indications:** Prenoxad Injection is intended for emergency use in the home or other non-medical setting by appropriate individuals or in a health facility setting for the complete or partial reversal of respiratory depression induced by natural and synthetic opioids, including methadone and certain other opioids such as dextropropoxyphene and certain mixed agonist/antagonist analgesics: nalbuphine and pentazocine. Prenoxad Injection should be carried by persons at risk of such events. It may also be used for the diagnosis of suspected acute opioid overdose. **Dosage and Administration: Prenoxad Injection is for administration by intramuscular injection.** Prenoxad Injection may only be made available once the prescriber has assessed the suitability and competence of a client or representative to administer naloxone in the appropriate circumstances. Prenoxad Injection is administered as a part of a resuscitation intervention in suspected overdose casualties, where opioid drugs may be involved or suspected. It may need to be used in a non-medical setting. The prescriber should take appropriate steps to ensure that the patient thoroughly understands the indications and use of Prenoxad Injection. The prescriber should review with the patient or any other person who might be in a position to administer Prenoxad Injection to a patient experiencing a suspected opioid overdose event. **In patients where breathing does not appear to be normal:** Administration of Prenoxad Injection should be preceded by calling emergency services and requesting an ambulance. Following this, 30 chest compressions and if possible 2 rescue breaths (Basic Life Support SINGLE CYCLE) should be given; 0.4ml Prenoxad Injection solution should then be administered by intramuscular injection into the outer thigh muscle or muscles of the upper arm, through clothing if necessary. A further 3 cycles of chest compressions and rescue breaths should then be given followed by administration of 0.4ml Prenoxad Injection. Three cycles of chest compression and rescue breaths should take approximately 2 minutes. This should be repeated until an ambulance arrives or the patient begins breathing normally / regains consciousness. The patient when breathing normally or has regained consciousness should be placed in the recovery position (lying on their side, mouth open pointing towards the ground) and observed continuously. **In patients where breathing is normal but the patient is unrousable or suspected to be unconscious**: Patient should be placed in the recovery position (lying on their side, mouth open pointing towards the ground). 0.4ml Prenoxad Injection solution should be administered by intramuscular injection into the outer thigh muscle or muscles of the upper arm, through clothing if necessary, and an ambulance should be called, 0.4ml Prenoxad Injection solution should then be administered every 2-3 minutes and continued until the ambulance arrives and or the patient regains consciousness. The patient should be continuously observed but particularly their breathing. If there is a decrease in breathing it is important that 0.4ml Prenoxad Injection solution is given every 2 -3 minutes. Parenteral drug products should be inspected visually for particulate matter and discolouration prior to administration whenever solution and container permit. **Adults: Opioid overdosage (known or suspected). Use by individuals in the community.** 400 micrograms or 0.4ml of Prenoxad Injection solution by intramuscular injection into the outer thigh or muscles of the upper arm as part of the resuscitation intervention. The dose of 0.4ml can be repeated every 2-3 minutes in subsequent resuscitation cycles until the contents of a syringe are used up. The duration of action of certain opioids can outlast that of an IV bolus of Naloxone, e.g. dextropropoxyphene, dihydrocodeine and methadone. In situations where one of these opioids is known or suspected it is recommended that an infusion of Naloxone be used to produce sustained antagonism to the opioid without repeated injection. **Children:** The Prenoxad Injection presentation is not intended to be used for children in the home setting other than by an appropriately trained healthcare professional. In the event of a child being given or taking an opioid inappropriately an ambulance should be called and resuscitation started if required. **Neonatal Use:** Naloxone should only be used in Neonates under medical supervision. **Elderly:** Use as for adults. **Consult SmPC for further information. Contra-Indications:** Known hypersensitivity to Naloxone or any of the excipients. **Warnings and Precautions:** Patients must be instructed in the proper use of Prenoxad Injection (see above). Prenoxad Injection is intended as an emergency treatment and the patient should be advised to seek medical help immediately. It should be administered cautiously to patients who have received large doses of opioids or to those physically dependent on opioids since too rapid reversal of opioid effects by Prenoxad may precipitate an acute withdrawal syndrome in such patients. The same caution is needed when giving Prenoxad to neonates delivered to such patients. Hypertension, cardiac arrhythmias, pulmonary oedema and cardiac arrest have been described. For signs and symptoms of opioid withdrawal in a patient physically dependent on opioids please see SmPC. Patients who have responded satisfactorily to Prenoxad should be kept under medical observation for at least 2 hours. Repeated doses of Prenoxad may be necessary

since the duration of action of some opioids may exceed that of Prenoxad Injection. Prenoxad Injection is not effective against respiratory depression caused by non-opioid drugs. Reversal of buprenorphine-induced respiratory depression may be incomplete. If an incomplete response occurs, respiration should be mechanically assisted. Abrupt postoperative reversal of opioid depression may result in nausea, vomiting, sweating, tremulousness, tachycardia, increased blood pressure, seizures, ventricular tachycardia and fibrillation, pulmonary oedema and cardiac arrest which may result in death. Several instances of hypotension, hypertension, ventricular tachycardia and fibrillation, pulmonary oedema and cardiac arrest have been reported in postoperative patients. Death, coma and encephalopathy have been reported as sequel of these events. Although a direct cause and effect relationship has not been established, Prenoxad should be used with caution in patients with pre-existing cardiac disease and in those receiving medications with potential adverse cardiovascular effects e.g. hypotension, ventricular tachycardia or fibrillation and pulmonary oedema. Caution should be exercised, and patients monitored when Prenoxad Injection is administered to patients with renal insufficiency/failure or liver disease. 1 ml of naloxone hydrochloride contains 3.497 mg of sodium which is less than 1 mmol sodium (23 mg) per dose, i.e. essentially 'sodium- free'. **Consult SmPC for further information. Interactions:** The effect of naloxone hydrochloride is due to the interaction with opioids and opioid agonists. When administered to subjects dependent on opioids, in some subjects the administration of naloxone hydrochloride can cause pronounced withdrawal symptoms. Hypertension, cardiac arrhythmias, pulmonary oedema and cardiac arrest have been described. With a standard naloxone hydrochloride dose there is no interaction with barbiturates and tranquillizers. Data on interaction with alcohol are not unanimous. In patients with multi-intoxication as a result of opioids and sedatives or alcohol, depending on the cause of the intoxication, one may possibly observe a less rapid result after administration of naloxone hydrochloride. When administering naloxone hydrochloride to patients who have received buprenorphine as an analgesic complete analgesia may be restored. It is thought that this effect is a result of the arch-shaped dose-response curve of buprenorphine with decreasing analgesia in the event of high doses. However, reversal of respiratory depression caused by buprenorphine is limited. Severe hypertension has been reported on administration of naloxone hydrochloride in cases of coma due to a clonidine overdose. **Pregnancy and Lactation:** *Pregnancy*: The safety of this medicinal product for use in human pregnancy has not been established. Animal studies have shown reproductive toxicity. The potential risk for humans is unknown, therefore, Prenoxad should not be used during pregnancy unless clearly necessary. In a pregnant woman who is known or suspected to be opioid-dependent, risk benefit must be considered before Prenoxad Injection is administered, since maternal dependence may be accompanied by foetal dependence. In this type of circumstance, the neonate should be monitored for respiratory rate and signs of opioid withdrawal. *Use in labour and delivery*: Prenoxad may be administered to mothers during the second stage of labour to correct respiratory depression caused by opioids used to provide obstetrical analgesia. It is not known if Naloxone affects the duration of labour and/or delivery. *Breast-feeding*: It is not known whether Naloxone is excreted in human milk. Because many drugs are excreted in human milk caution should be exercised when Prenoxad Injection is administered to a nursing mother. Therefore, breast-feeding should be avoided in the first 24 hours after treatment. **Effects on ability to drive and use machines:** Patients who have received Prenoxad to reverse the effects of opioids should be warned to avoid road traffic, operate machinery or engage in other activities demanding physical or mental exertion for at least 24 hours, since the effect of the opioids may return. **Undesirable Effects: Consult SmPC for the full list of undesirable effects.** *Very common (≥1/10):* nausea. *Common (≥1/100 to <1/10):* dizziness, headache, tachycardia, hypotension, hypertension and cardiac arrhythmia (including ventricular tachycardia and fibrillation) have also occurred with the postoperative use of naloxone hydrochloride. Adverse cardiovascular effects have occurred most frequently in postoperative patients with a pre-existing cardiovascular disease or in those receiving other drugs that produce similar adverse cardiovascular effects. Vomiting. Postoperative pain. **Overdose:** There is limited clinical experience with Naloxone overdosage in humans. Consult SmPC for management guidance. **Product Licence Number:** PL 12064/0125 **Product Licence Holder:** Aurum Pharmaceuticals Ltd, Bampton Road, Harold Hill, Romford, Essex RM3 8UG. **Basic NHS Price:** £18.00 **Legal Category:** POM. **Further information:** Martindale Pharma, Bampton Road, Romford, RM3 8UG. Tel: 01277 266 600. **Date of Preparation:** April 2023. **Job Bag Number:** UK-PREN-47

Adverse events should be reported. Reporting forms and information can be found at https://yellowcard.mhra.gov.uk/ or search for MHRA Yellow Card in the Google Play or Apple App Store.
Adverse events should also be reported to Martindale Pharma, an Ethypharm Group Company. Tel: 01277 266 600. e-mail: drugsafety.uk@ethypharm.com

Morning Break, Networking & Refreshments

Chairs Mid-Morning Address

Kate Davies CBE
National Director for Armed Forces, Health and Justice and Sexual Assault Services - NHS England

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Oxleas NHS Improving lives

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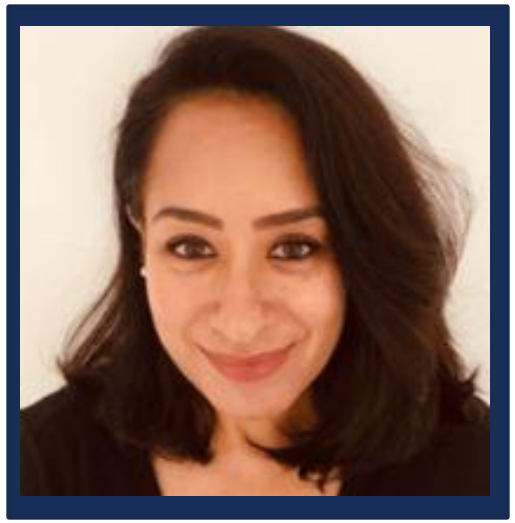
Headline Sponsor Plenary



Dr Varinder Panesar-Talbot
Consultant Forensic Psychologist - HMP Wandsworth, Oxleas NHS Foundation Trust

Hannah Ronald
Head of Safety
HMP - Wandsworth

Jessica Bosi
Custodial Manager of Safer Custody - HMPPS

Headline Sponsor Plenary

SONAR
A JWPM PRODUCT

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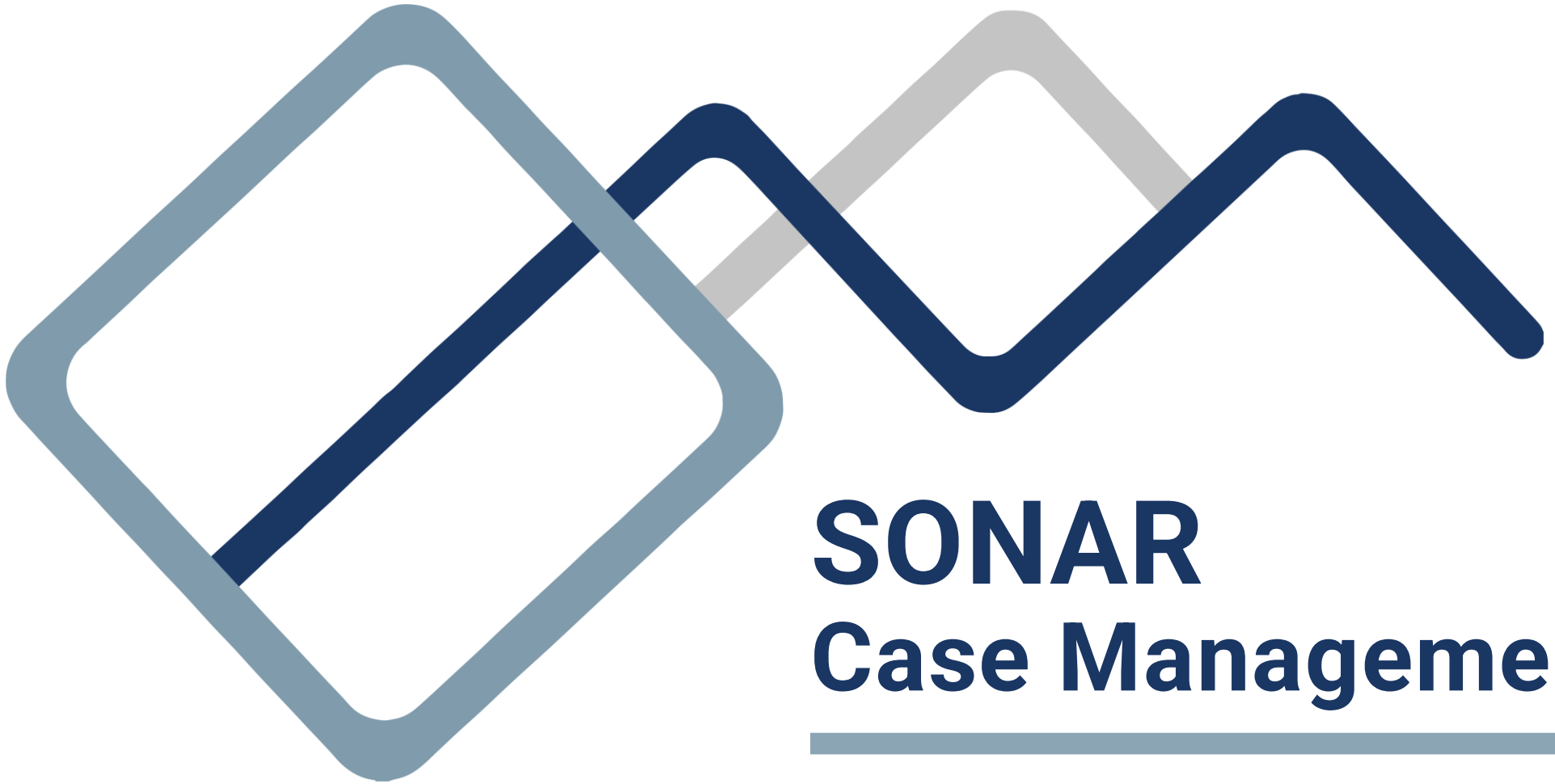


SONAR
Case Management System

John White – Founder & CEO

10th Health and Justice Summit : Building Bridges in Health and Justice

Agenda

Why SONAR?

Beginnings

Need for Change – 2016 to 2023

SONAR – The Team

SONAR - Story So Far

Principles of an Ideal System

SONAR – Building the Bridges in Health & Justice

SONAR – Built So Far

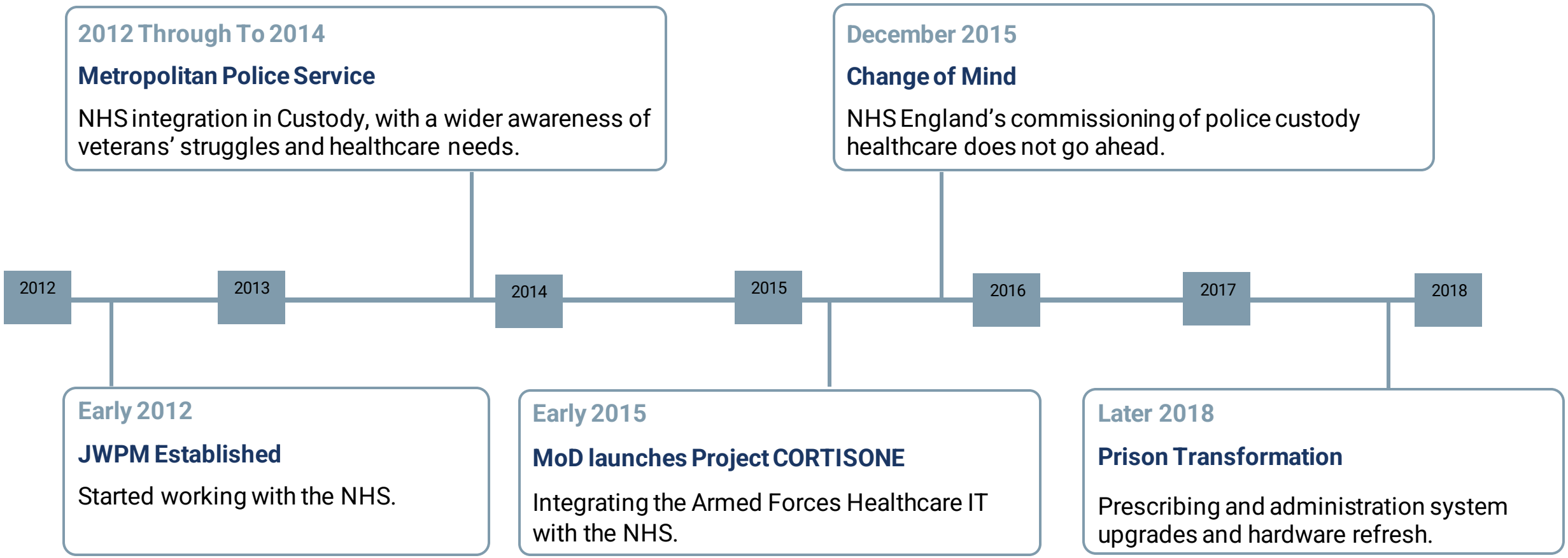
SONAR – Future Bridges to be Built

SONAR – I don't have all the answers.

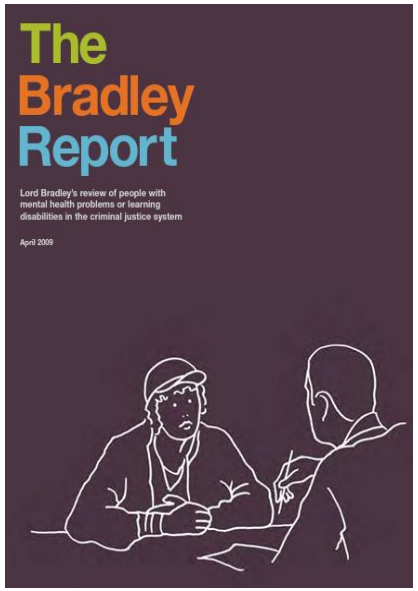
John White – Why SONAR?

- 2000 – John had served 13 years in the Military in various operations and conflicts and to this day suffers from PTSD. His situation after leaving the Forces was disposed to become a “Service User”.
- 2014 – All began with the Metropolitan Police Service.
- 2015 – Programme CORTISONE.
- 2018 – JWPM came into its own.
- 2020 – COVID-19 and the start of the journey for SONAR CMS.
- 2023 – SONAR will address not only the medical needs but also the social care needs. This could include Offender Accommodation post release, Probation appointments, Link & Peer Support to reduce recidivism.

Beginnings

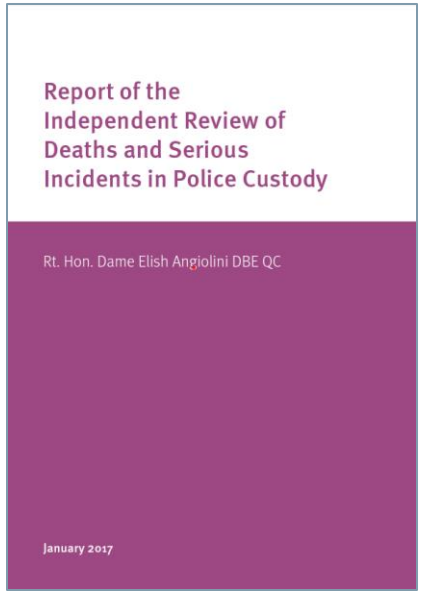

2012 Through To 2014
Metropolitan Police Service
NHS integration in Custody, with a wider awareness of veterans' struggles and healthcare needs.
December 2015
Change of Mind
NHS England's commissioning of police custody healthcare does not go ahead.
2012
2013
2014
2015
2016
2017
2018
Early 2012
JWPM Established
Started working with the NHS.
Early 2015
MoD launches Project CORTISONE
Integrating the Armed Forces Healthcare IT with the NHS.
Later 2018
Prison Transformation
Prescribing and administration system upgrades and hardware refresh.

Need for Change - 2009 to 2023



Lord Bradley - *April 2009*

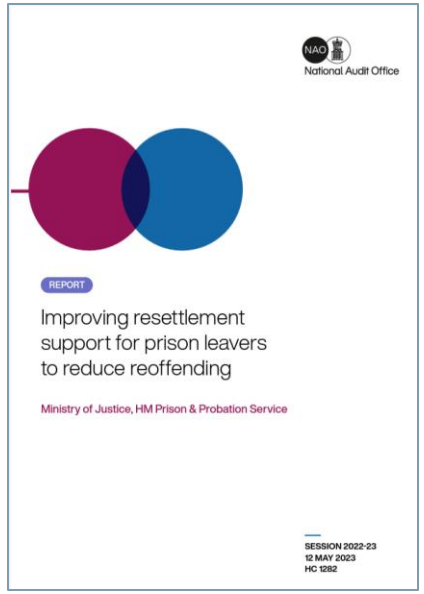
"My recommendations… will, I hope, establish a new baseline of services for the future. I hope they will ensure that over time offenders with mental health problems or learning disabilities are properly identified and assessed, appropriately sentenced and helped with their rehabilitation and resettlement..."



Dame Angiolini - *January 2017*

"NHS commissioning of healthcare in police custody was due to have commenced in April 2016, but was halted by the Government earlier in the year.

This report strongly recommends that this policy is reinstated and implemented."



NAO – May 2023

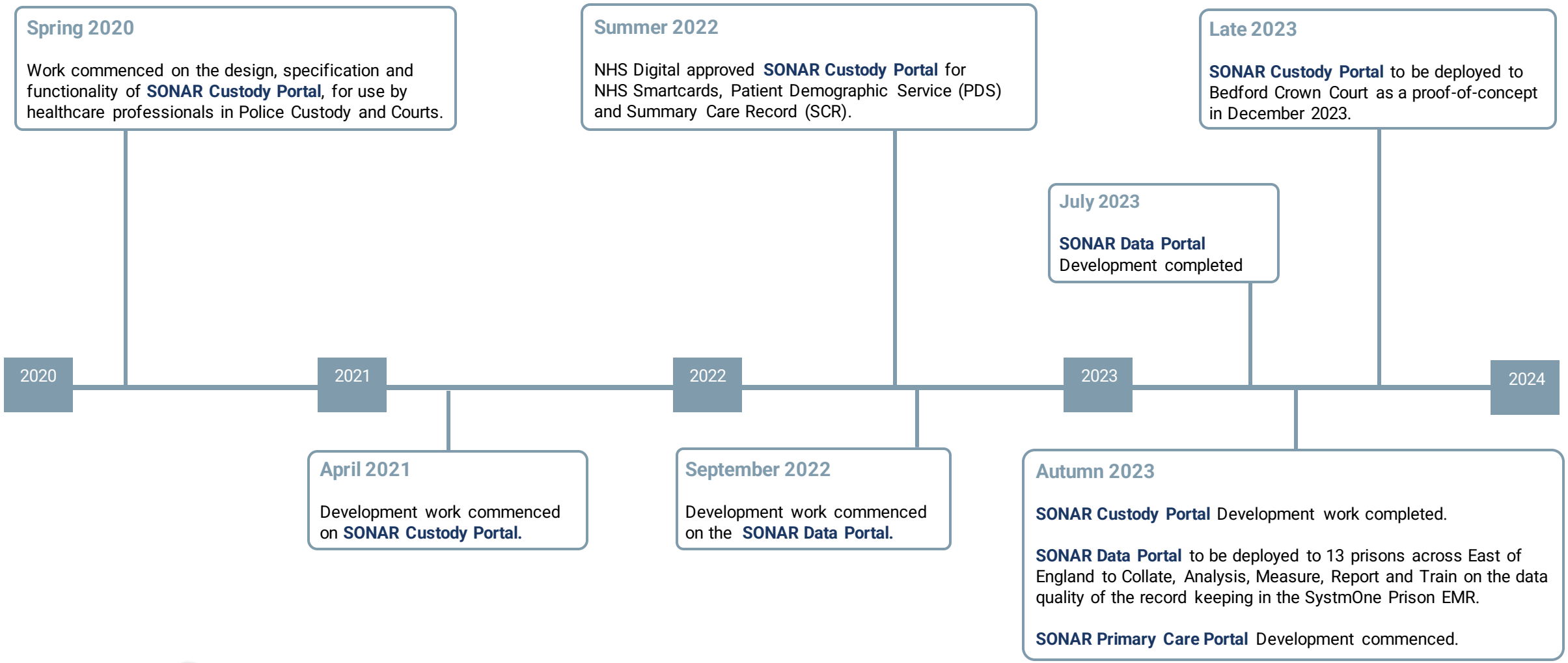
"We identified differences in the information stored in HMPPS's three IT systems which support the resettlement process.

It was difficult to track the progress of prison leavers' resettlement and whether their identified needs were met."

SONAR – The Team

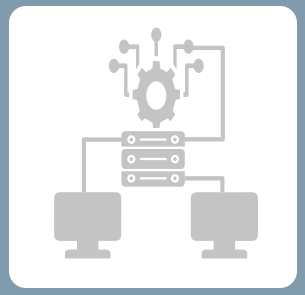
- We are a team of twelve
- Collectively 50 years and more of experience in Health & Justice
- Skills, Knowledge and Experience
  - Primary Care
  - Community
  - Mental Health
  - Police, Courts and Prison
  - Custodial Detention
- Expert Knowledge on
  - Current Health & Justice IT Systems
  - HJIS Programme
  - Others including Community and Mental Health

SONAR - Story So Far



Principles of an Ideal System

Full Technology Stack - AI



Designed by You!

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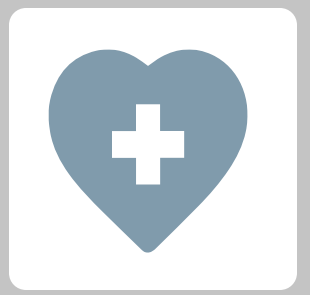
A JWPM PRODUCT

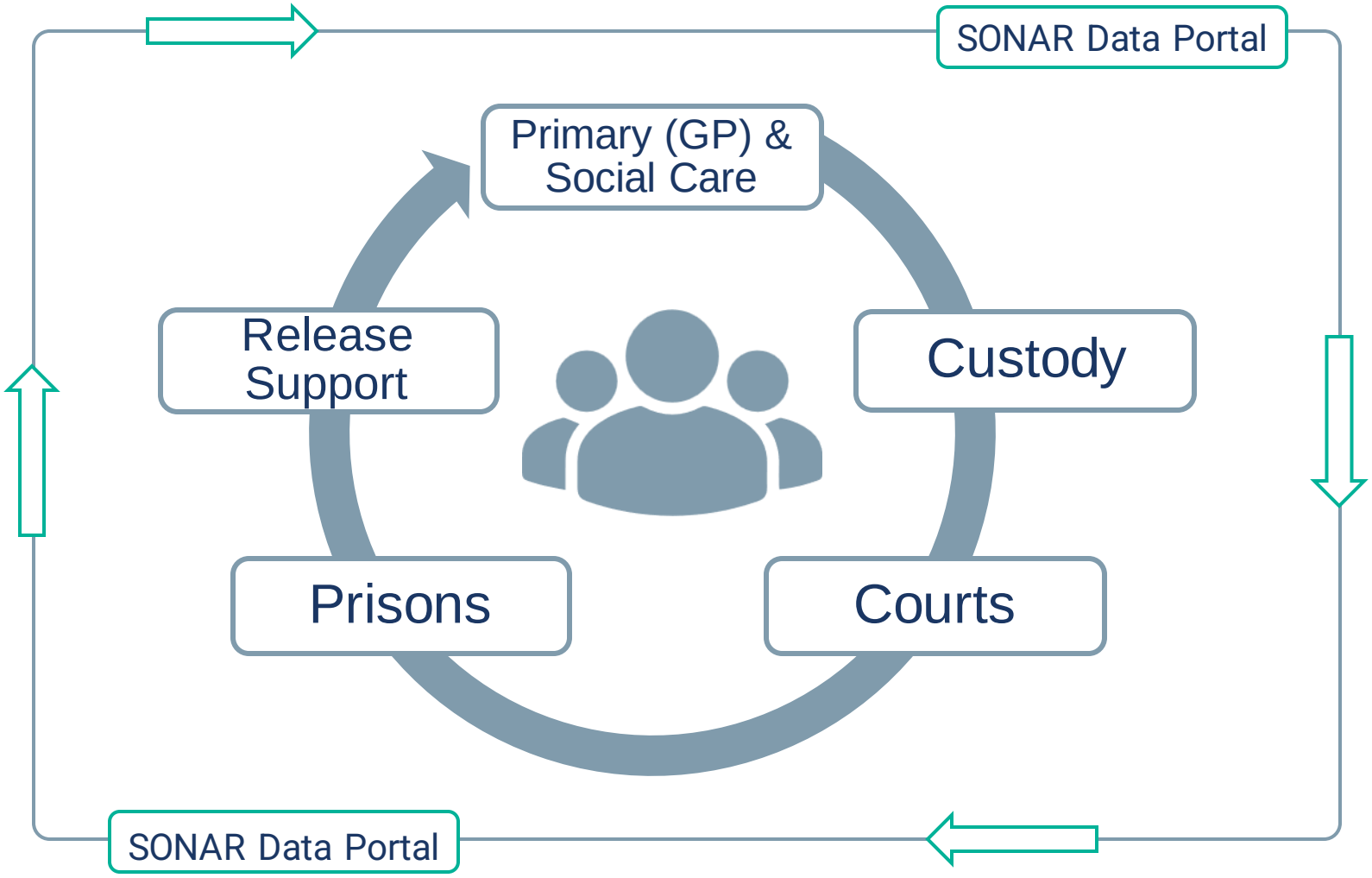
Tailor-made for the Criminal Justice System



Physical Healthcare
Mental Wellbeing
Social Care

Full Criminal Justice Journey

SONAR – Building the Bridges in Health & Justice



The SONAR Data Portal

Originally designed to:

Collate, Analyse, Measure and Report on data quality and KPI performance.

Will improve current healthcare and will enable future forecasting of healthcare trends and needs.

SONAR – Built So Far

Police Custody

- 4 Sites Go Live – Dec 2023
- 4 Sites Go Live – Jan 2024

Courts

- Pilot

Prisons

- Data Portal
- Data Quality – Dec 2023

Release Support Hub

- OPCC Discussion Ongoing

SONAR – Future Bridges to be Built

Police Custody

- Partnerships
- Police Scotland
- PSNI

Courts

- 2 Providers

Prisons

- HJIS/DECITS
- Home Nations

Release Support Hub

- Pilot

GP IT

- GPIT/DSICS

Other

- Restorative Justice
- Youth Justice
- Addiction Services
- Prog. CORTISONE

SONAR – I don’t have all the answers.

- What are the key challenges in healthcare IT and data sharing, within the CJS?
- Can we achieve better outcomes – not only healthcare but also housing, employment and family ties?
- How can commissioning support a joined-up system?
- For England, should NHS England take responsibility for the commissioning of healthcare in police custody?
- How can the healthcare CJS community help design systems that work best for practitioners?

Thank You!

For a chat, for more information, for a demo, please visit our stand or:

jwhite@sonarcms.co.uk

+44(0) 7850 020 106

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@SONARCMSLtd

SONAR CMS Ltd

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RCGP

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Keynote Presentation

Dr Sarah Allen
Lead Psychologist for CNWL Health and Justice Services - CNWL NHS Trust

Dr Frances Maclennan
Consultant Clinical Psychologist - North West London NHS Trust

NHS
Central and North West London
NHS Foundation Trust

Working with Complexity and Keeping Hope Alive

Dr Frances Maclennan and
Dr Sarah Allen

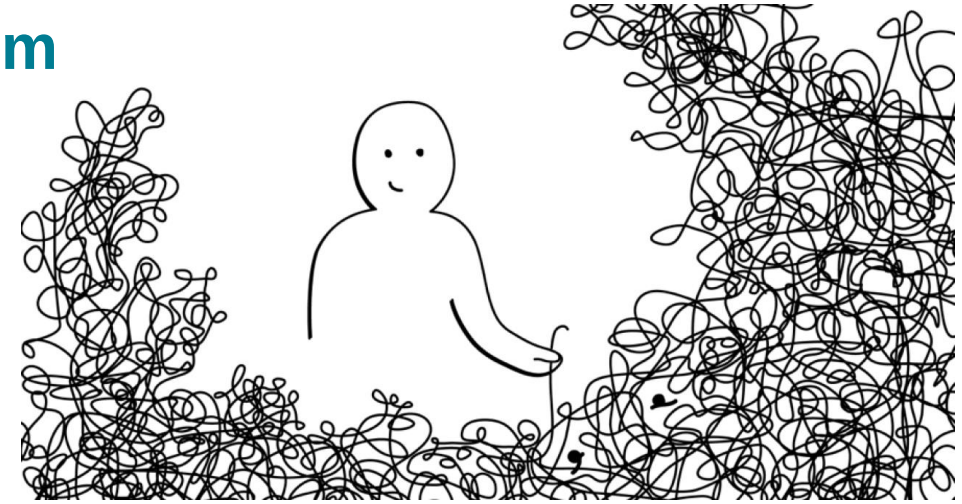
Health and Justice Summit

10.10.2023

Wellbeing for life

Complexity

- Complexity in the people
- Complexity in the system
  - in the Long Term High Secure Estate
  - Traumatised systems
- Complexity in relationships across the system
- Complexity in us



Responses to complexity

NHS
Central and North West London
NHS Foundation Trust

- Fragmentation
  - Primary tasks
  - Goals
  - Governance
- Othering
- Hardens prison life
- Urge to work in silos
- Inhibits creativity, connection and change

Alternative responses

NHS
Central and
North West London
NHS Foundation Trust

- Collaboration and integration across systems
- Cultural curiosity
- Respect
- Relationships
- Flexibility
- Trauma informed systems
- Shared thinking

- Attainability and sustainability?

Keeping hope alive

NHS
Central and
North West London
NHS Foundation Trust

- Meets people where they are at
- Stabilisation
- Progression
- Rehabilitation

- Outreach
- Formulation driven
- Founded in the relational
- Embedded in the CJS – Progression is not a separate clinical goal

What makes this possible?

NHS
Central and North West London
NHS Foundation Trust

- Flexible funding
- Positive risk taking
- Energy
- Supportive system enabling thinking
- Culture carriers
- Early success
- Playful
- Different
- Safety

geese

FINDING RHYTHMS

Outcomes

NHS
Central and North West London
NHS Foundation Trust

- Fewer segregation episodes
- Reduction in violence
- Progressive moves
- QI project

Anecdotal success – enthusiasm, energy, hope

- Shifting narratives
  - View of the men
  - View of the staff
- Change in who we are seeing – addressing health inequalities
- Gatecrashing groups!

“Without the support of SPaR I’d have done another madness”
“ At last someone is listening”
“This makes a difference”
“The programme has given me some hope”
“If you and the team, ever question why you are here… remember you have given me hope, change and self-belief”
“I have never been the person on the stage being clapped until last week”

“We had a wonderful celebration – it really was a boost and encouragement for all of us! I hope it is both the little moments and the big moments that help us make prison a transformative experience for the men in our care (and the staff!!)”

Outcomes

NHS
Central and North West London
NHS Foundation Trust

- **Four high quality albums**

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RC GP

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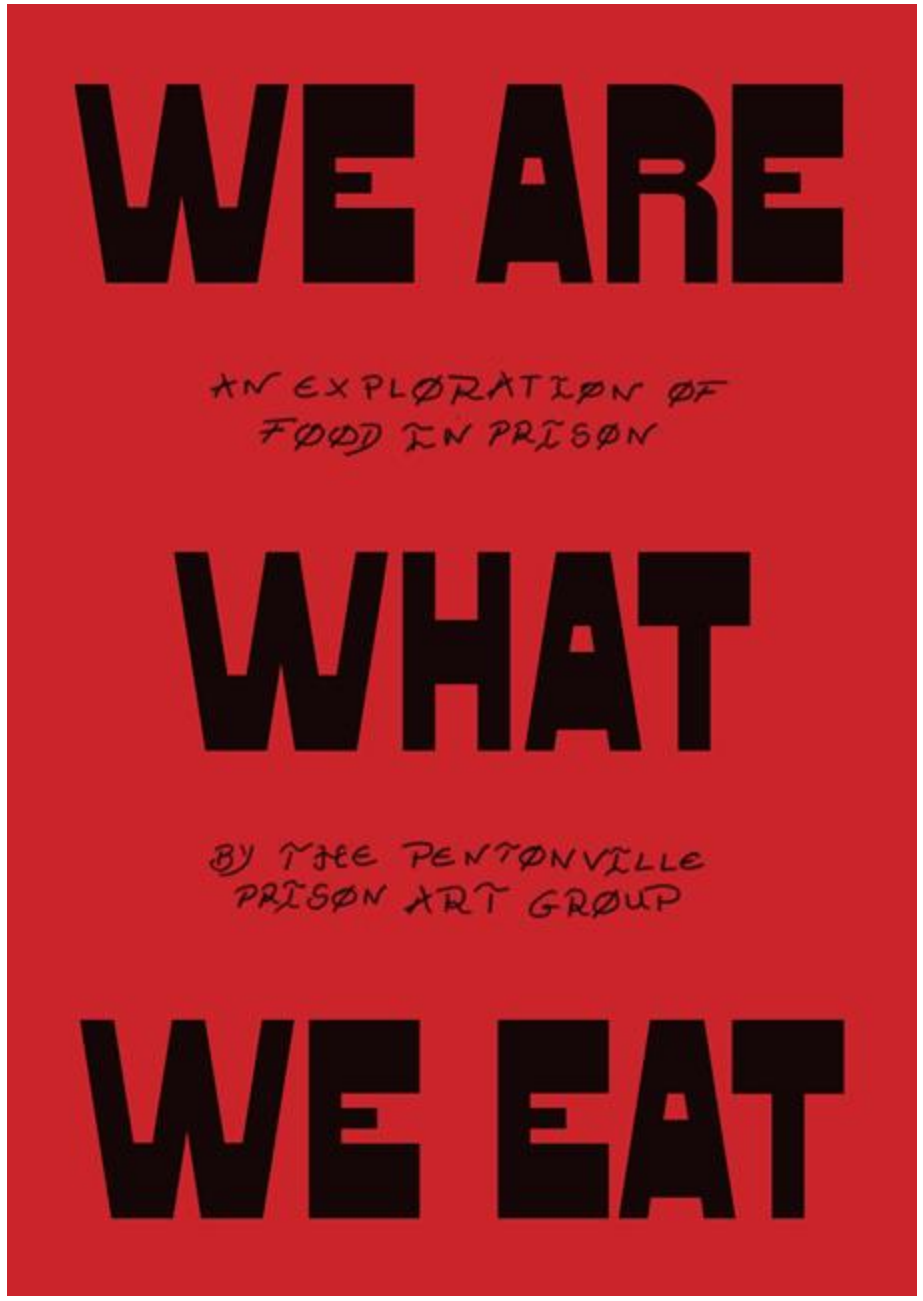
Keynote Presentation

Guy Atkins

Artist-researcher



An exploration of food in prison by the Pentonville Prison Art Group

Guy Atkins
Artist-researcher


FREE ENTRY
Docklands open Monday-Sunday, 10am-5pm
Plan your visit
For families
For schools
Collections
MUSEUM OF LONDON
Museum of London Docklands
Museum of London
West Smithfield
Discover
Shop
Support us
Account
MILK
CANT COOK
FOOD POLICE...
STARVO
NUMBER
Jail
Chick
'We Are What We Eat': an exploration of food in prison


DO NOT SPLIT
10 Books
Ref. EX104
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Reading Room Companion
a rare and valuable COLLECTION of diverse CURIOSITIES
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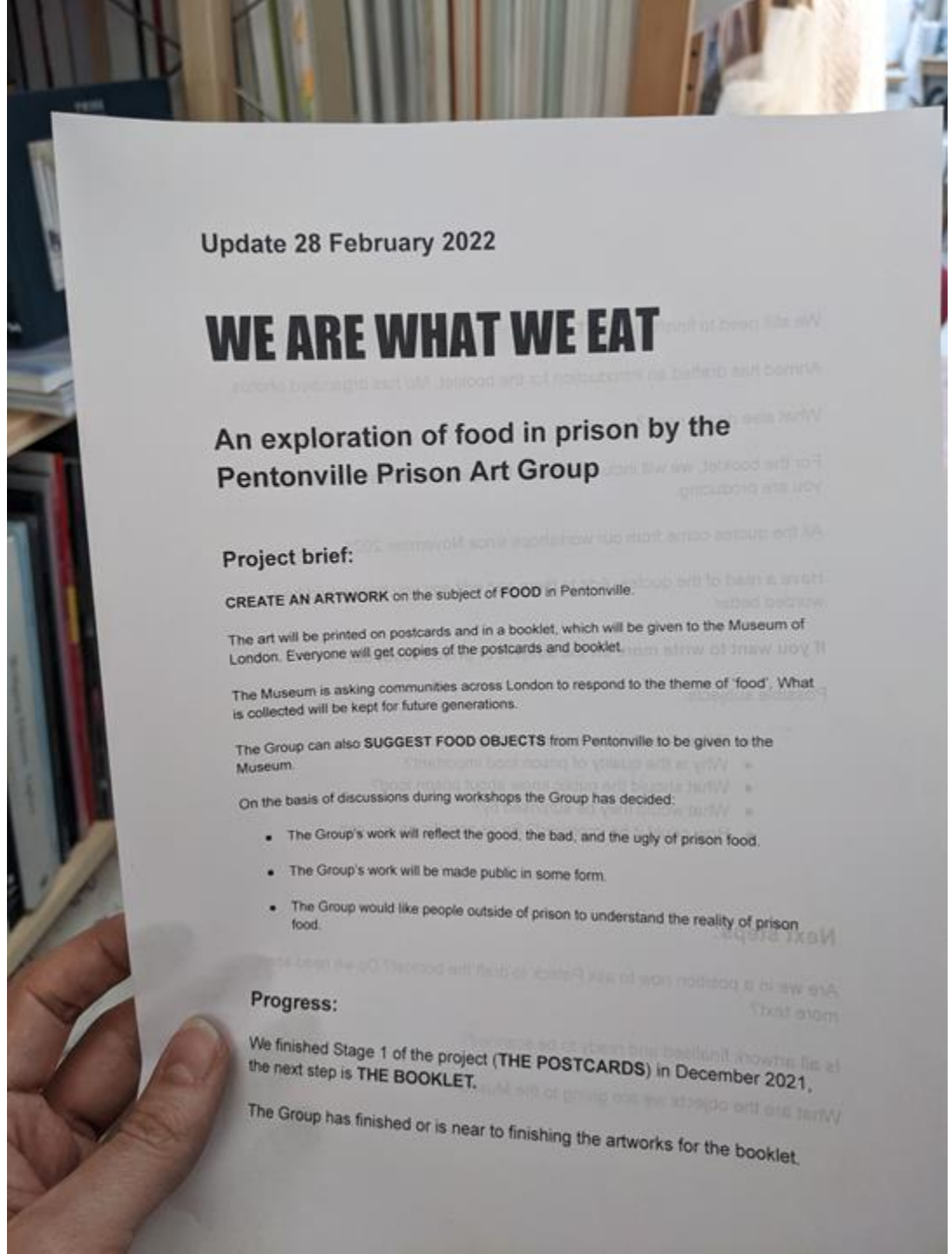
The Days and Nights of London Now – As Told by Those Who Love It, Hate It, Live It, Left It and Long for It
LONDONERS
CRAIG TAYLOR
MUSEUM OF LOND
POST CARD



Update 28 February 2022

WE ARE WHAT WE EAT

An exploration of food in prison by the Pentonville Prison Art Group

Project brief:

CREATE AN ARTWORK on the subject of **FOOD** in Pentonville.

The art will be printed on postcards and in a booklet, which will be given to the Museum of London. Everyone will get copies of the postcards and booklet.

The Museum is asking communities across London to respond to the theme of 'food'. What is collected will be kept for future generations.

The Group can also **SUGGEST FOOD OBJECTS** from Pentonville to be given to the Museum.

On the basis of discussions during workshops the Group has decided:

- The Group's work will reflect the good, the bad, and the ugly of prison food.
- The Group's work will be made public in some form.
- The Group would like people outside of prison to understand the reality of prison food.

Progress:

We finished Stage 1 of the project (**THE POSTCARDS**) in December 2021, the next step is **THE BOOKLET.**

The Group has finished or is near to finishing the artworks for the booklet.

Project Food: We Are

Dear Ahmed,

I was really disappointed not to be abl
person. I hope you like them. I think th
reflect a lot of what we've spoken abou
forward to hearing your thoughts on th

Before we meet next time, have a think
to go, where they should go on display
Pentonville and outside. Are there plac
go on display as a set?

Now we've finished the postcards, we
BOOKLET.

Above all, keep producing the artwo
the better the booklet will be. I like that
styles, still life sketches, drawings of p
word art, documentary, surreal.

But we also need to think about **TEXT**.

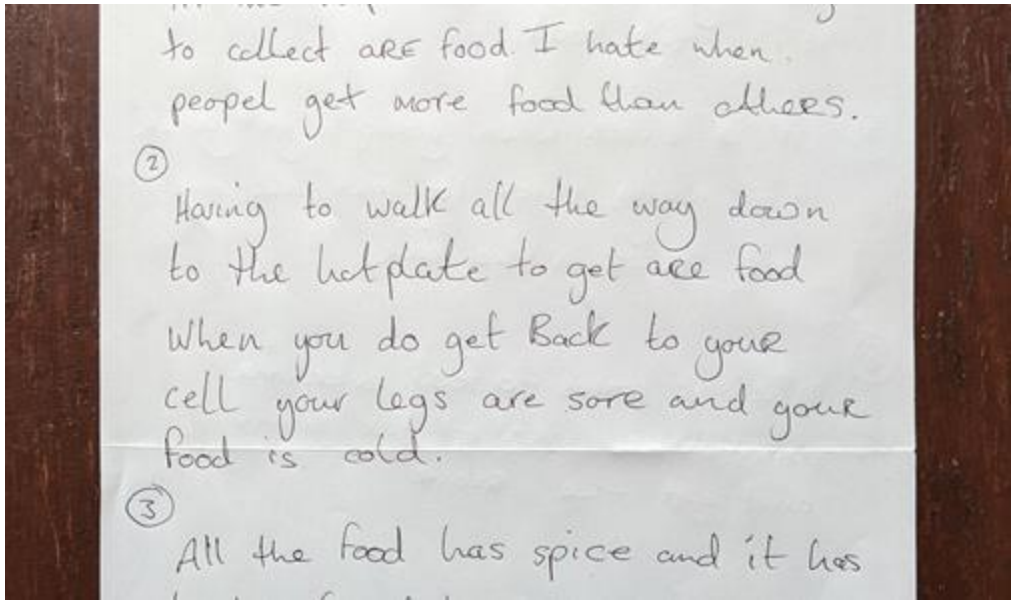
On the next pages are some of the the
far on food in Pentonville.

For the booklet, it would be good to inc
you are producing.

The quotes will help the booklet be as
ideas about prison and food:

- The quotes can be anonymous.
- They can relate to the images yo
topic

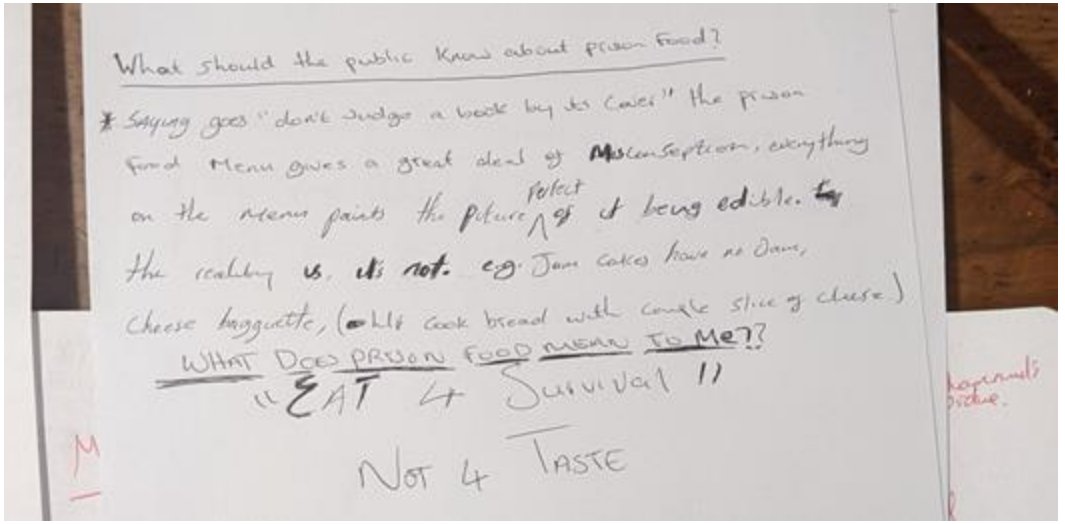
(THE THINKER OF NEWTON)



to collect are food I hate when peopel get more food than others.

(2) Having to walk all the way down to the hotplate to get ace food When you do get Back to your cell your legs are sore and your food is cold.

(3) All the food has spice and it has



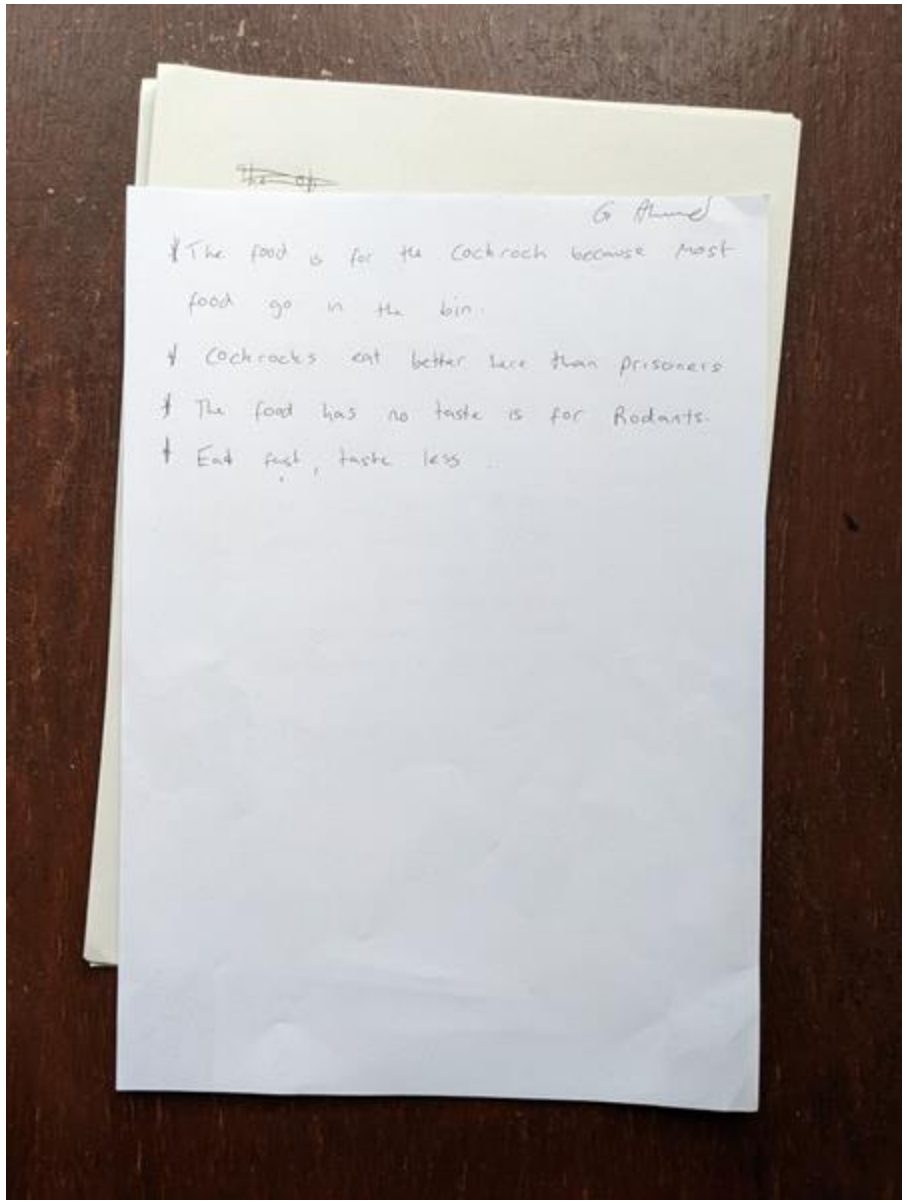
What should the public Know about prison Food?

* Saying goes "don't judge a book by its Cover" the prison Food Menu gives a great deal of Misconception, everything on the menu paints the picture Reflect of it being edible. The the reality is, it's not. eg. Jam cakes have no Jam, Cheese baguette, (we'll cook bread with couple slice of cheese)

WHAT DOES PRISON FOOD MENU TO ME??

"EAT 4 SURVIVAL"

NOT 4 TASTE



G Ahmed

* The food is for the cockroach because most food go in the bin.
* Cockroaches eat better here than prisoners
* The food has no taste is for Rodents.
* Eat fast, taste less


ANIMAL
Science
000s
Information
Computing
Philosophy
100s
Religion
200s
300s
400s
WE ARE
WHAT
WE EAT
WE ARE
WHAT
E EAT

“They say a picture speaks a thousand words. If only my taste buds could paint a picture.”

Ahmed M

Download ‘**We Are What We Eat**’ from https://www.museumoflondon.org.uk/discover/we-are-what-we-eat-food-prison

or email me at **guyatkins@gmail.com**

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RCGP

Chairs Closing Address for Plenary Sessions

Dr Sunil Lad

National Clinical Director for Health and Justice - NHS England

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Lunch, Networking & Refreshments

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RC GP

Keynote Presentation

Professor Harry Kennedy

Consultant forensic psychiatrist, Professor of Forensic Psychiatry - Trinity College Dublin

CONVENZIS

Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

The Place of Prison Mental Health Services in the National Model of Care

Harry Kennedy, Professor of Forensic Psychiatry, Trinity College Dublin;
Hon. Skou Professor of Forensic Psychiatry, University of Aarhus, Denmark;
Hon. Visiting Professor of Forensic Psychiatry, University of Bari 'Aldo Moro', Italy.

The Place of Prison Mental Health Services in the National Model of Care

How we deliver planned purposeful health services is increasingly set out in written, structured models of care. Goals, pathways and processes, treatment delivery and evaluation are the four essential elements of a model of care.

The history of forensic psychiatry and mental health in prisons is currently in the form of custom and practice shaped by reports, commissions and inquiries dating back to Butler amongst many.

What has been achieved? For prisons, the emphasis has been almost exclusively on diversion. But the incidence and prevalence of severe mental illnesses in prisons remains unchanged or incressed.

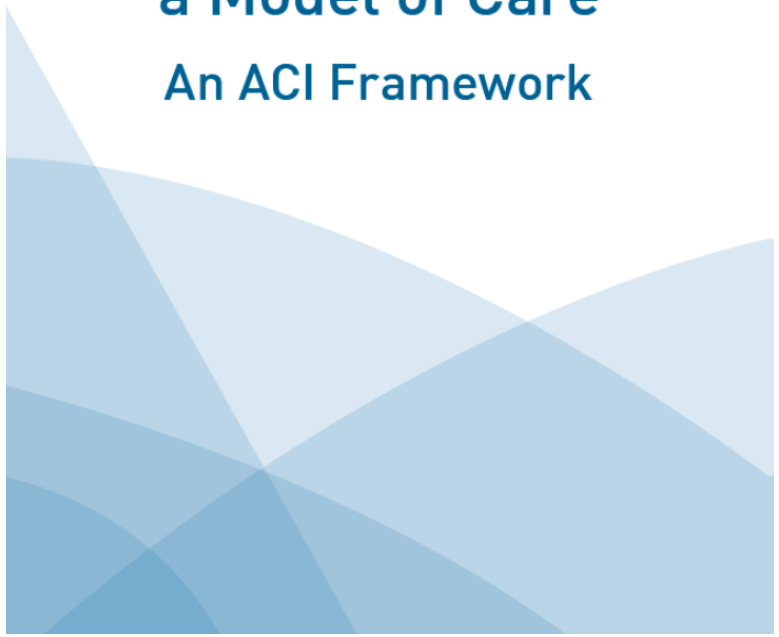
What is the situation in other countries?

What is the de facto ‘custom and practice’ model of care for psychiatric and mental health services in prisons now?

What should it be for the future?

Models of Care: definition

- **A "Model of Care" broadly defines the way health services are delivered. It outlines best practice care and services**
- for a person, population group or patient cohort as they progress through the stages of a condition, injury or event.
- It aims to ensure people get the right care, at the right time, by the right team and in the right place
- Often includes a 'logic model' relating inputs (resources) to 'outputs' (health gains)

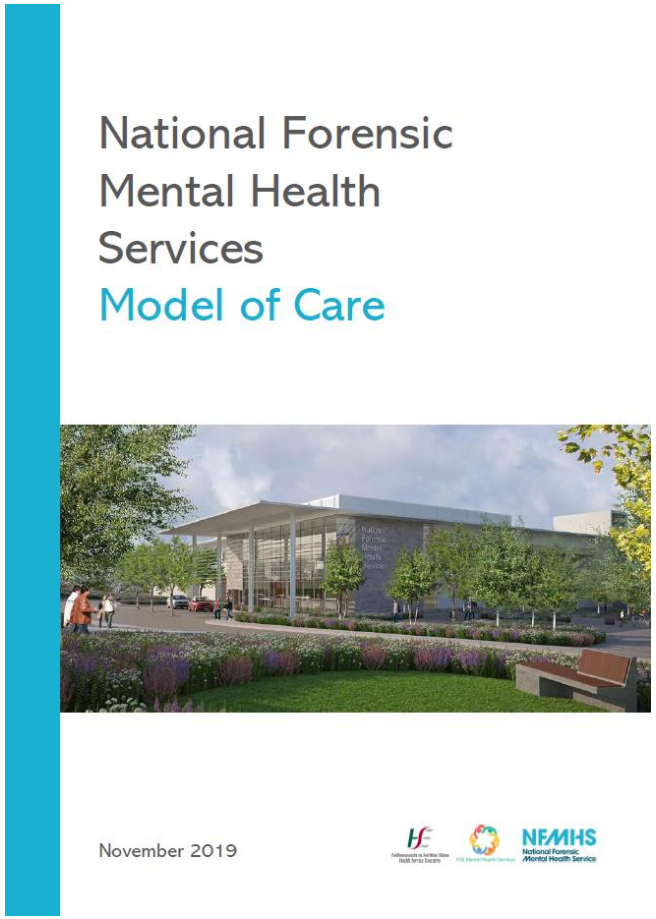


A National Model of Care?

Model of Care

- 13,000 words
- Plain English
- To be read by all staff e.g. during induction
- All policies, procedures and guidelines must be compatible
- All parts of the system are inter-dependent
- “If you can’t measure it, you can’t see it or it doesn’t exist” Chris Webster

- Not a brochure for patients or their families
- Not a contract document



Model of Care

1. Goals not Principles
2. Pathways and processes
3. Treatments
4. Evaluation and logic models

History of current custom and practice in prison psychiatric / mental health services

Victorian inquiries

Glancy & Butler (1975) – medium secure units
Reed (1992) – diversion

A Time of Change

Psychiatry or mental health?
Psychiatry or neurology?
Psychiatry or metabolic medicine / gerontology?

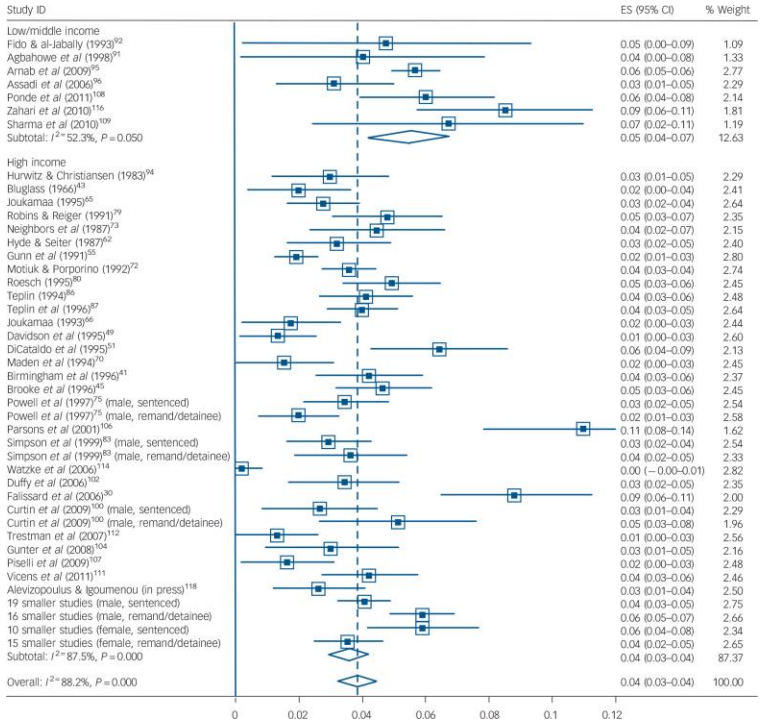
Goals

To divert everyone with a severe mental illness from the criminal justice system to mental health services

even if the offending is not related to severe mental illness?
even if mental responsibility is not reduced
Personality disorder?
Substance misuse and intoxication?
Too vulnerable for prison
too disruptive for prison?
Mental illness is not ‘severe’?
mental illness is not treatable?

Diversion as primary goal for a model of psychiatric care in prisons….

Has Failed



Seena Fazel and Katharina Seewald 2018

Our main findings were that rates of psychosis in prisoners were significantly higher in low- and middle-income countries than in high-income ones (5.5% in low–middle- *v.* 3.5% in high-income nations).

Contrary to expert opinion, [119] there were no significant differences in rates of psychosis and depression between male and female prisoners or between detainees (or remand) and sentenced prisoners.

In the 17 US samples included, there appeared to be an increasing prevalence of depression over the 31 years covered by these particular studies (1974–2005).

In addition, we found no differences in depression rates between men and women, detainees (or remand) and sentenced prisoners, or other study characteristics that may have explained heterogeneity.

The overall prevalences of 3.7% of male and female prisoners with a psychotic illness, and 11.4% with major depression have not materially changed since a 2002 review based on 56 publications of mental illness

The pooled percentage for psychotic disorder was 3.6% [95% confidence interval (CI) 3.0–4.2%], for affective disorder 4.3% (95% CI 2.1–7.1%), for alcohol use disorder 28.3% (95% CI 19.9–37.4%), for substance use disorder 50.9% (95% CI 37.6–64.2%)

THE LANCET
Global Health

ARTICLES | VOLUME 7, ISSUE 4, E461-E471, APRIL 2019

Severe mental illness and substance use disorders in prisoners in low-income and middle-income countries: a systematic review and meta-analysis of prevalence studies

Gergő Baranyi, MPH • Carolin Scholl, MSc • Seena Fazel, FRCPsych • Vikram Patel, PhD • Stefan Priebe, FRCPsych • Adrian P Mundt, PhD

We identified 23 publications reporting prevalence estimates of severe mental illness and substance use disorders for 14 527 prisoners from 13 LMICs. In this population, the estimated pooled 1 year prevalence rates for psychosis were 6·2% (95% CI 4·0–8·6), 16·0% (11·7–20·8) for major depression, 3·8% (1·2–7·6) for alcohol use disorders, and 5·1% (2·9–7·8) for drug use disorders. We noted increased prevalence at prison intake and geographic variations for substance use disorders. For alcohol use disorders, prevalence was higher in the southeast Asian region than in the eastern Mediterranean region; and drug use disorders were more prevalent in the eastern Mediterranean region than in Europe. Prevalence ratios indicated substantially higher rates of severe mental illness and substance use disorders among prisoners than in the general population (the prevalence of non-affective psychosis was on average 16 times higher, major depression and illicit drug use disorder prevalence were both six times higher, and prevalence of alcohol use disorders was double that of the general population).

Scientific Modelling in Clinical Practice

2. Covid-19, SARS-CoV-2 and The Emergency.

Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand

Neil M Ferguson, Daniel Laydon, Gemma Nedjati-Gilani, Natsuko Imai, Kylie Ainslie, Marc Baguelin, Sangeeta Bhatia, Adhiratha Boonyasiri, Zulma Cucunubá, Gina Cuomo-Dannenburg, Amy Dighe, Ilaria Dorigatti, Han Fu, Katy Gaythorpe, Will Green, Arran Hamlet, Wes Hinsley, Lucy C Okell, Sabine van Elsland, Hayley Thompson, Robert Verity, Erik Volz, Haowei Wang, Yuanrong Wang, Patrick GT Walker, Caroline Walters, Peter Winskill, Charles Whittaker, Christl A Donnelly, Steven Riley, Azra C Ghani.

On behalf of the Imperial College COVID-19 Response Team

WHO Collaborating Centre for Infectious Disease Modelling
MRC Centre for Global Infectious Disease Analysis
Abdul Latif Jameel Institute for Disease and Emergency Analytics
Imperial College London

Correspondence: neil.ferguson@imperial.ac.uk

Summary

The global impact of COVID-19 has been profound, and the public health threat it represents is the most serious seen in a respiratory virus since the 1918 H1N1 influenza pandemic. Here we present the results of epidemiological modelling which has informed policymaking in the UK and other countries in recent weeks. In the absence of a COVID-19 vaccine, we assess the potential role of a number of public health measures – so-called non-pharmaceutical interventions (NPIs) – aimed at reducing contact rates in the population and thereby reducing transmission of the virus. In the results presented here, we apply a previously published microsimulation model to two countries: the UK (Great Britain specifically) and the US. We conclude that the effectiveness of any one intervention in isolation is likely to be limited, requiring multiple interventions to be combined to have a substantial impact on transmission.

requirements would remain within surge capacity.

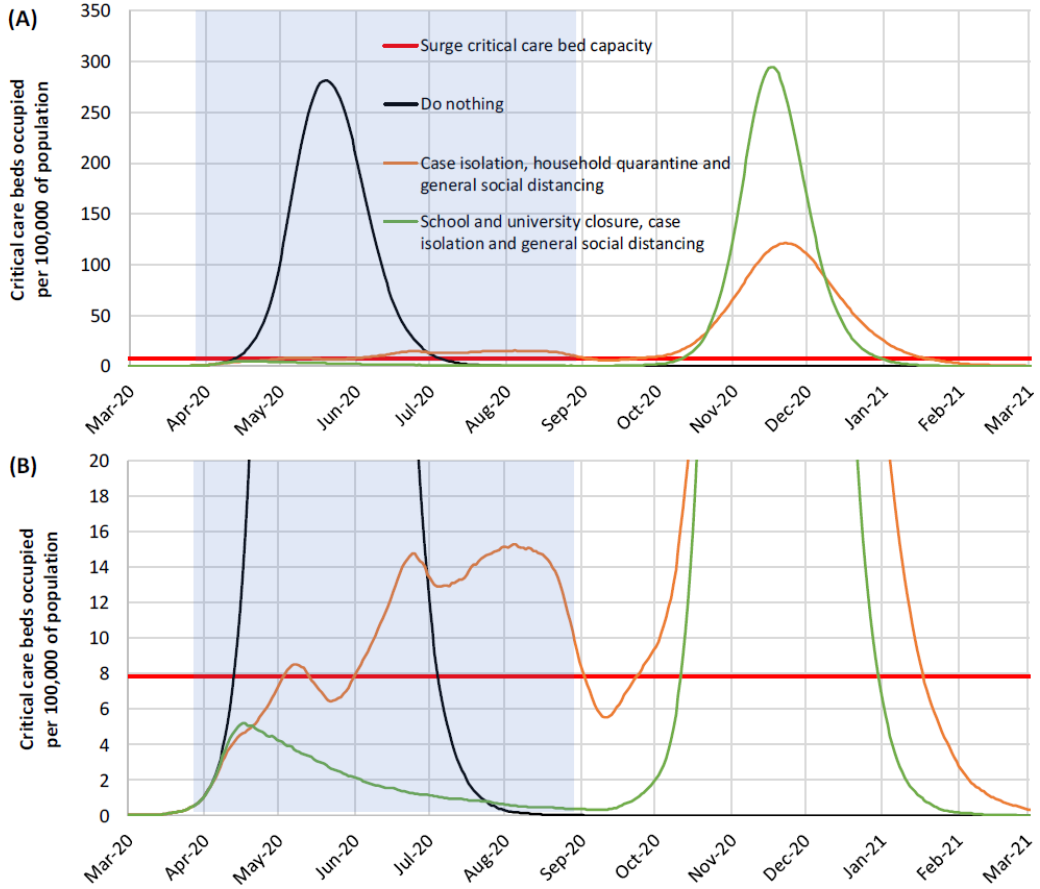


Figure 3: Suppression strategy scenarios for GB showing ICU bed requirements. The black line shows the unmitigated epidemic. Green shows a suppression strategy incorporating closure of schools and universities, case isolation and population-wide social distancing beginning in late March 2020. The orange line shows a containment strategy incorporating case isolation, household quarantine and population-wide social distancing. The red line is the estimated surge ICU bed capacity in GB. The blue shading shows the 5-month period in which these interventions are assumed to remain in place. (B) shows the same data as in panel (A) but zoomed in on the lower levels of the graph. An equivalent figure for the US is shown in the Appendix.

DOI: https://doi.org/10.25561/77482

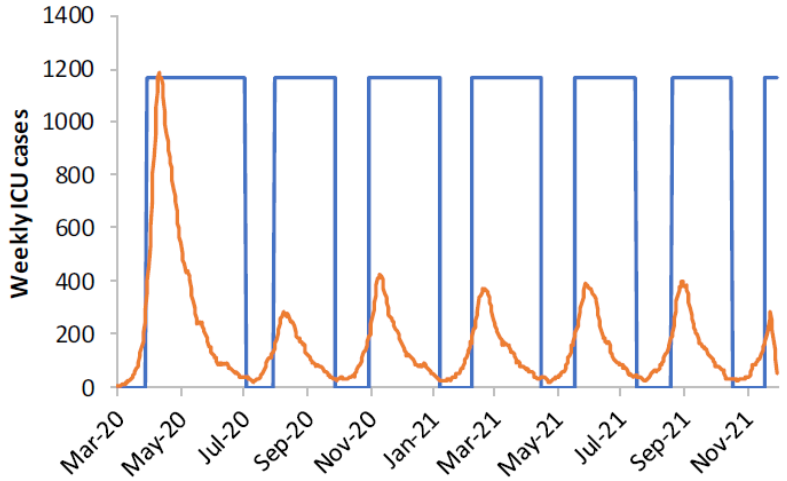
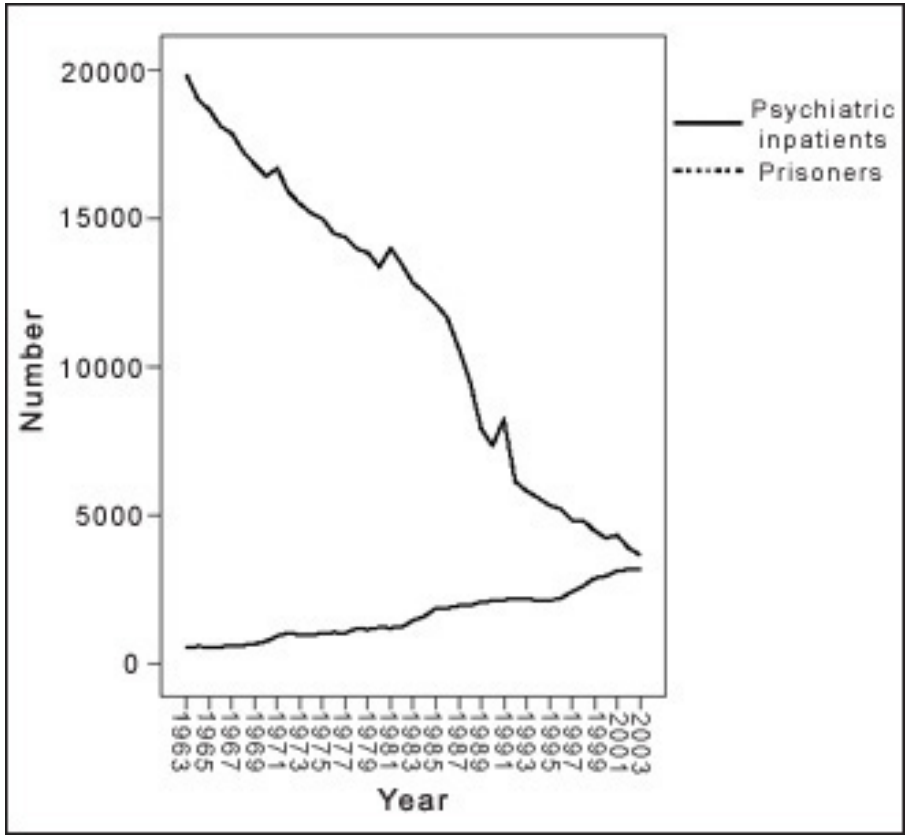


Figure 4: Illustration of adaptive triggering of suppression strategies in GB, for R_0=2.2, a policy of all four interventions considered, an "on" trigger of 100 ICU cases in a week and an "off" trigger of 50 ICU cases. The policy is in force approximate 2/3 of the time. Only social distancing and school/university closure are triggered; other policies remain in force throughout. Weekly ICU incidence is shown in orange, policy triggering in blue.



Number of psychiatric in-patients and prisoners in Ireland, 1963-2003.

Kelly B. Penrose's 'Law' in Ireland: An Ecological Analysis of Psychiatric Inpatients and Prisoners. Ir Med J. 2007 Feb;100(2):373-4

Dynamic Data 1983-2013-Ireland: General Psychiatric Admissions vs Prison Committals

C O'Neill et al

Endemic modelling

An infectious disease is said to be endemic when it can be sustained in a population without the need for external inputs. This means that, on average, each infected person is infecting exactly one other person (any more and the number of people infected will grow sub-exponentially and there will be an epidemic, any less and the disease will die out). In mathematical terms, that is:

$$R_0 S = 1.$$

Ultra High Risk of Psychosis

Pat McGorry et al, Origen Service, Melbourne
Stage schizophrenia in the way that oncologists stage cancer
Stage 0 = ultra high risk – intervene to prevent or at least defer onset.
All research concerns ‘help-seekers’

Special issue: youth mental health. March 2015

Flynn et al. BMC Psychiatry 2012, 12:100
http://www.biomedcentral.com/1471-244X/12/100

BMC Psychiatry

RESEARCH ARTICLE Open Access

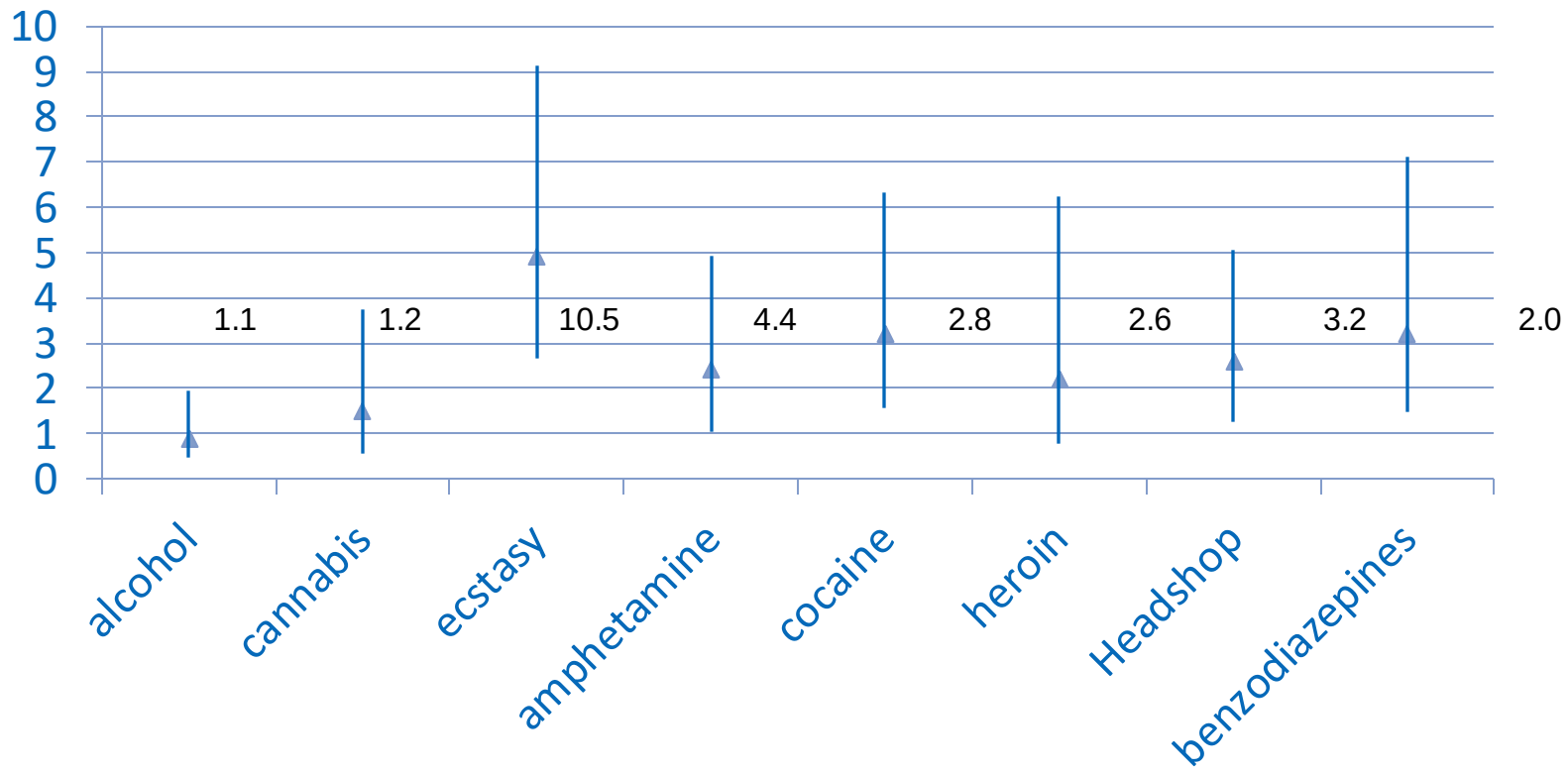
Ultra high risk of psychosis on committal to a young offender prison: an unrecognised opportunity for early intervention

Darran Flynn[1], Damian Smith[1], Luke Quirke[1], Stephen Monks[1] and Harry G Kennedy[1,2*]

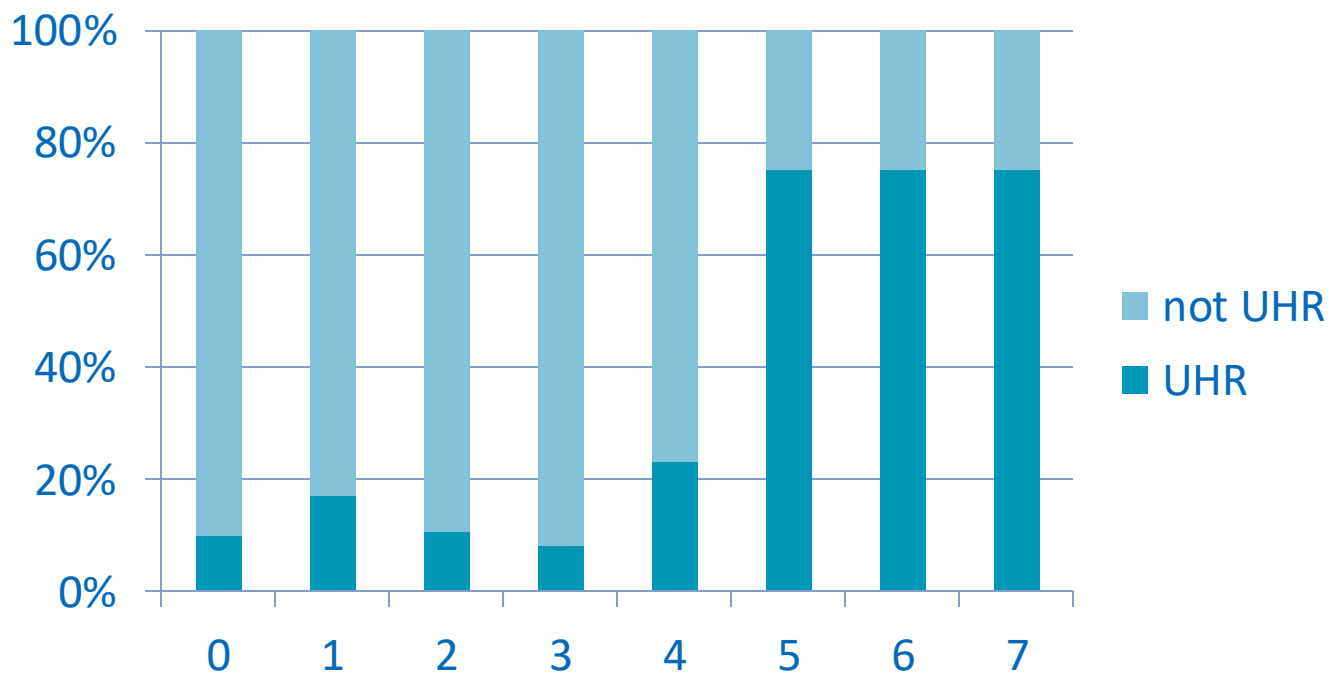
Abstract

Background: The ultra high risk state for psychosis has not been studied in young offender populations. Prison populations have higher rates of psychiatric morbidity and substance use disorders. Due to the age profile of young offenders one would expect to find a high prevalence of individuals with pre-psychotic or ultra-high risk mental states for psychosis (UHR). Accordingly young offender institutions offer an opportunity for early interventions which could result in improved long term mental health, social and legal outcomes. In the course of establishing a mental health in-reach service into Ireland's only young offender prison, we sought to estimate unmet mental health needs.

Methods: Every third new committal to a young offenders prison was interviewed using the Comprehensive Assessment of At-Risk Mental States (CAARMS) to identify the Ultra High Risk (UHR) state and a structured interview for assessing drug and alcohol misuse according to DSM-IV-TR criteria, the Developmental Understanding of Drug



Relative Risk (95% CI) for UHR psychosis



Number of ‘problem use’ substances

Conjecture

Psychosis in sentenced prisons is a stable equilibrium $R_0S=1$

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Psychosis prevalence in prisons is the equilibrium between susceptibility (UHR) and exposure to

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(b) Violence threat of violence (which is also related to drugs in prison
Diversion cannot reduce it

SCREENING AT POINT OF RECEPTION

The major intervention should be education about drugs and alcohol.

A drug-free environment is essential –

A violence free environment is essential

Mental health education, motivational counselling and cycle of change work

.

Prevent homelessness on release.

Community follow-up programmes – social care.

Interventions for UHR

A right to a drug-free environment for those who want it.
A duty of care to all – prevent deaths from accidental overdose.
A progressive programme -

- Culture change by ‘nudging’ – prevent spread of misuse and addiction
- Incentivise those who volunteer for a drug-free wing – privileges, remission.
- Prosecute those who bring drugs in.
- Secure perimeters.
- Closed visits

Drug Free Prisons

1. **Screening:** Are all new remands screened on committal? How long does it take?
2. **Identification:** Identify major mental illness in keeping with expected rates?
3. **Diversion:** Is healthcare arranged in appropriate locations? How long does it take? Is this the best use of resources?
4. **Efficiency:** Ratio of assessments to psychosis cases and diversion outcomes
5. **Acts of Self Harm**: Data collection and audit
6. **Risk-Need Responsivity:** Are diversion outcomes appropriate in terms of risk and clinical need?
7. **Mapping:** Are all patients accounted for? “Counting in, counting out”.

Outcome Standards:

Health services are not an alternative to criminal justice (don't medicalise normality).

Diversion for all mentally ill is not possible; diversion for severe mental illness has failed.

An opportunity for public health interventions aimed at screening and active engagement in a high risk group

An obligation to 'nudge' towards mental health
A duty of care to keep safe from drug use and drug culture (preventing death by accidental overdose and suicide)

Preventing schizophrenia is NOT on offer in the present state of knowledge, but lessening the disability is.

Juvenile Justice: an opportunity and a duty of care

Pathways 1

Psychiatry will merge back into neurology, metabolic medicine, public health, primary care. Value: excellence – continuously improving outcomes.

Mental Health Legislation progressively raises the threshold for involuntary detention and treatment.

Mental Health Legislation makes it progressively less easy to prevent violence by means of restrictive practices – seclusion, restraint, medication without consent.

Secure hospitals have lower staff to patient ratios, lower skills mix and more violence by patients against patients and by patients against staff.

Secure hospitals are filling with long term slow-stream patients. Quality of life not better outcomes.

Pathways 2

Prisons – never more populous. Value good order and discipline.

Decades of diversion have not reduced the prevalence of psychosis, drug misuse or rates of suicide.

Prisons have lower staff to patient ratios and higher rates of violence by inmates against inmates and by inmates against custodial staff.

Precision medicine and personalised medicine: Excellence and hope

At Risk Mental States – staging

Drug Induced Psychoses – largest effect sizes.

Schizophrenia and bi-polar disorder – scientific progress for hope

Neurodegenerative disorders – Genetic e.g. Huntington's, Alzheimer's, Vascular Cognitive Impairment, Parkinsonism, Post-viral / retroviral, Post-concessional, Alcohol related, drug-related

Reformed Prisons

Violence free

Drug free

Address psychological and personal resilience

Motivational work to end cycles of domestic violence
- sobriety
- education and occupational training

Culture and dignity – e.g. New Zealand & Canada first nations projects – for all

Future Prison Model of Care:
Goalsvfor a model of care

1. Respect for rights and dignity
2. Intoxicant free
3. Violence free
4. Restore normal life expectancy and general health
5. Build resilience – self-actualisation and self-transcendence

Future Prison Model of Care: Pathways

1. Stratified therapeutic security to prevent violence

2. Incentivise sobriety and peaceful behaviour

3. Divert to psychiatric services only for acute treatment – then return to safe ‘landing pads’ and fixed tariffs

4. Divert to community measures only while successful – sober / clean, non-violent, adherent to conditions.

5. Dangerous offenders dealt with under criminal law, not mental health law.

Future Prison Model of Care: Treatment

1. Psychiatric treatment will be increasingly biological and successful – for mental illnesses.

2. Psychological treatments must be goal directed and must demonstrate effectiveness.

3. Social supports are the bed rock of any treatment plan – housing first, sober / clean, primary care and benefits, education and occupational training

Future Prison Model of Care: Evaluation

Logic model

– Resources in, health gains out
- Resources in, social gains out?

Hermes, the messenger

Hermenoia –
blaming the messenger!

Seminars

Close of Day 2