10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RC GP

Day 2

CONVENZIS

10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RC GP

See today's Agenda here:

CONVENZIS

Chairs Opening Address

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

10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RC GP

Please scan the QR Code on the screen.
This will take you through to Slido, where you can interact with us.

SCAN ME

CONVENZIS

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

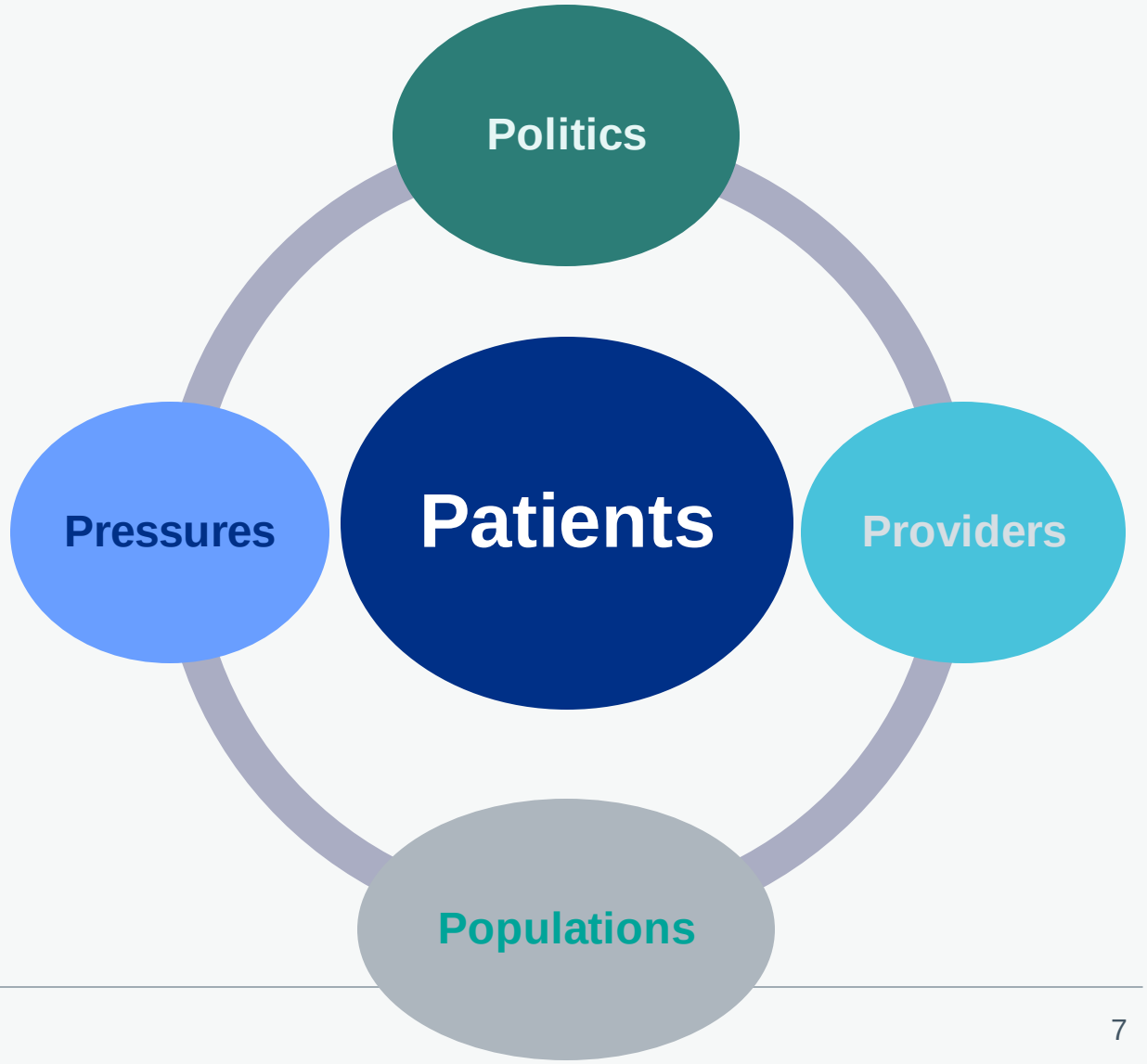
Health and justice: what's happening?

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

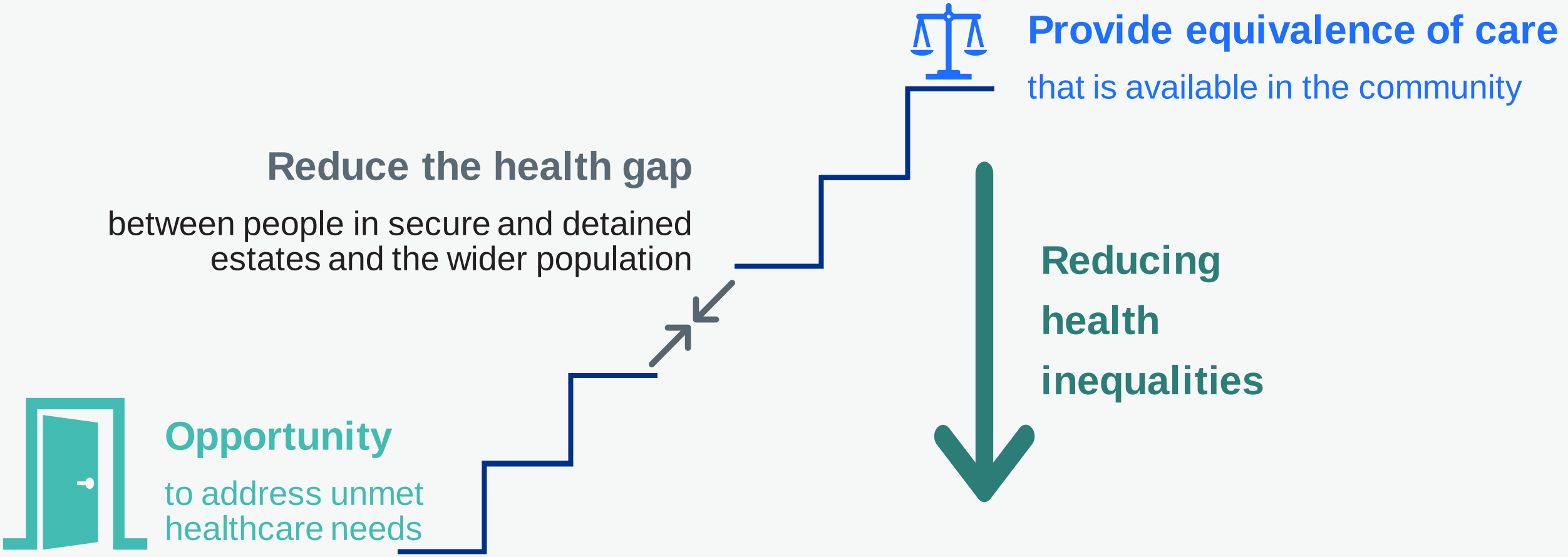
to improve access to equitable healthcare

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

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

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

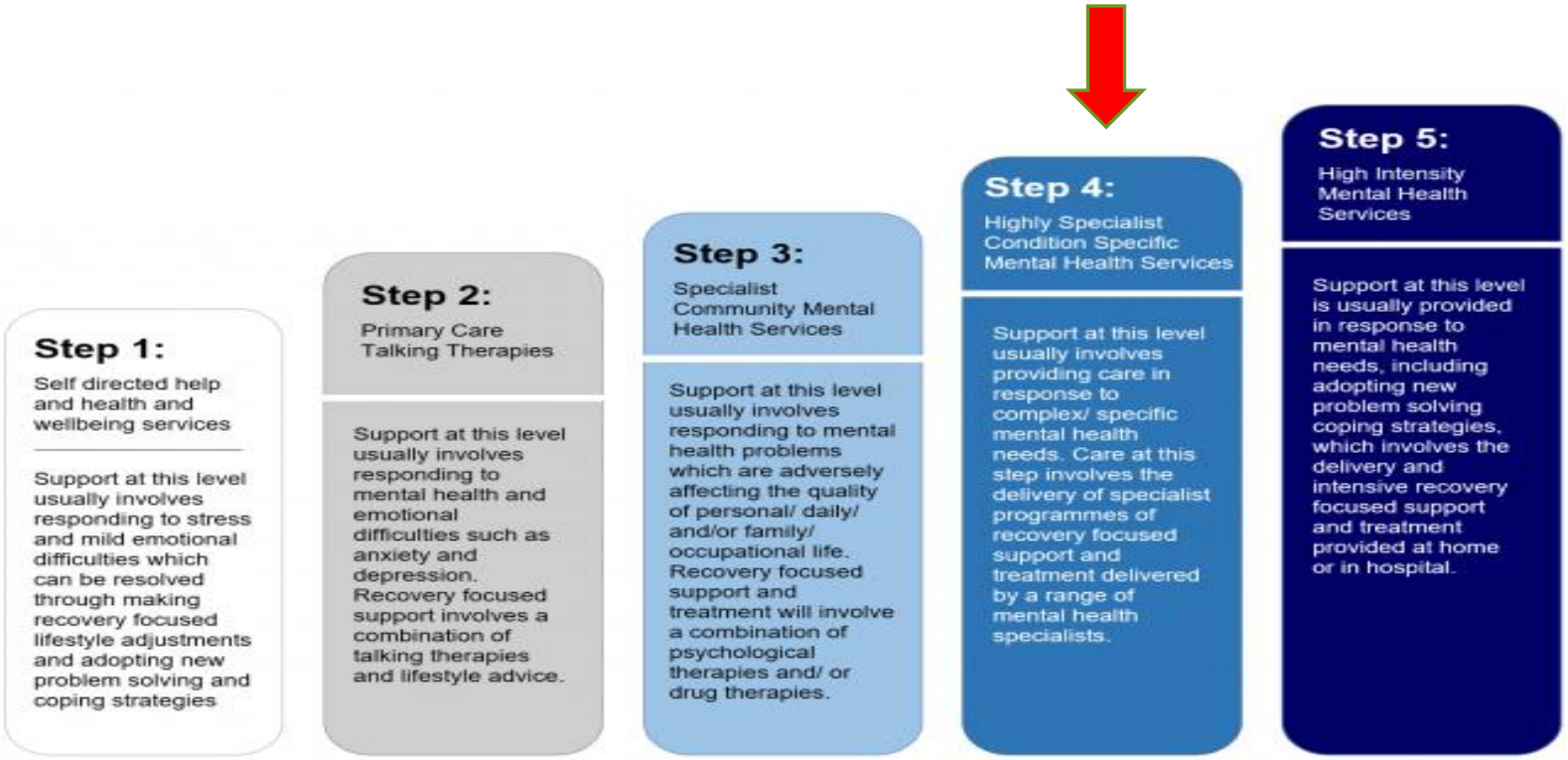
FCAMHSNI is a regional service (ie covers all 5 HSCT's)

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

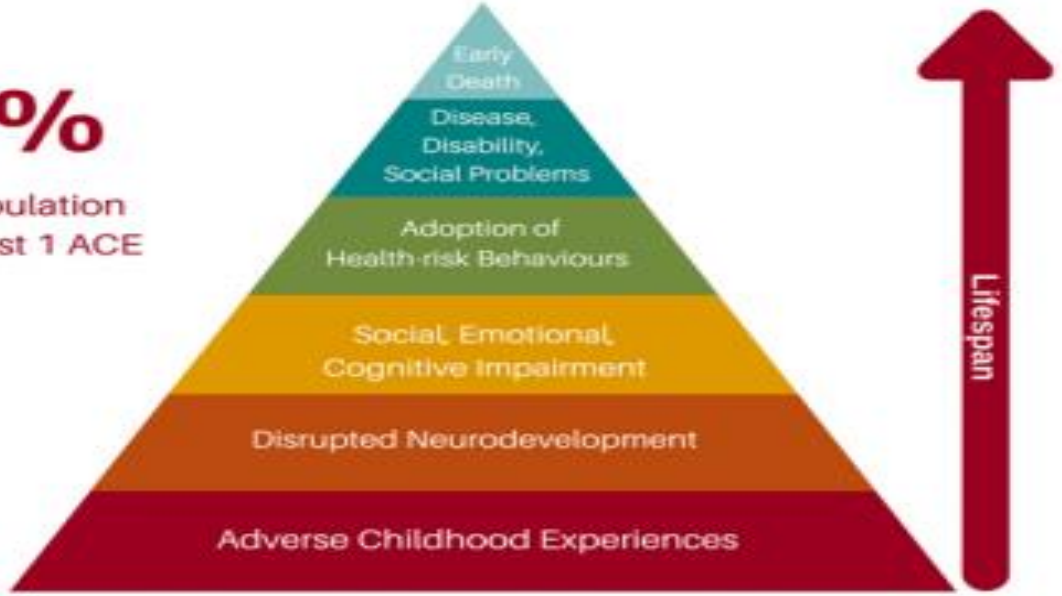
4 or more ACEs

- **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

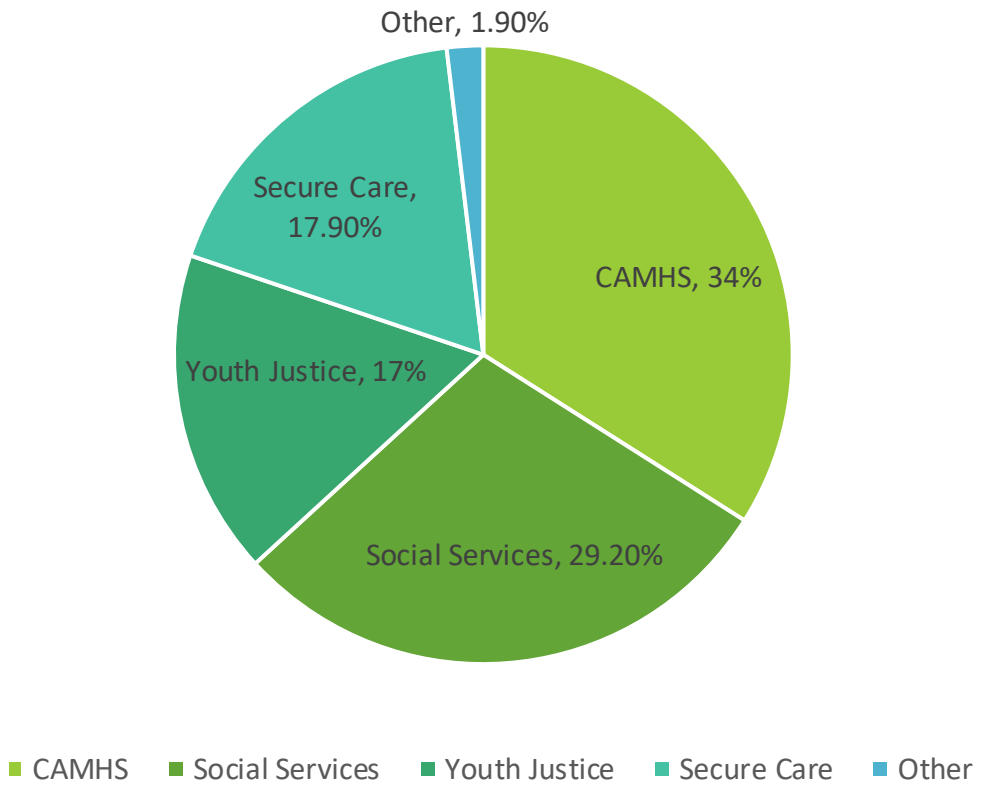
Results

- 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

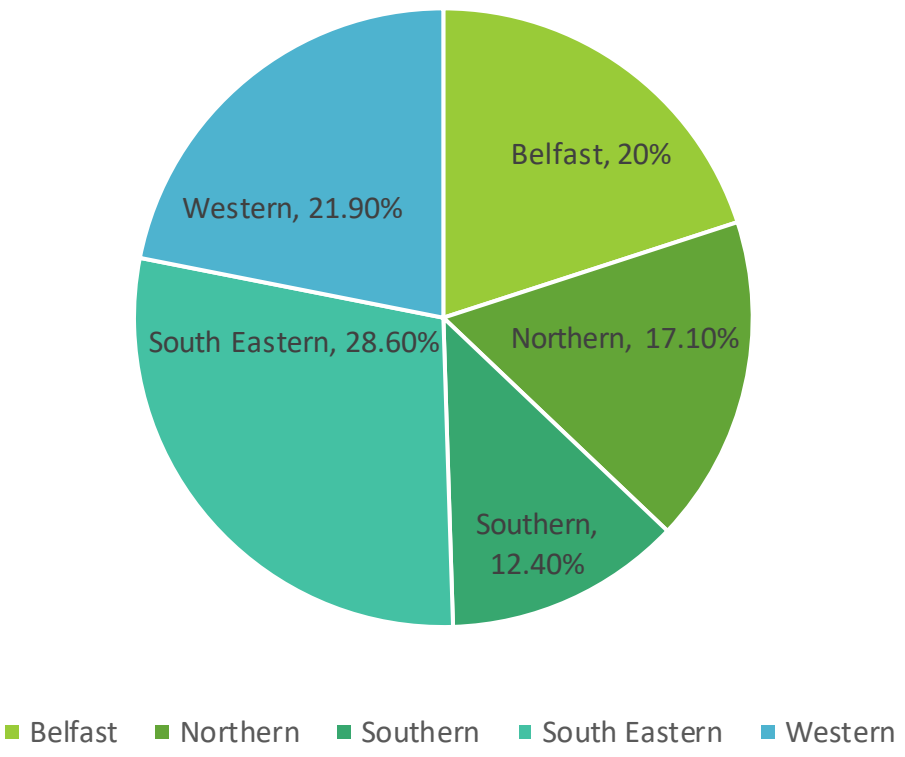
Results

- 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

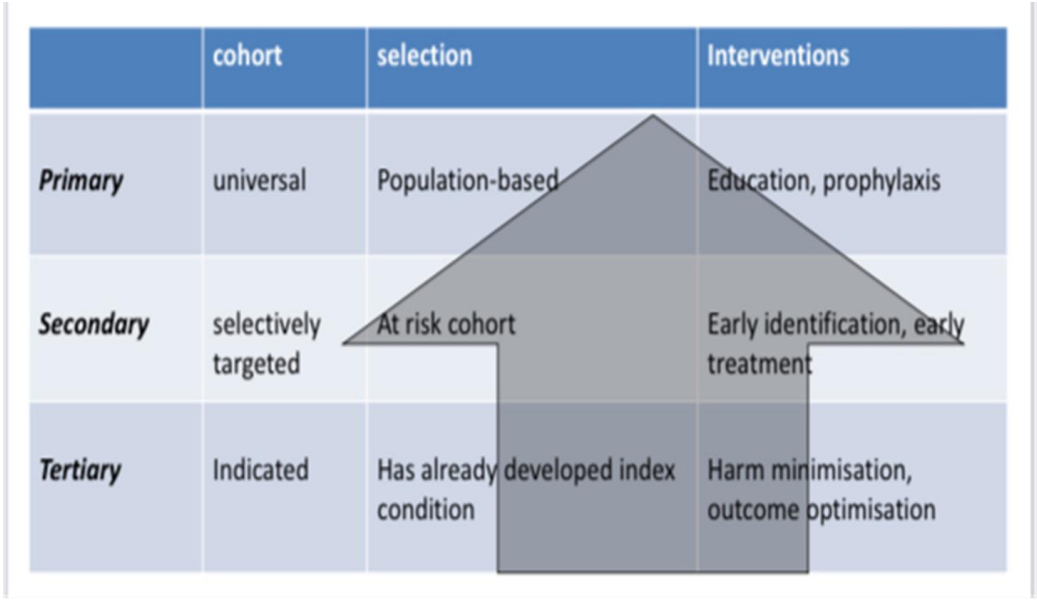
- 26% of NHS England referrals led to direct case input. FCAMHSNI direct case input is currently limited due to resources and service operates largely on a consultative model. Plan for review of this and development of more direct assessment /intervention work to align with NHS England.

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]

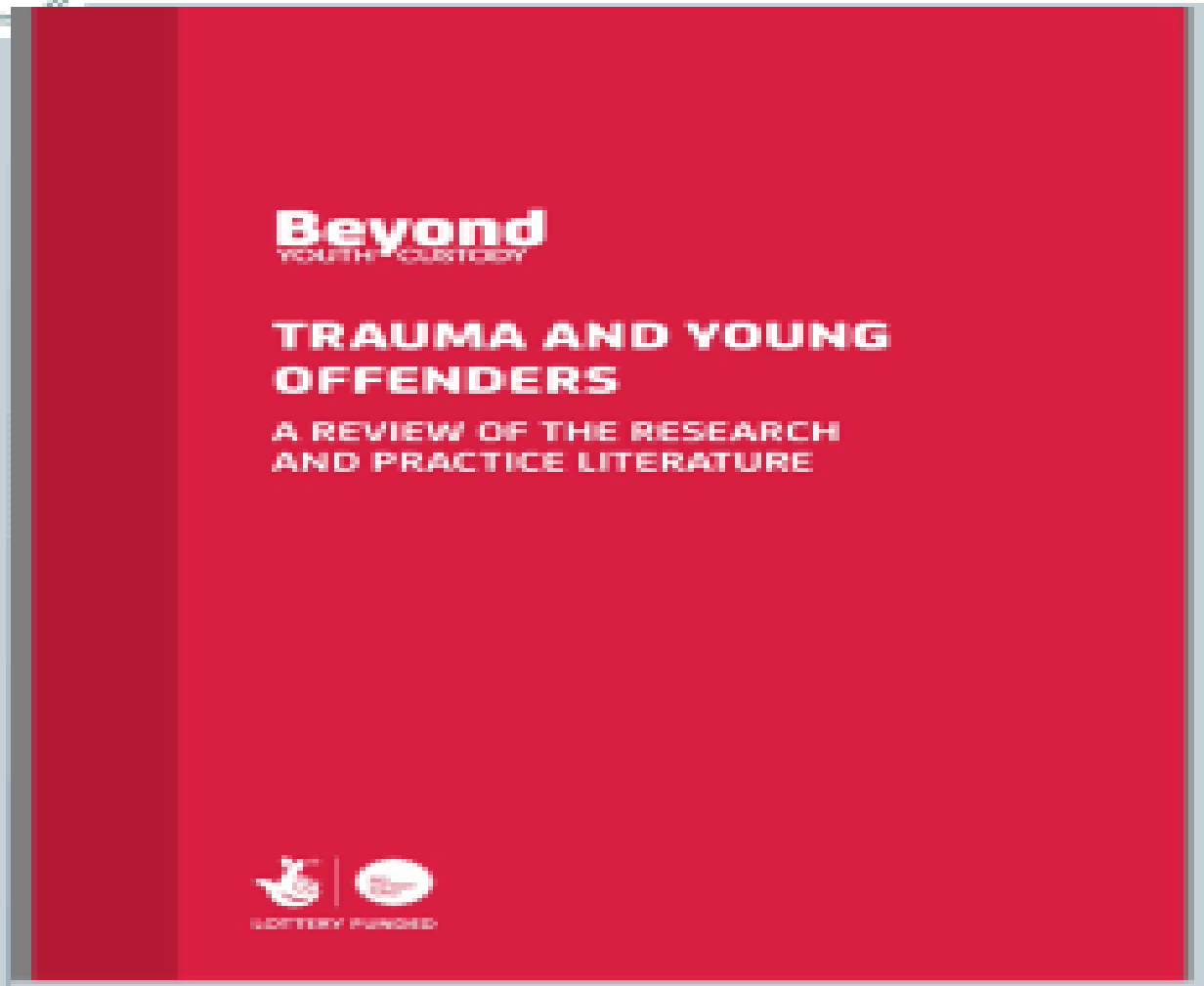
Poor parenting and family dysfunction explains up to 40% of problematic behaviour in children, indicating a need to focus predominantly on strengthening parenting skills and on building the child's resilience [Khan, 2010]

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!

10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RC GP

CONVENZIS

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

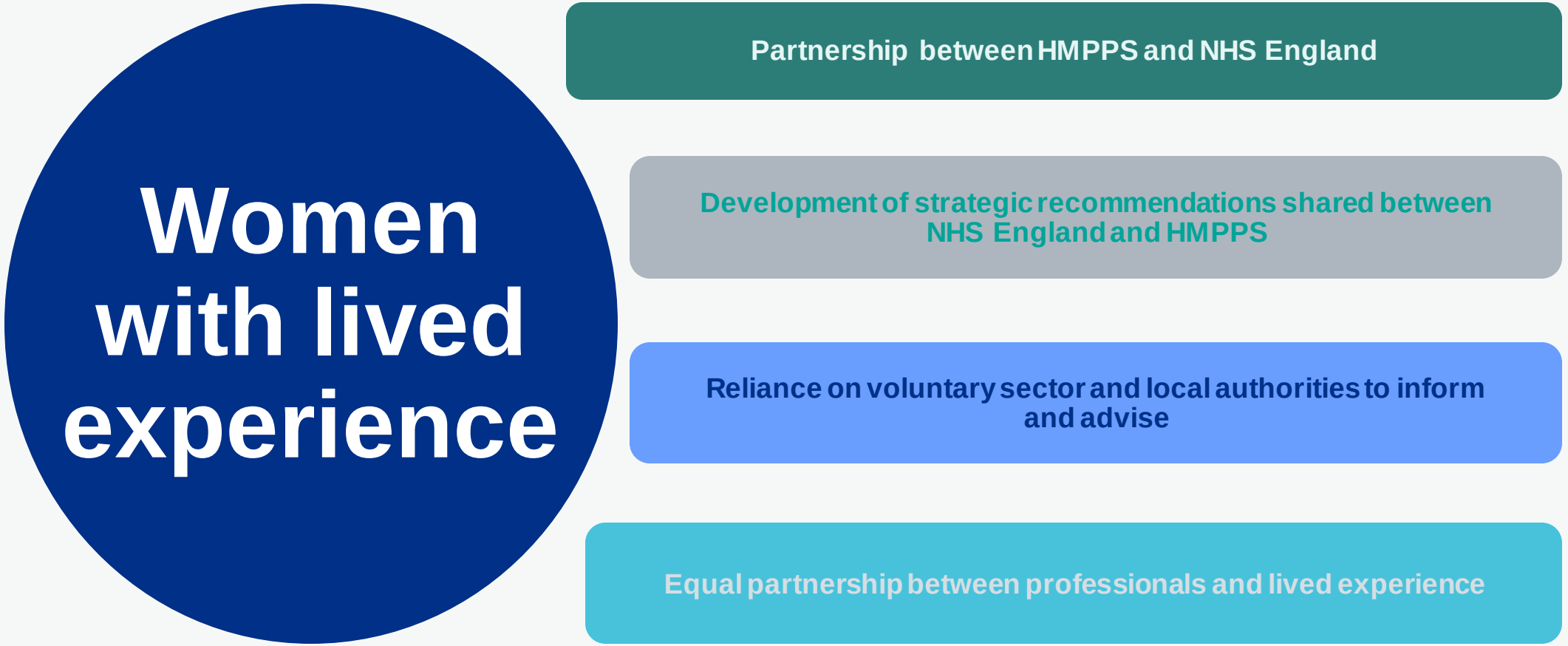
A preview of the national review

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."

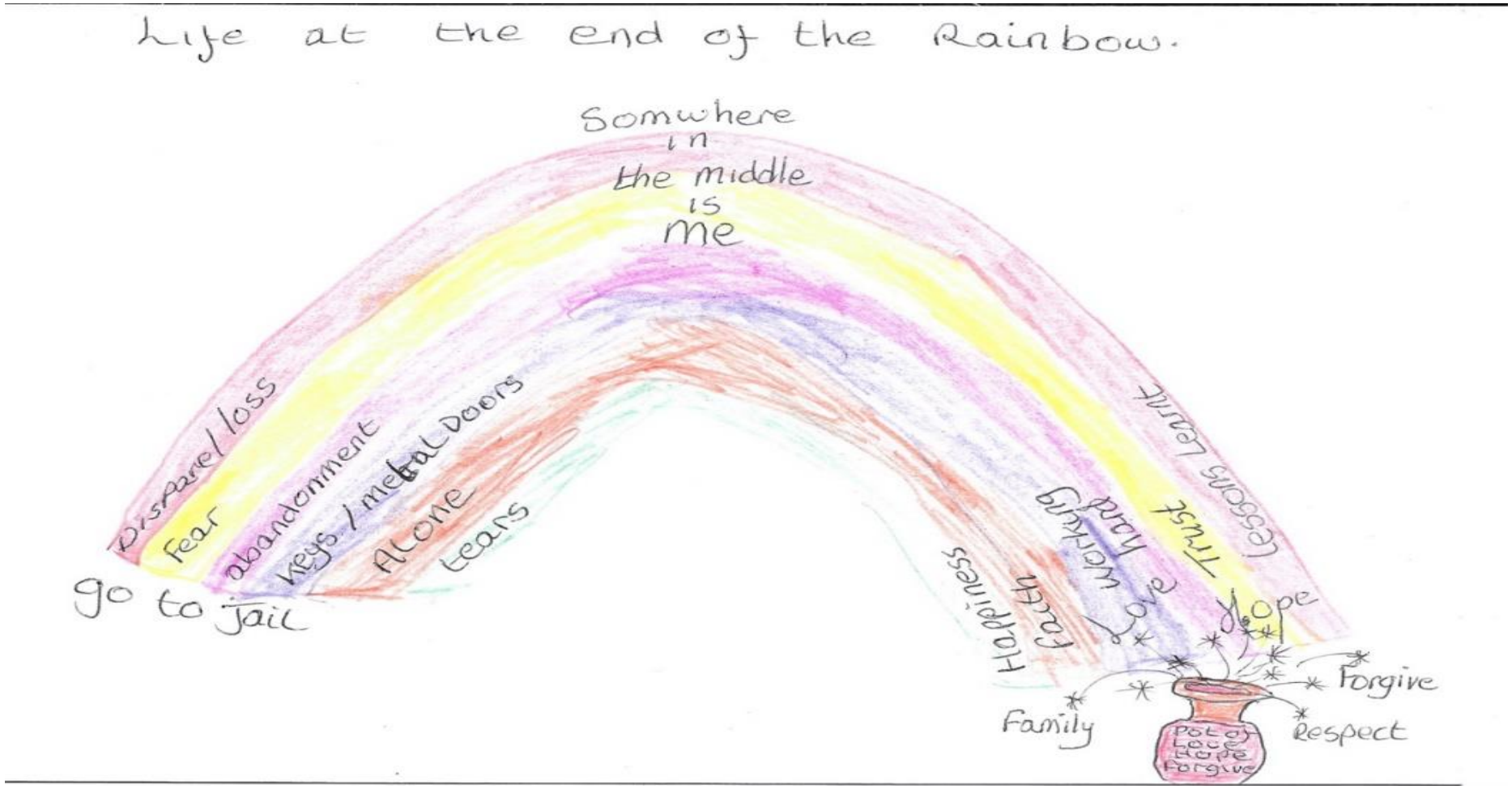
Next steps and implementation

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

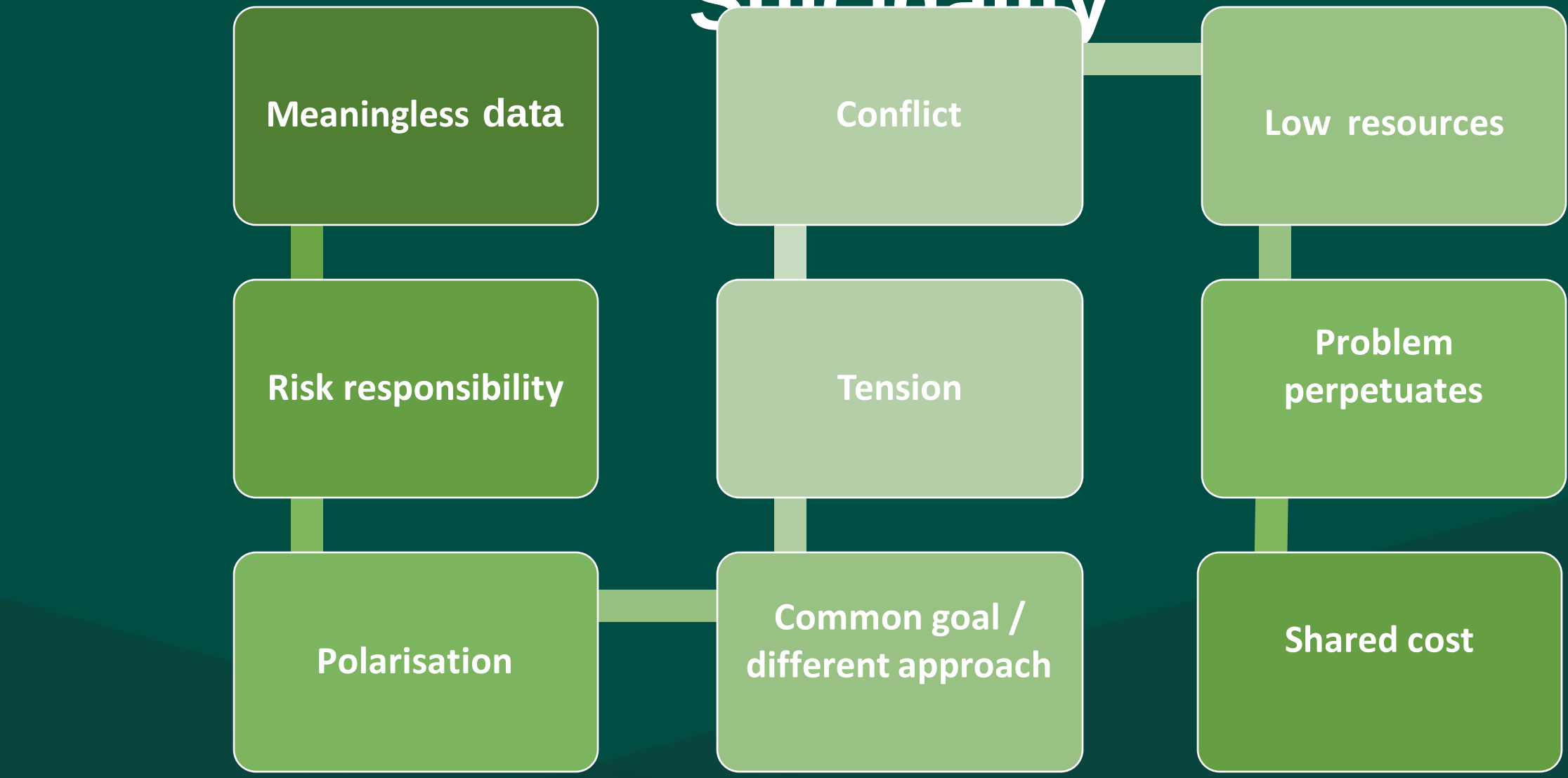
Seirbhís Phríosúin
na hÉireann
Irish Prison Service

10th Annual Health & Justice Summit
Belfast, Oct 2023

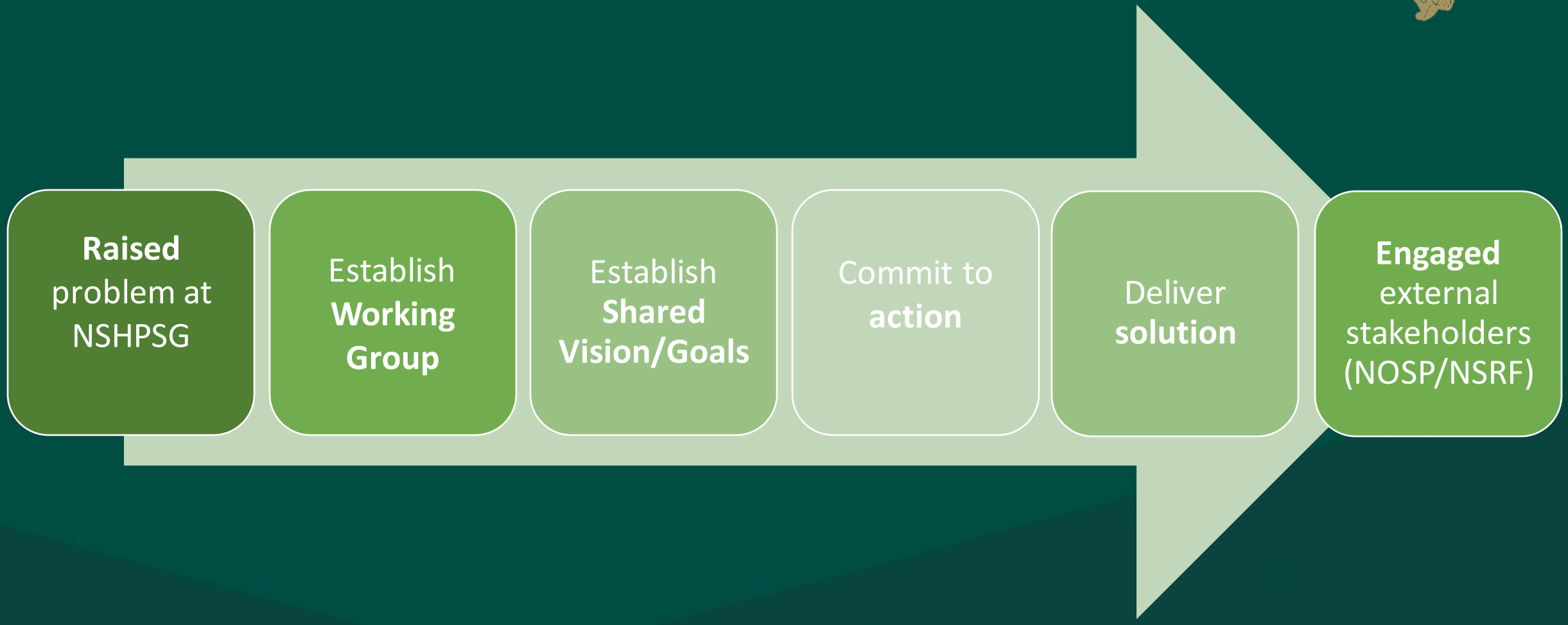
From Protectionism to Progress

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

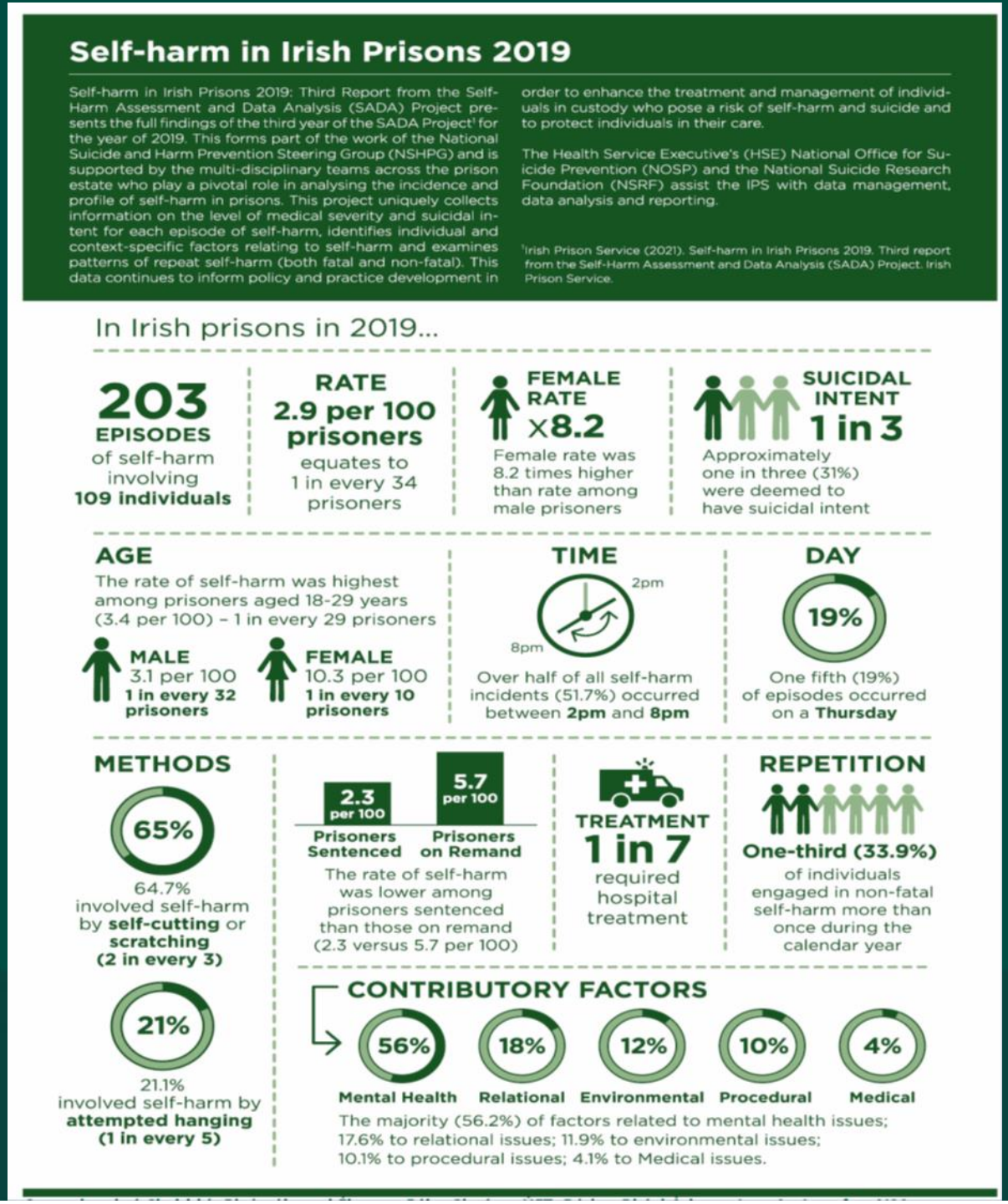
When, where

Quarterly review of data

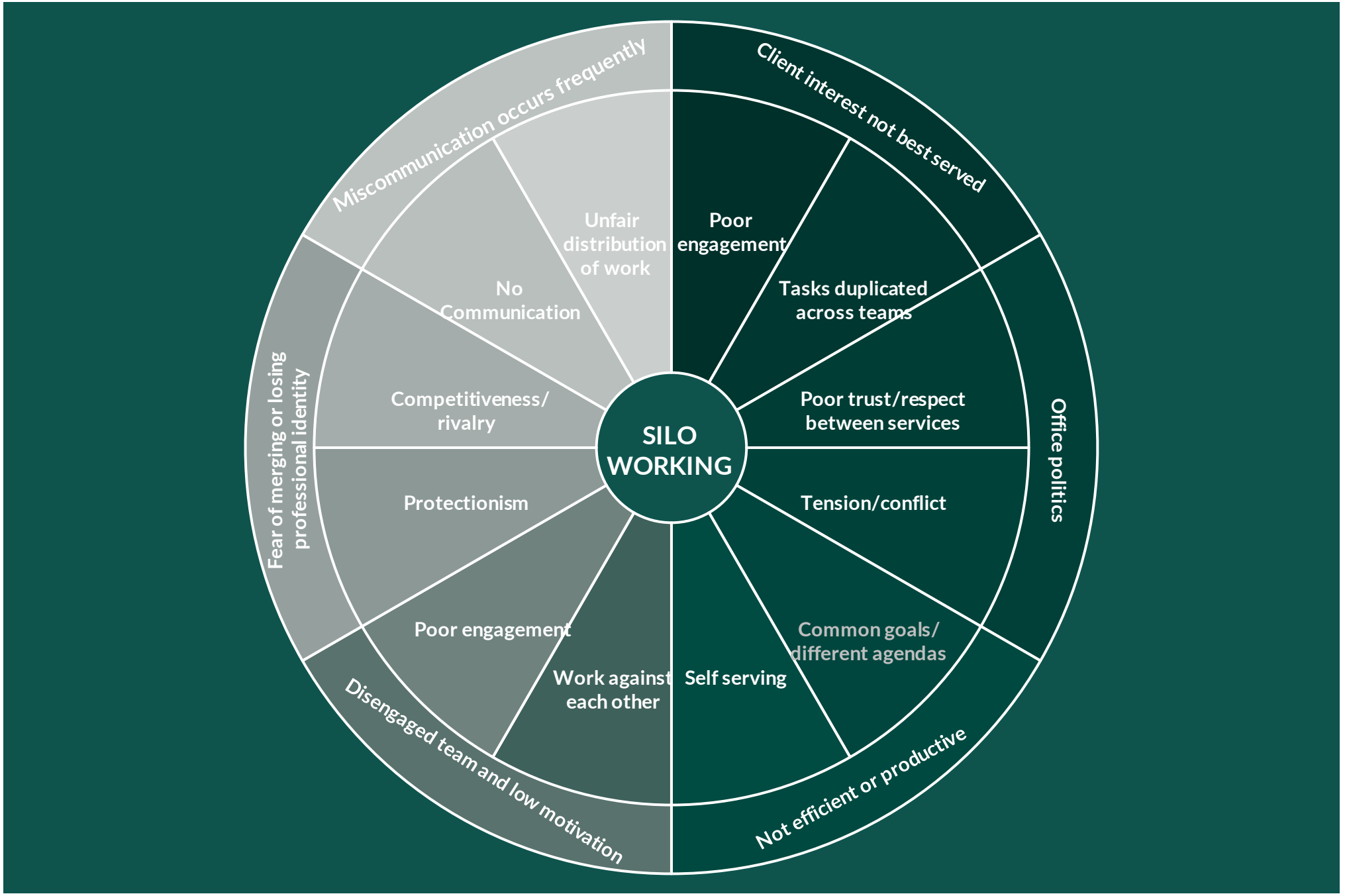
Infographics

Annual report

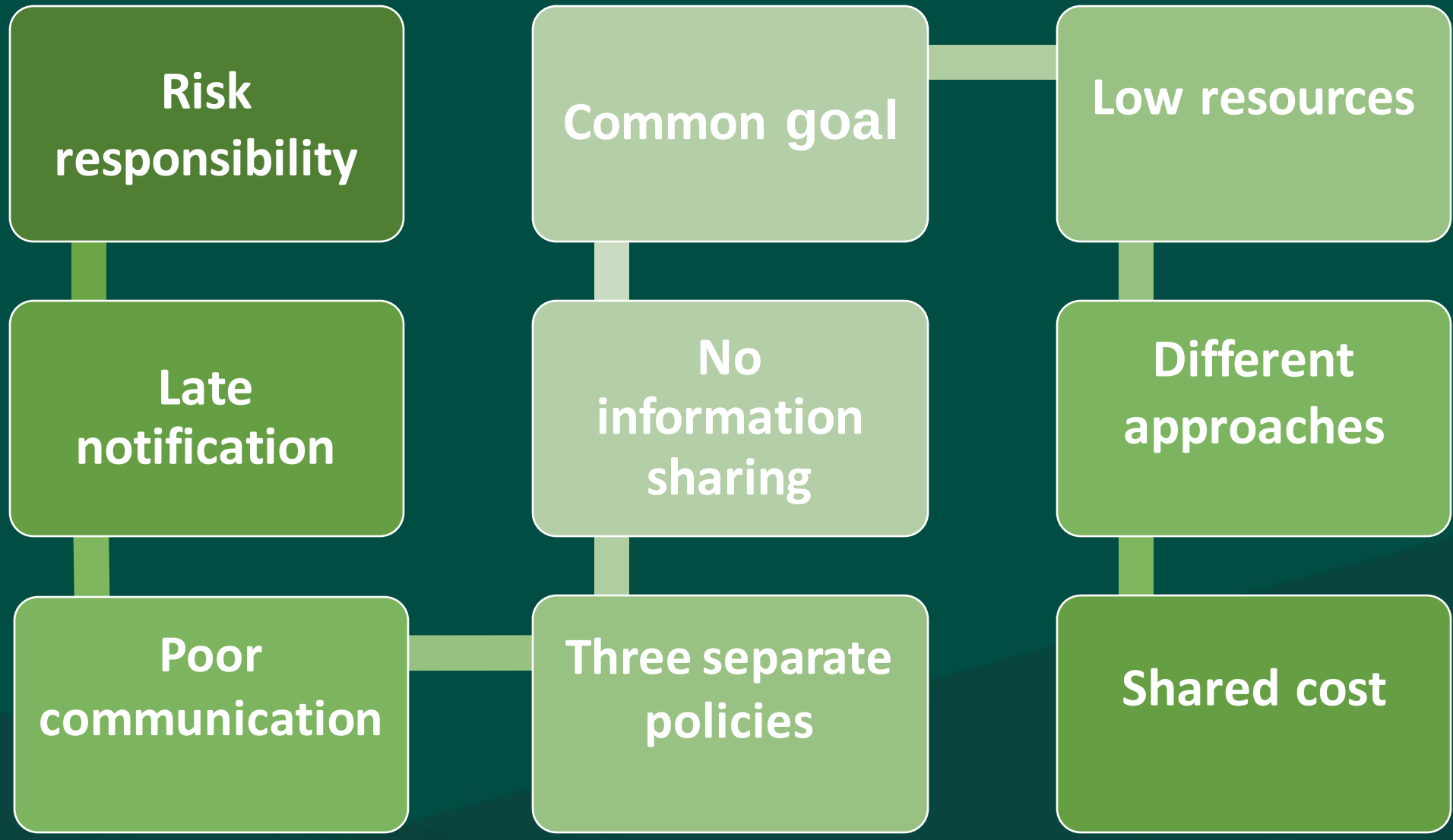
Research



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

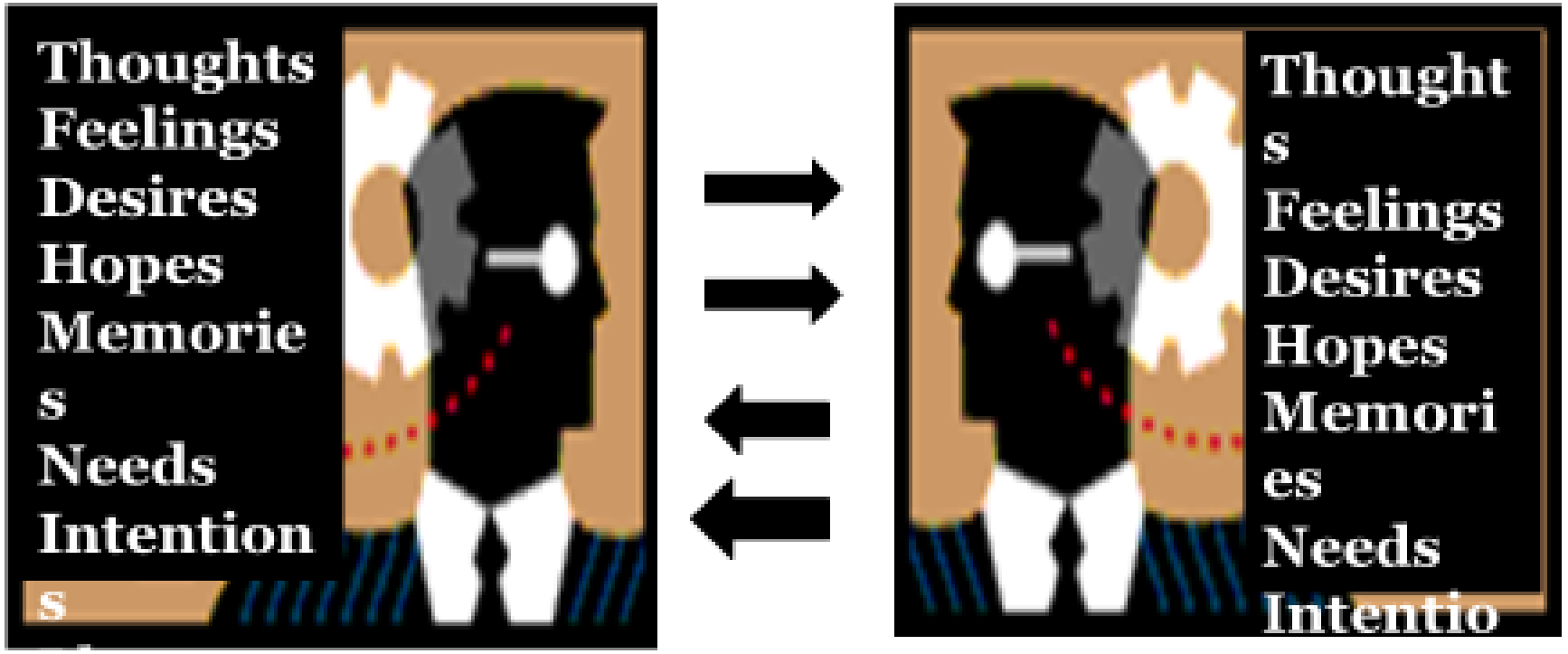
- One weekly multi-agency meeting
- Share the load
- External stakeholders
- Information sharing
- Shared formulation & approach
- Joint policies

Engagement

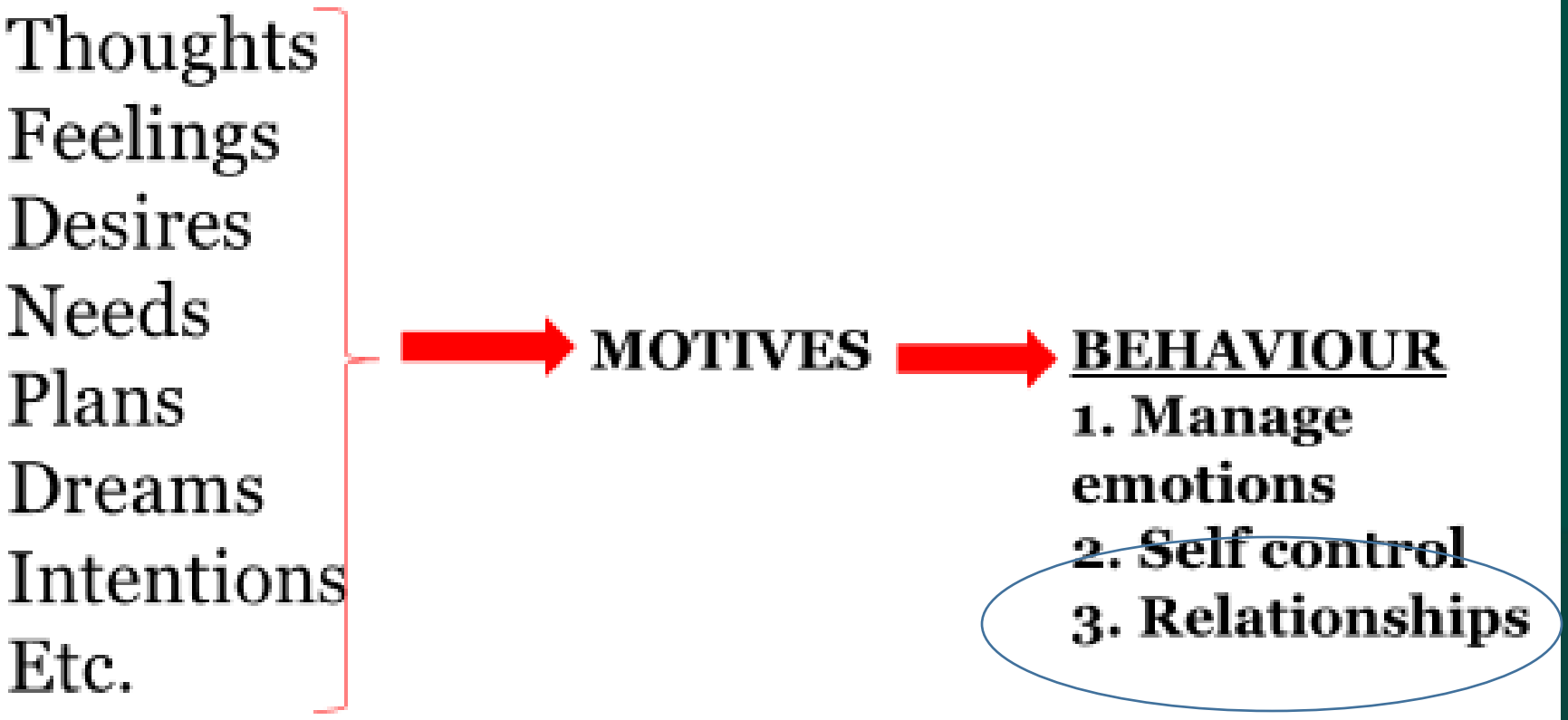
- Upward feedback & ongoing review
- Reinforce high value
- Improve contact between managers
- Early involvement of all services
- Joint decision making

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

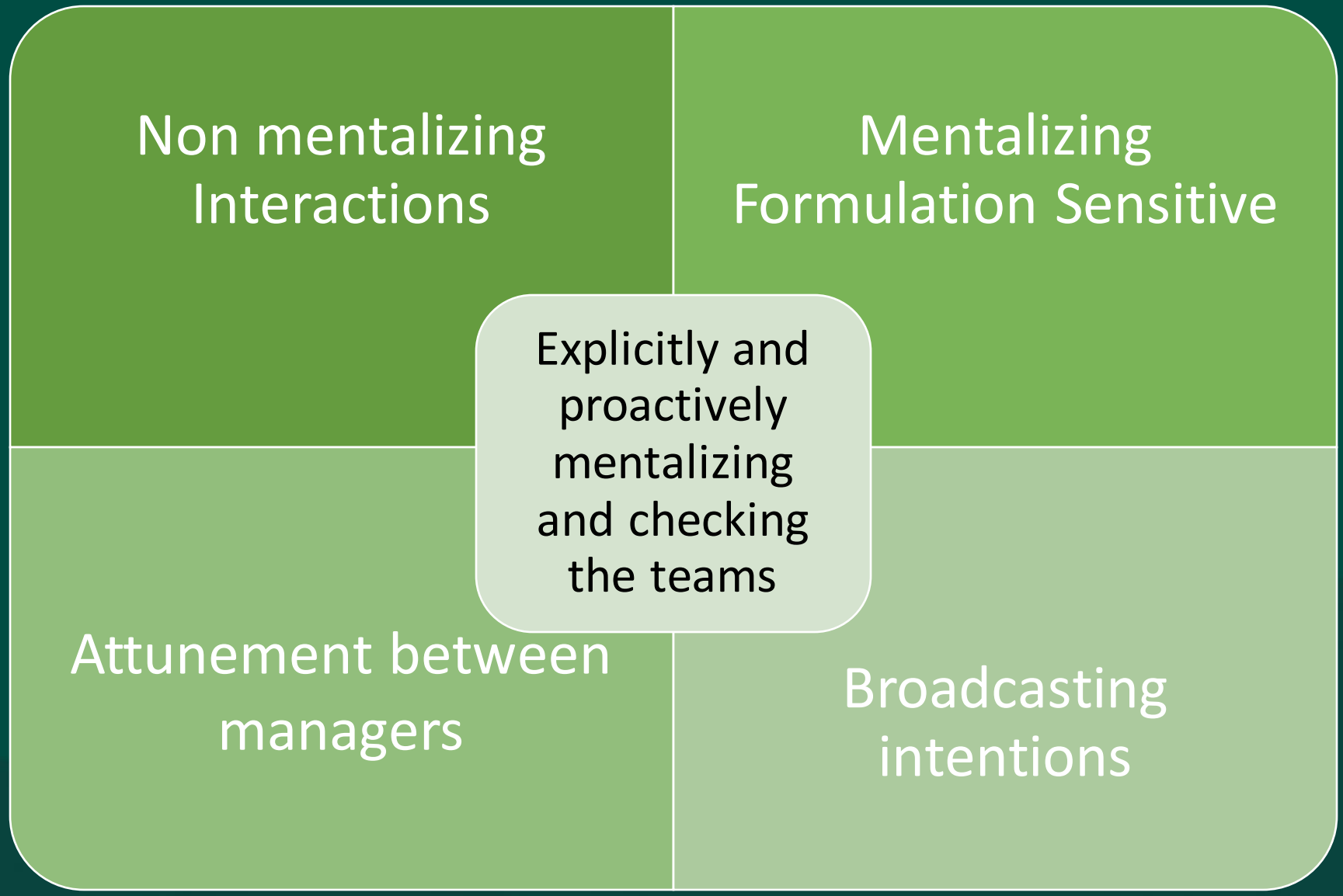
He / she is passing the buck

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:

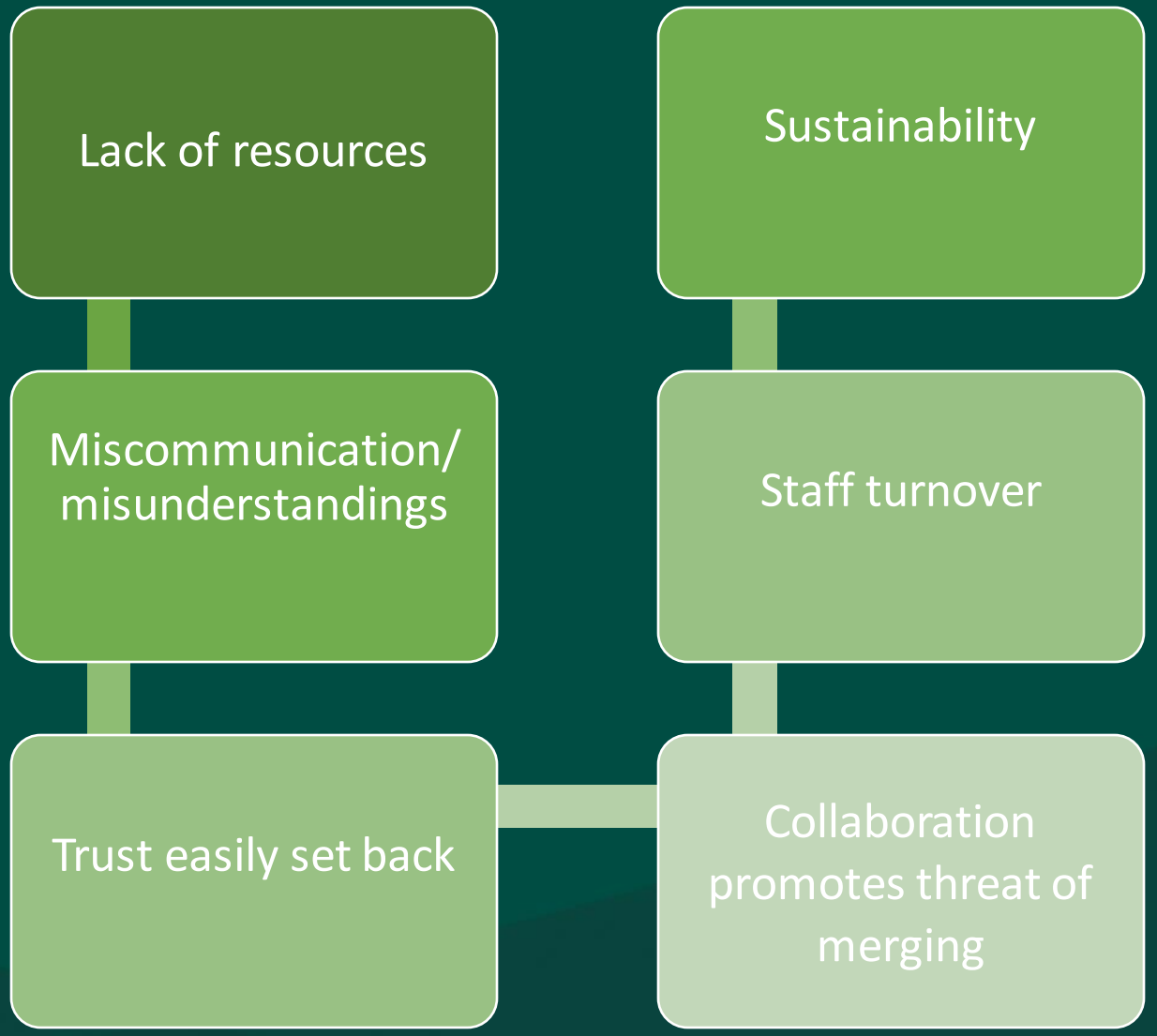
Involvement of ‘front line’ staff at outset

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

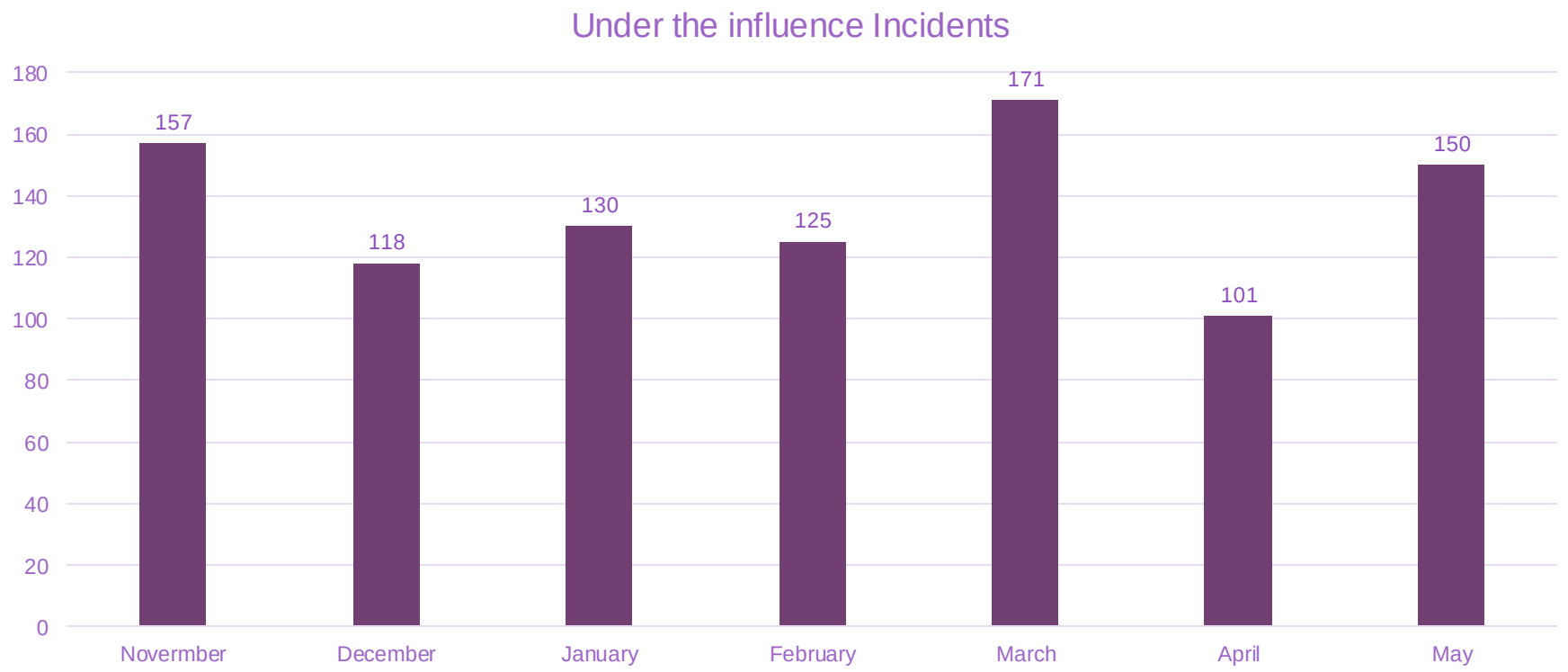
Practice Plus Group

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.**

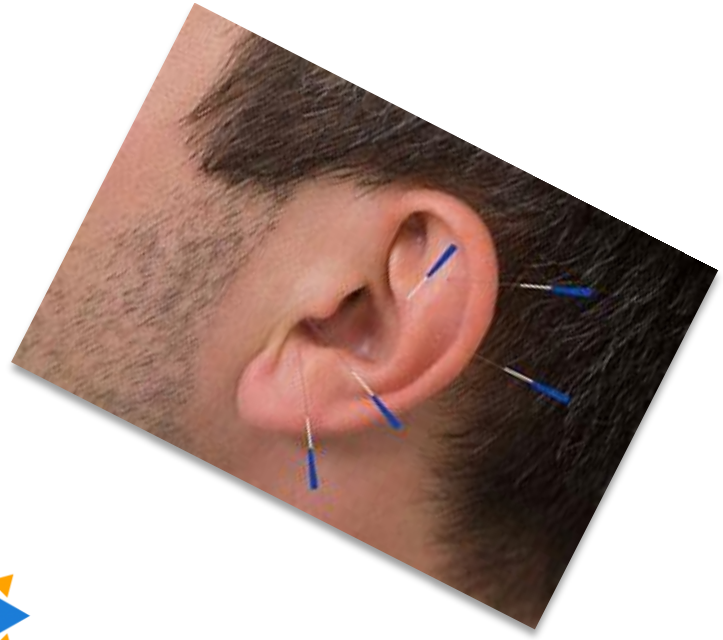
Partnership working

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

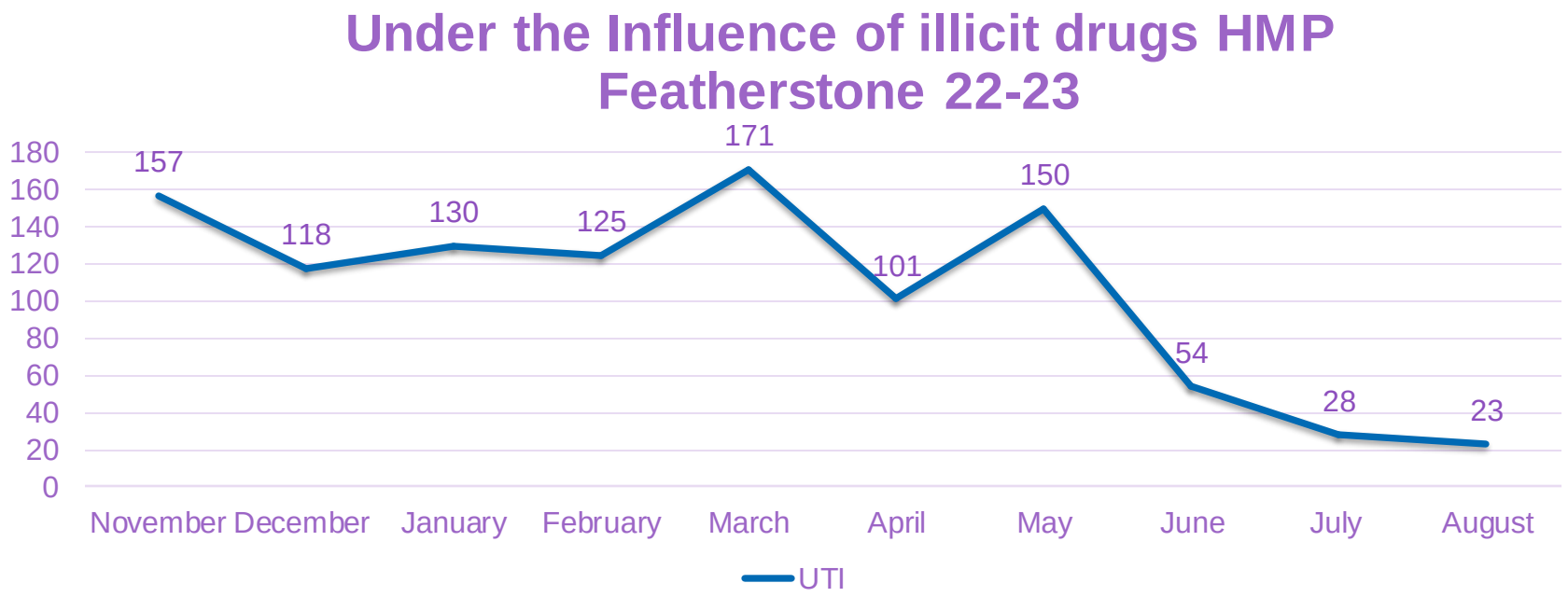
- Sam's role on the DRW
- Delivering structured interventions
- The DRW community



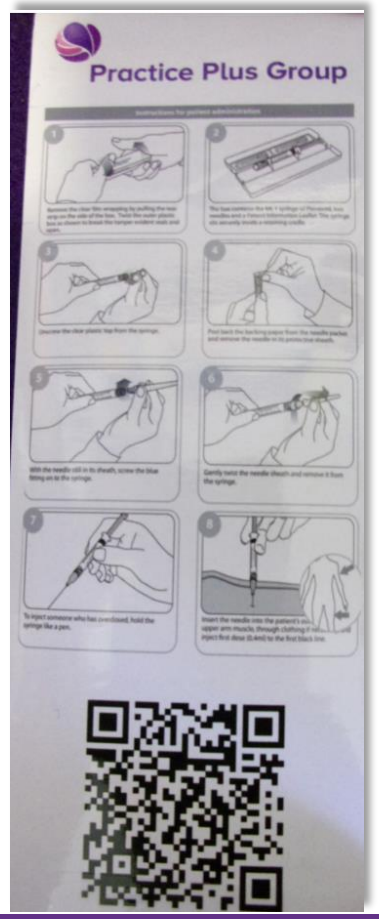
Peer support - Sam

- 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

10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

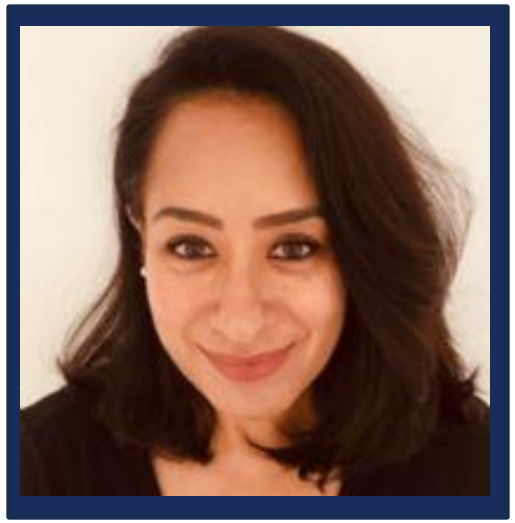
RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RCGP

Oxleas NHS Improving lives

CONVENZIS

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

HMP Wandsworth's Segregation: A Trauma-Informed Approach

Gov. Hannah Ronald – Head of Safety

CM Jess Bosi – Custodial Manager of Safer Custody

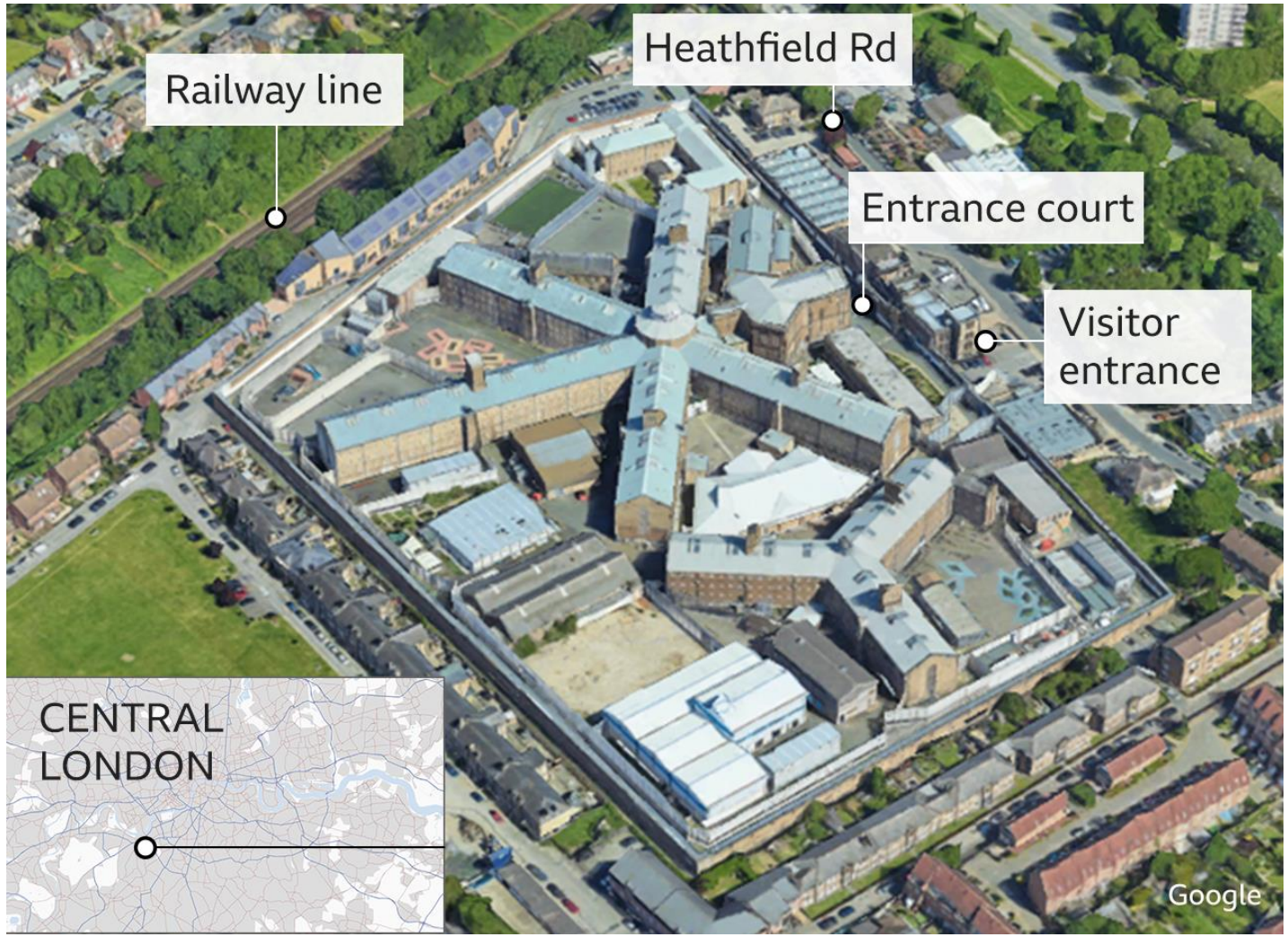
Dr Varinder Panesar-Talbot – Consultant Psychologist

"Inmates going weeks without time outdoors in overcrowded and rodent-infested prison, report finds"

"Wandsworth prison break highlights chronic staffing shortages and lack of training in the service"

HMP Wandsworth

HMP Wandsworth



The Context

Cat B/C men's local prison
Built in 1851 designed for 1000 men, current op cap. 1628
Remand prison, over 100 new prisoners a week
Almost 50% of population: immigration, deportation, repatriation, extradition cases
1700 arrivals with self-harm history in last year
50% estimated to be neurodiverse
90% estimated to have substance misuse or mental health needs
Around 70 open ACCTs

The Segregation Unit

Houses 22 prisoners
All single cells
Basement – E1
Historically a place of punishment where prisoners have no contact with others
Dedicated staff group – 1 CM, 2 SOs, 12 officers
Separate exercise yard
Limited access to off-unit activities

The Segregation (according to staff)

- Manic, fast-paced, very stressful, challenging prisoners
- I get mood swings, sleepless nights, I don't want to engage with others when I leave work, I'm more angry, more aggressive, have a shorter fuse
- Lack of support from management, feels like I'm just a number
- A headfuck dealing with people we're not trained to deal with, we're not mental health nurses
- We get to go home and have a drink, the prisoners don't
- I don't think we're making much of difference here, I'm looking for other jobs
- I've been injured so many times, I've had a few broken bones, I wanna say it's normal but it's not

The Segregation (according to prisoners)

- It’s fucking shit, food portions are shit, regime is shit, staff are alright but some of them are dickheads
- It’s a cross between a madhouse and a funhouse, a nursery but prison, it’s better than most segs – vapes, canteen, extra food, a regime even when the prison is in lockdown
- Getting stuck here is bad for your mental health
- A dungeon, all artificial light, no good for you, and the rats – they’re everywhere

Trauma is widespread

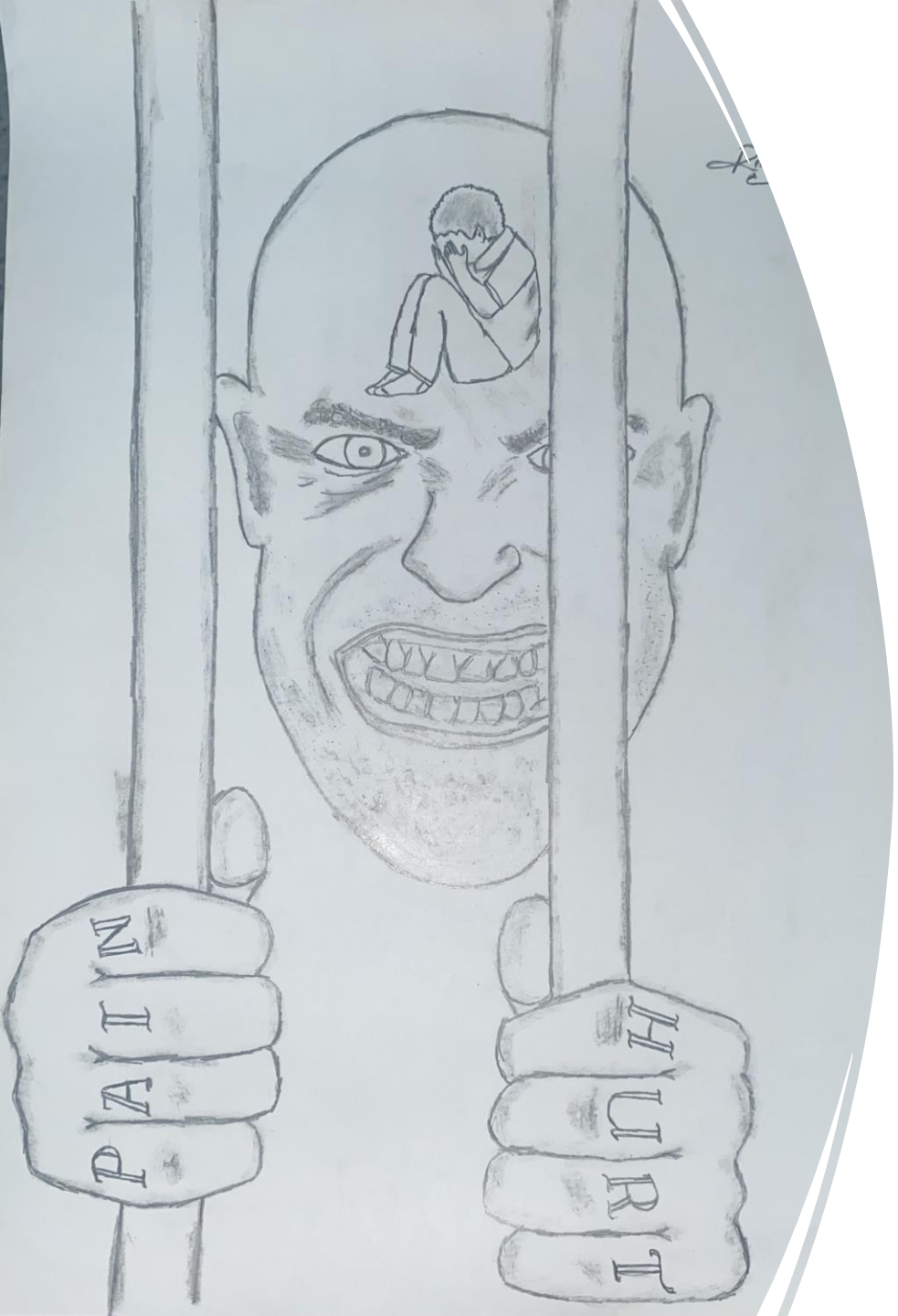
We can (inadvertently) re-traumatise those in our care

Trauma affects the core of our functioning


THOUGHT
Repeated,
DIAGNOSIS

PTSD	COMPLEX/DEVELOPMENTAL TRAUMA
Single event/ series of events over a short period of time	Series of events that repeatedly occurred over an extended period of time; traumatic events start at young age; trauma occurs in the context of close relationships; pervasive
Unpredictable	Predictable
Fear	Shame
Specific	Generalised
Restoration of healthy self	Creation of healthy self

PTSD versus Complex/Developmental Trauma



Suffering Inside

Created by a prisoner at HMP Pentonville

Trauma can be misunderstood or altogether missed

The divisions between services do not exist within people

Our service systems have evolved without trauma in mind

So, what can we do? (i.e., to become trauma-informed)

We can recognise and actively avoid re-traumatisating practices

We can use our human capacities

We can maximise people’s capabilities

We can work together

We can use the science instead of falling back on assumptions & old ways

We can challenge the status quo

Our Segregation: What we've started

A needs-led regime
Reintegration planning
Integrated working – MDT presence in GOOD reviews, CSiP reviews with healthcare
Investing in staff – reflective practice, upskilling, management
Risk-assessed structured activity
In-cell laptops
Key working

The Barriers

- Managing expectations – changing culture is the long game!
- An old, Victorian prison – physical environment foundation is archaic
- Old prison, also old attitudes
- Never enough resource to match need
- Prison officer training
- Remand nature
- Population nature
- Not meeting needs of young adults

What next?

- Safer Custody Nurse
- An ESS-type service
- A Neurodevelopmental needs pathway including ND unit
- Wider key working
- Improved complex case management
- Scaling up

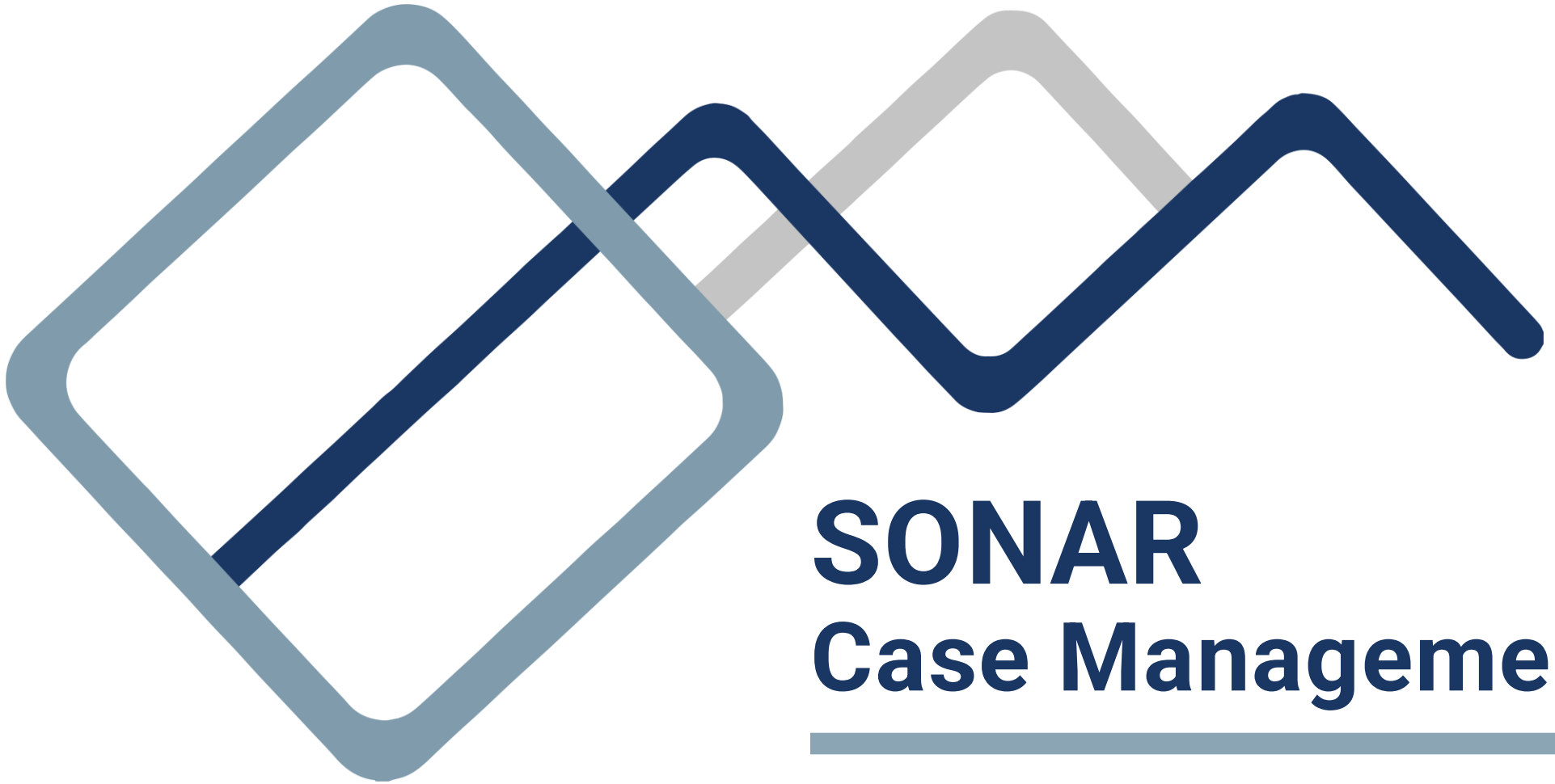
Big mountain, small steps

- Relationships shape our experiences
- Our brains change through these experiences
- Every interaction matters
- Marginal gains, small wins
- It has to be a whole-prison approach otherwise we burn out

Headline Sponsor Plenary

SONAR
A JWPM PRODUCT

CONVENZIS



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

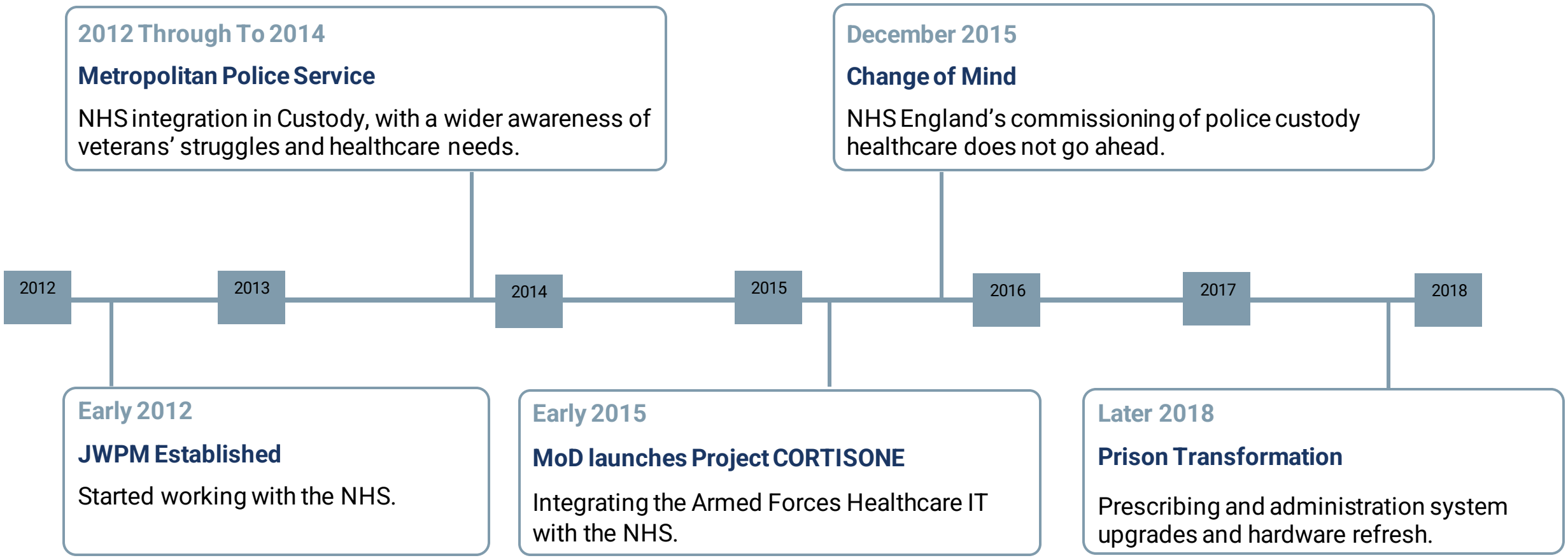
SONAR – Future Bridges to be Built

SONAR – I don't have all the answers.

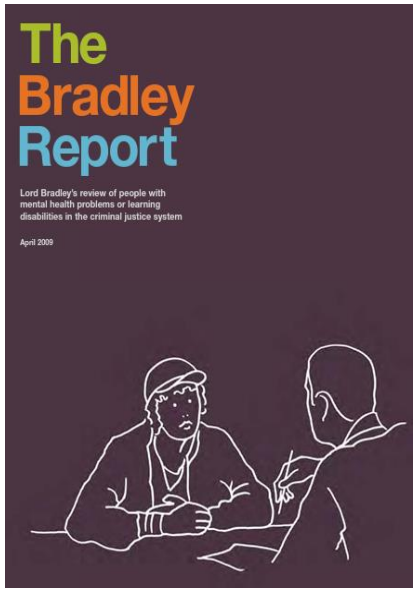
John White – Why SONAR?

- 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

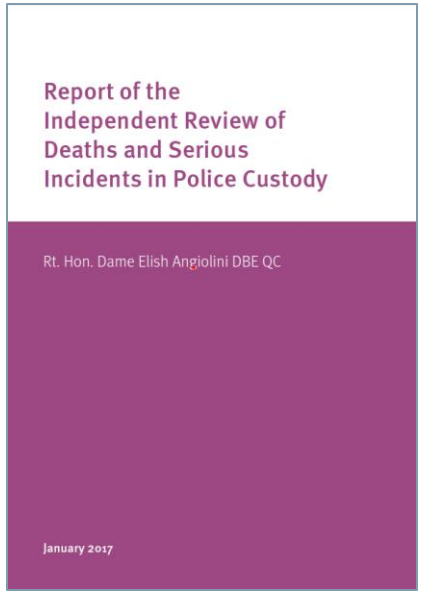

2012 Through To 2014
Metropolitan Police Service
NHS integration in Custody, with a wider awareness of veterans' struggles and healthcare needs.
December 2015
Change of Mind
NHS England's commissioning of police custody healthcare does not go ahead.
2012
2013
2014
2015
2016
2017
2018
Early 2012
JWPM 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*

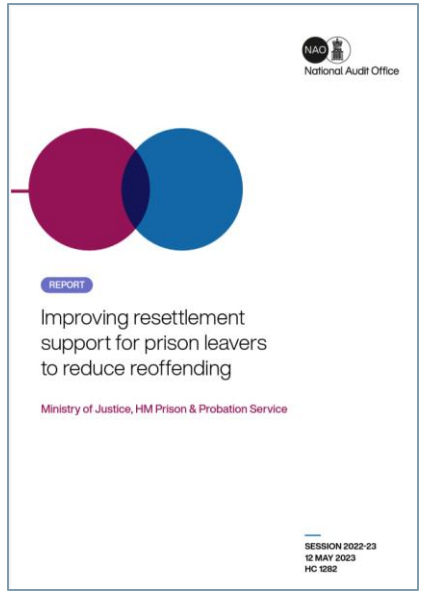
"My recommendations… will, I hope, establish a new baseline of services for the future. I hope they will ensure that over time offenders with mental health problems or learning disabilities are properly identified and assessed, appropriately sentenced and helped with their rehabilitation and resettlement..."



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

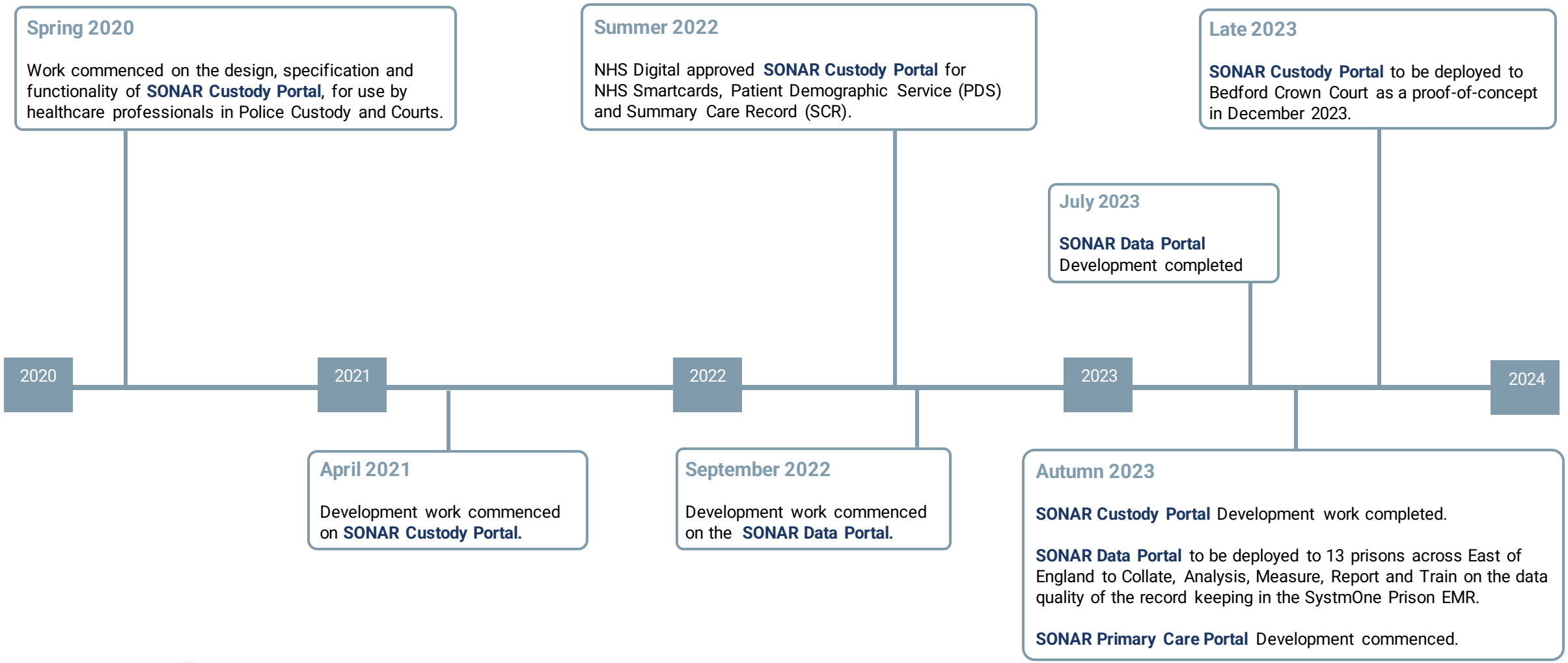
"We identified differences in the information stored in HMPPS's three IT systems which support the resettlement process.

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

SONAR – The Team

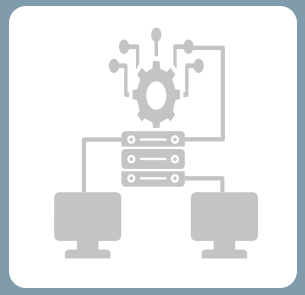
- We are a team of twelve
- Collectively 50 years and more of experience in Health & Justice
- Skills, Knowledge and Experience
  - Primary Care
  - Community
  - Mental Health
  - Police, Courts and Prison
  - Custodial Detention
- Expert Knowledge on
  - Current Health & Justice IT Systems
  - HJIS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

SONAR - Story So Far



Principles of an Ideal System

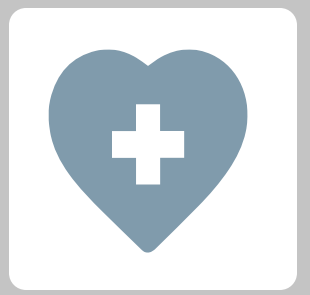
Full Technology Stack - AI



Designed by You!

SONAR
A JWPM PRODUCT

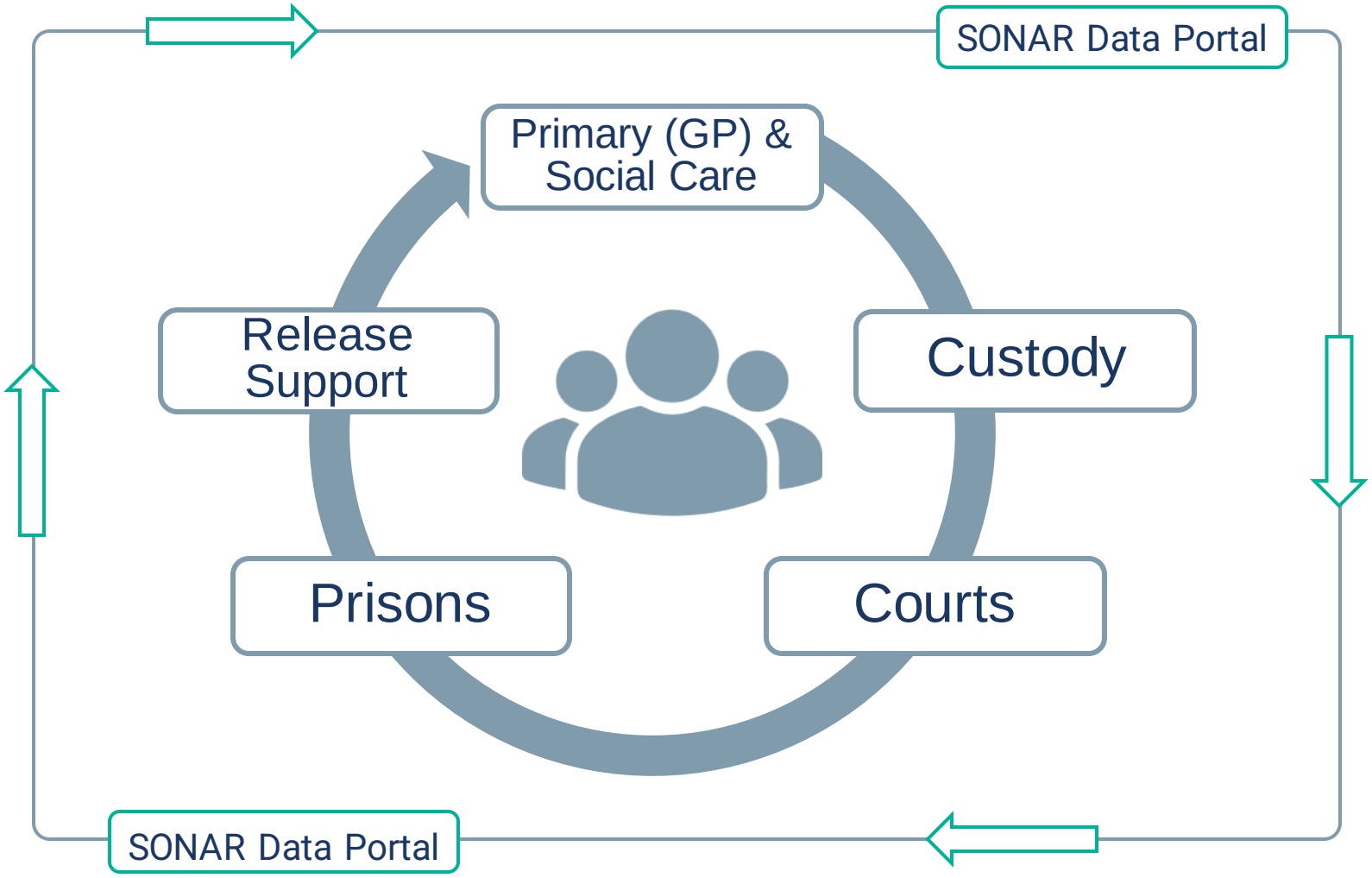
Tailor-made for the Criminal Justice System



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

Saxon House, Chelmsford, CM1 1HT

www.sonarcms.co.uk

@SONARCMSLtd

SONAR CMS Ltd

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

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

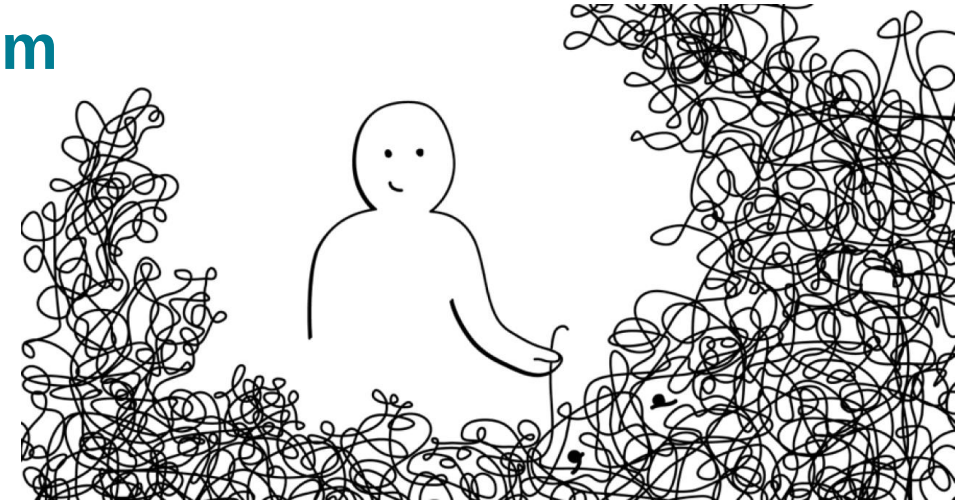
Health and Justice Summit

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**

10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

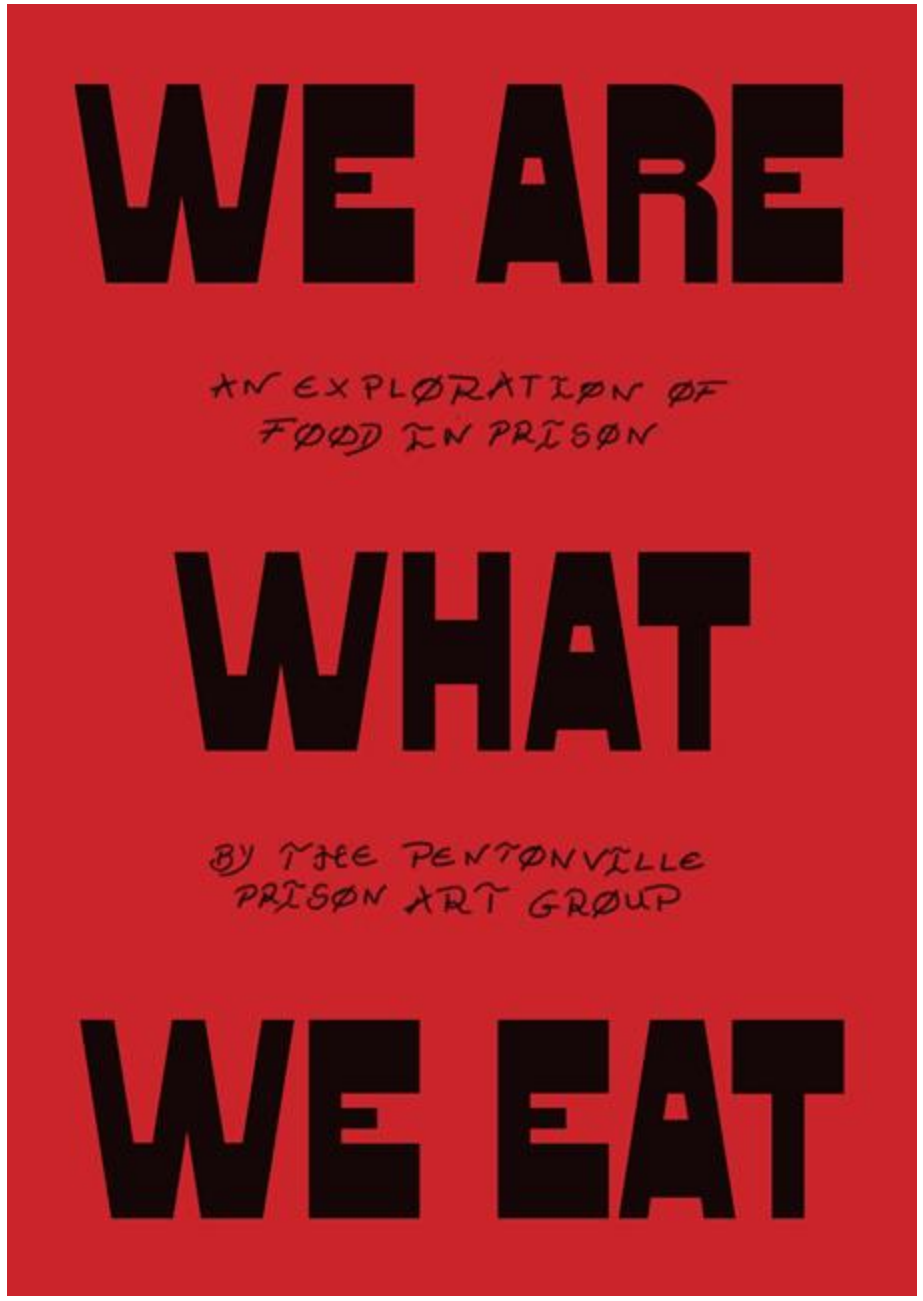
RC GP

CONVENZIS

Keynote Presentation

Guy Atkins

Artist-researcher

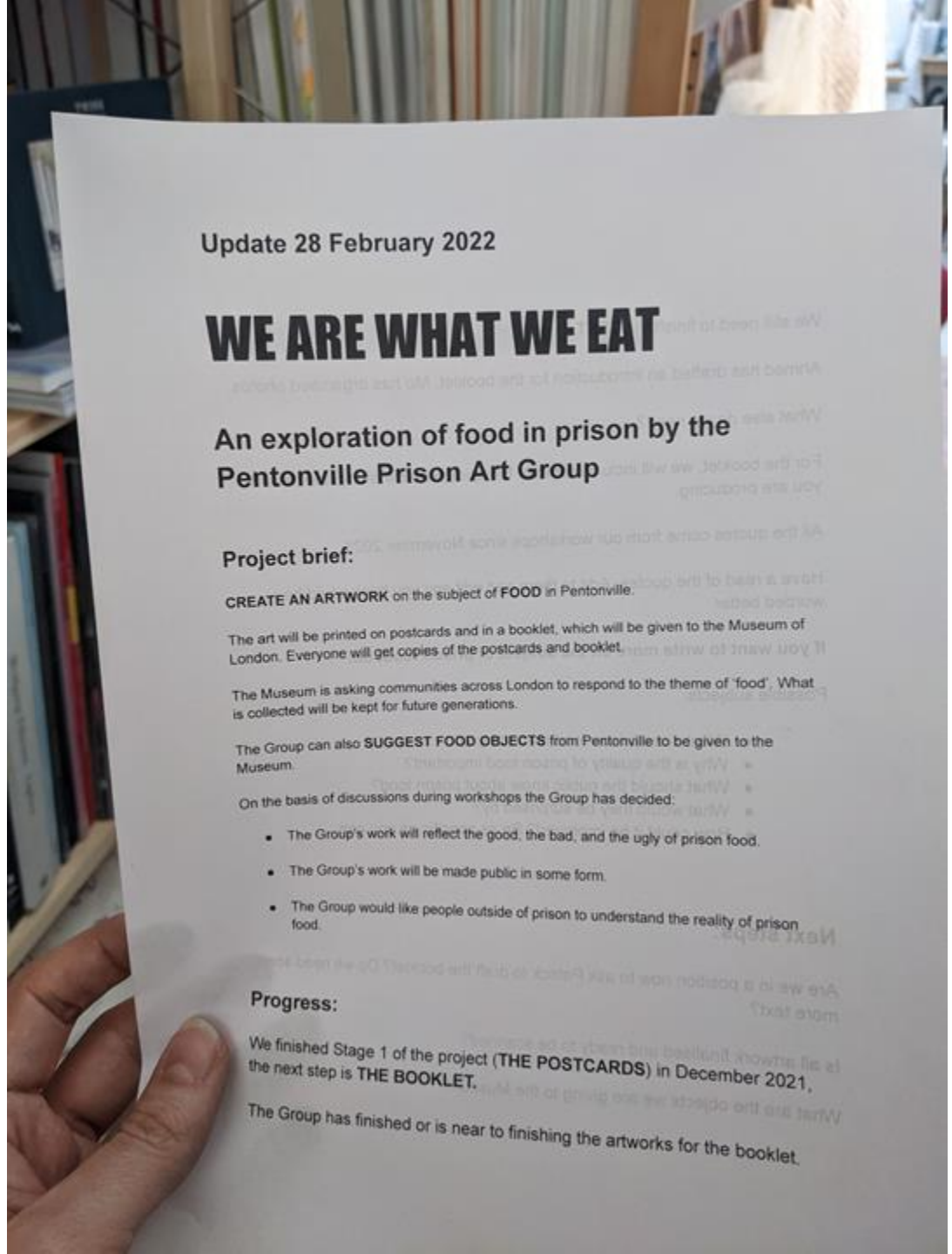


An exploration of food in prison by the Pentonville Prison Art Group

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
Ryman
250
PHOTO CORNERS
www.ryman.co.uk
Reading Room Companion
a rare and valuable COLLECTION of diverse CURIOSITIES
Henry Wellcome
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**.

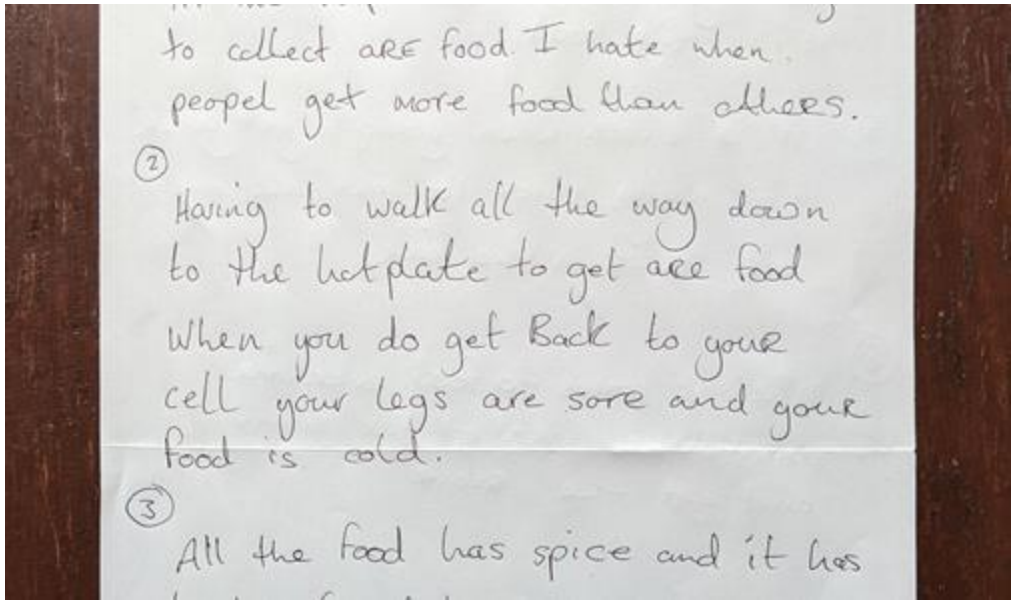
On the next pages are some of the the
far on food in Pentonville.

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

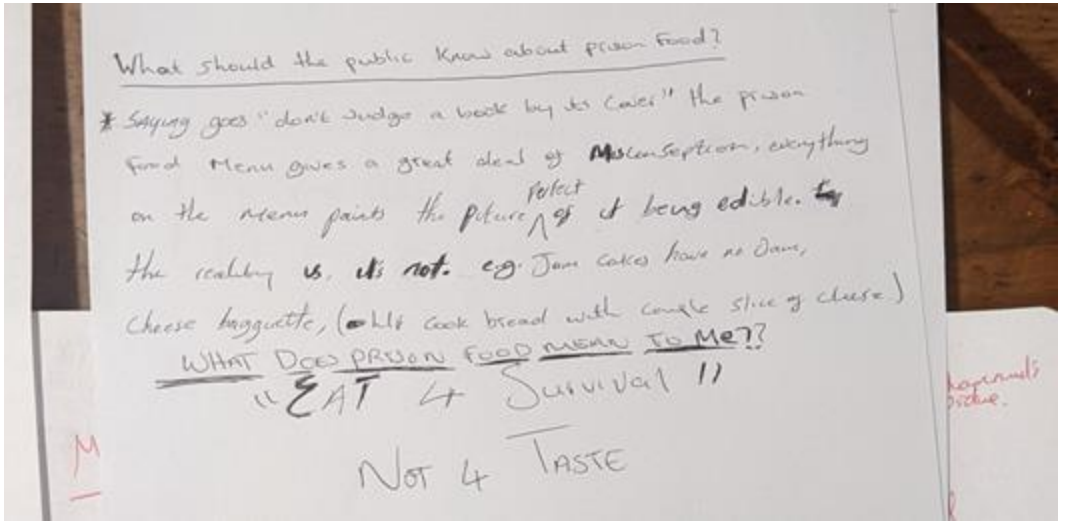
(THE THINKER OF NEWTON)



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



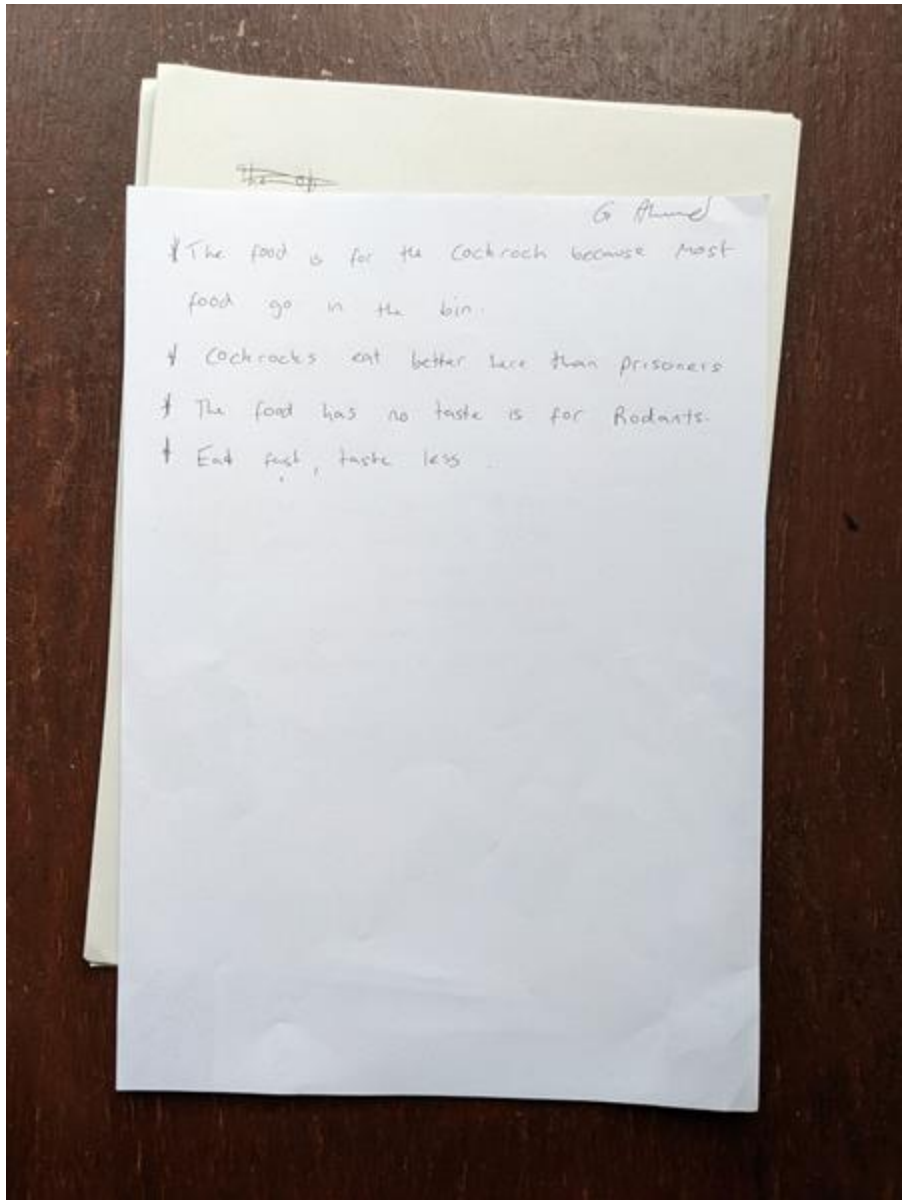
What should the public Know about prison Food?

* 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**

10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RCGP

Chairs Closing Address for Plenary Sessions

Dr Sunil Lad

National Clinical Director for Health and Justice - NHS England

CONVENZIS

Lunch, Networking & Refreshments

10TH RCGP, RCN & RCPSYCH HEALTH & JUSTICE SUMMIT

BUILDING BRIDGES IN HEALTH AND JUSTICE

Royal College of Nursing

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

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.

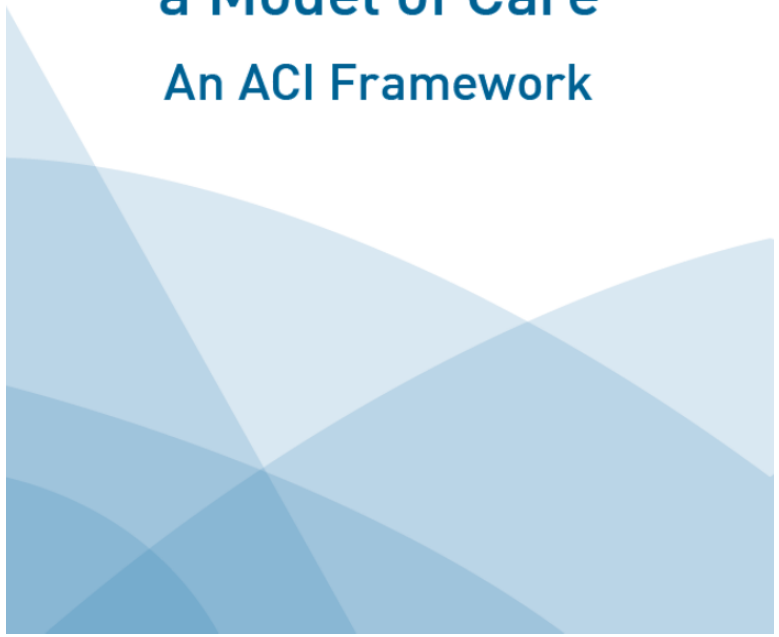
What is the situation in other countries?

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)

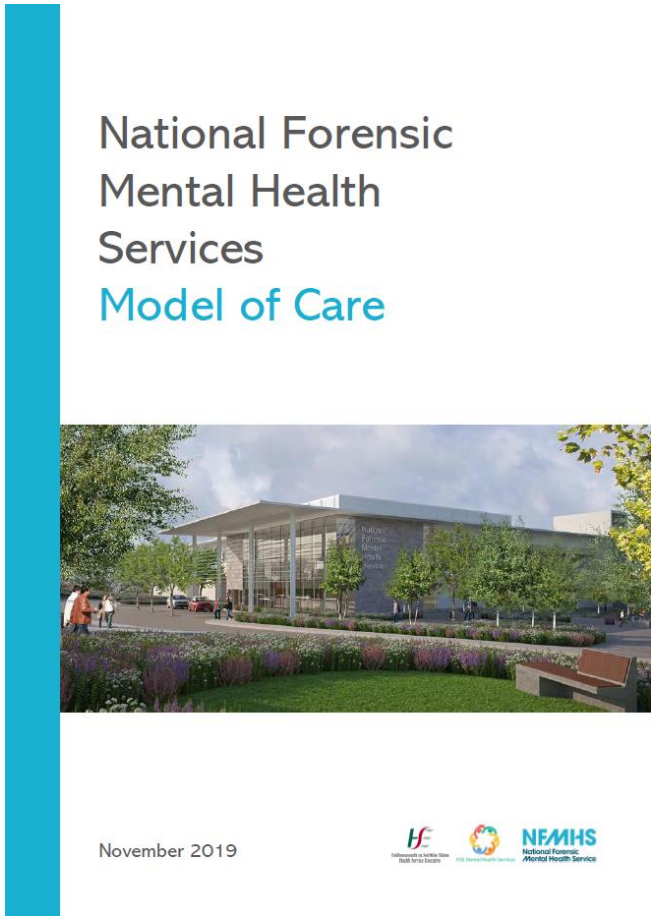


A National Model of Care?

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?

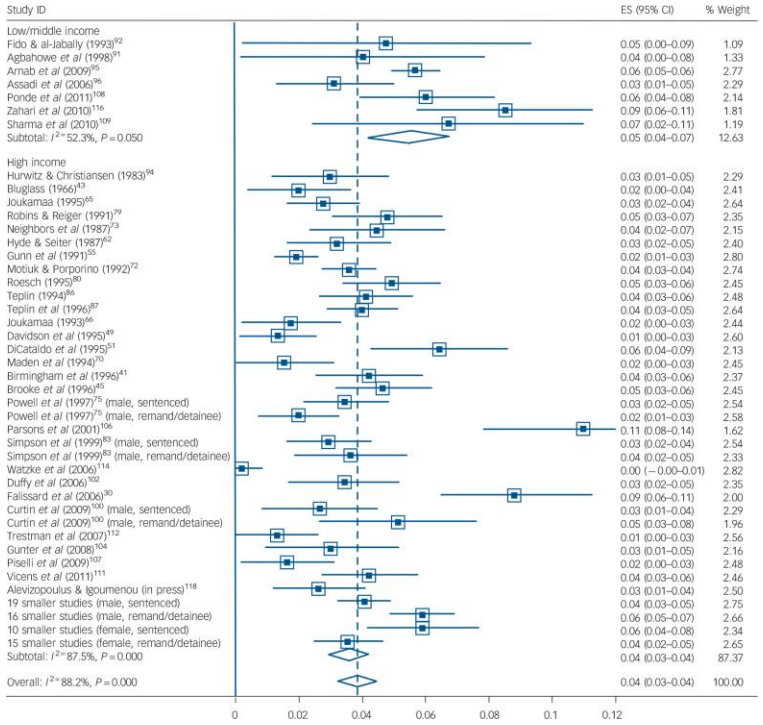
Goals

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.

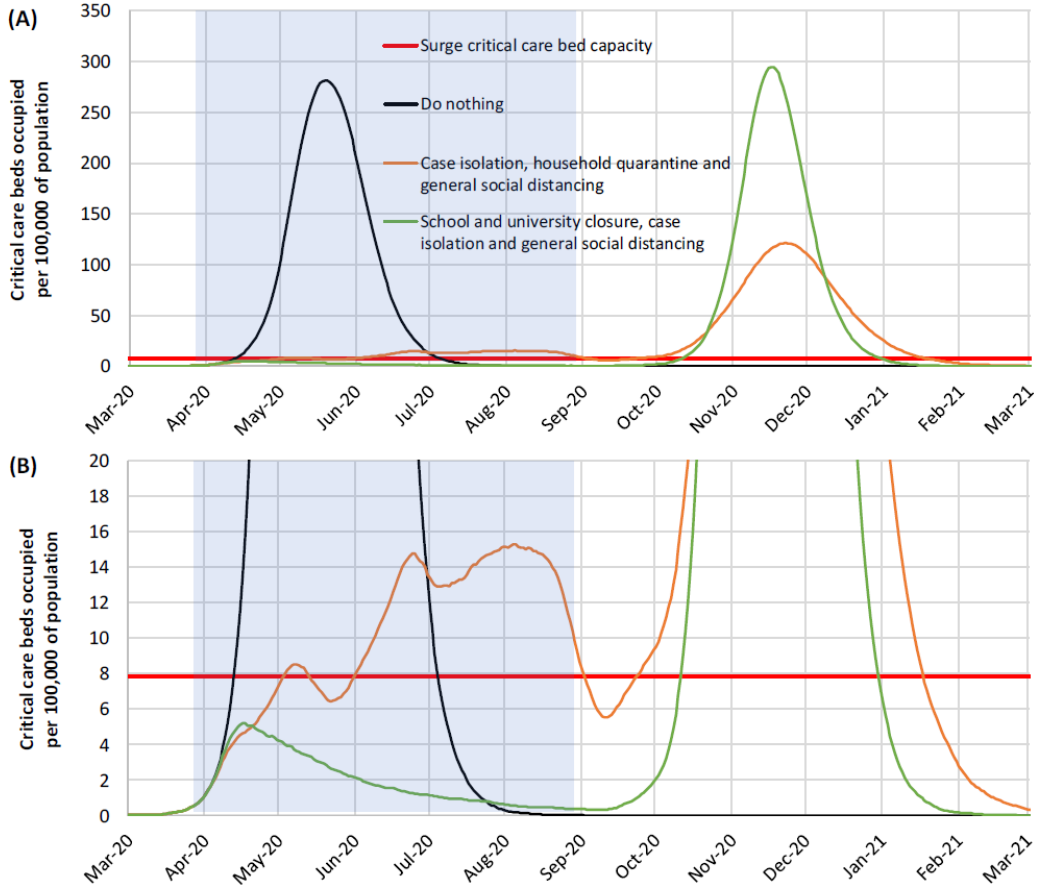


Figure 3: Suppression strategy scenarios for GB showing ICU bed requirements. The black line shows the unmitigated epidemic. Green shows a suppression strategy incorporating closure of schools and universities, case isolation and population-wide social distancing beginning in late March 2020. The orange 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

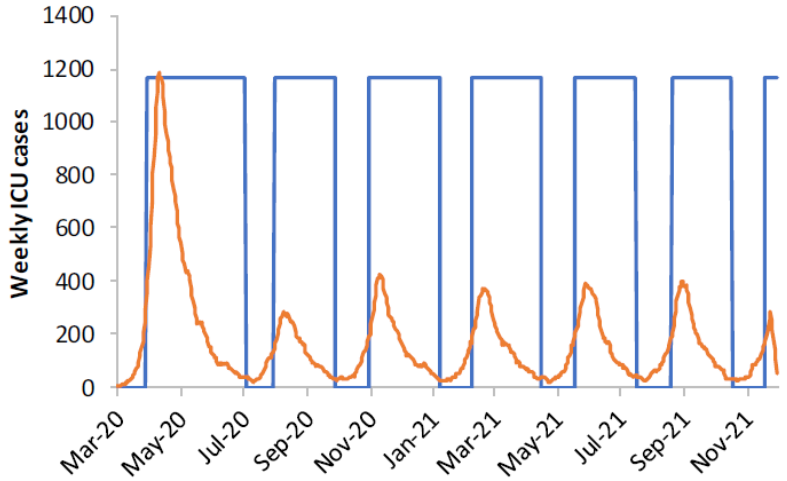
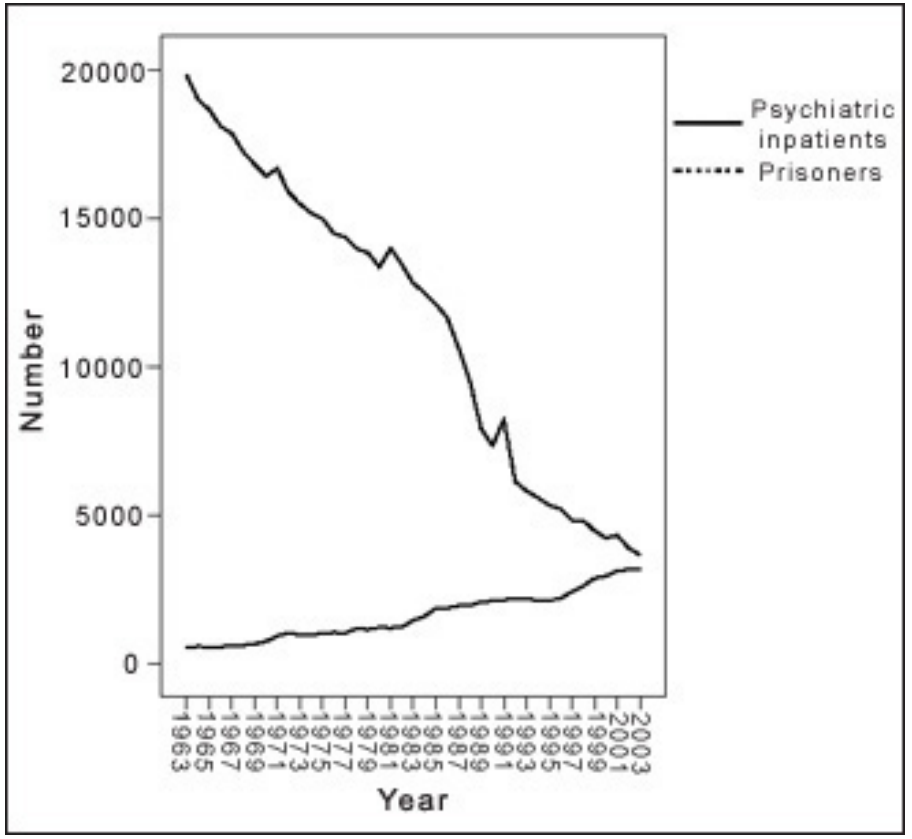


Figure 4: Illustration of adaptive triggering of suppression strategies in GB, for R_0=2.2, a policy of all four interventions considered, an "on" trigger of 100 ICU cases in a week and an "off" trigger of 50 ICU cases. The policy is in force approximate 2/3 of the time. Only social distancing and school/university 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

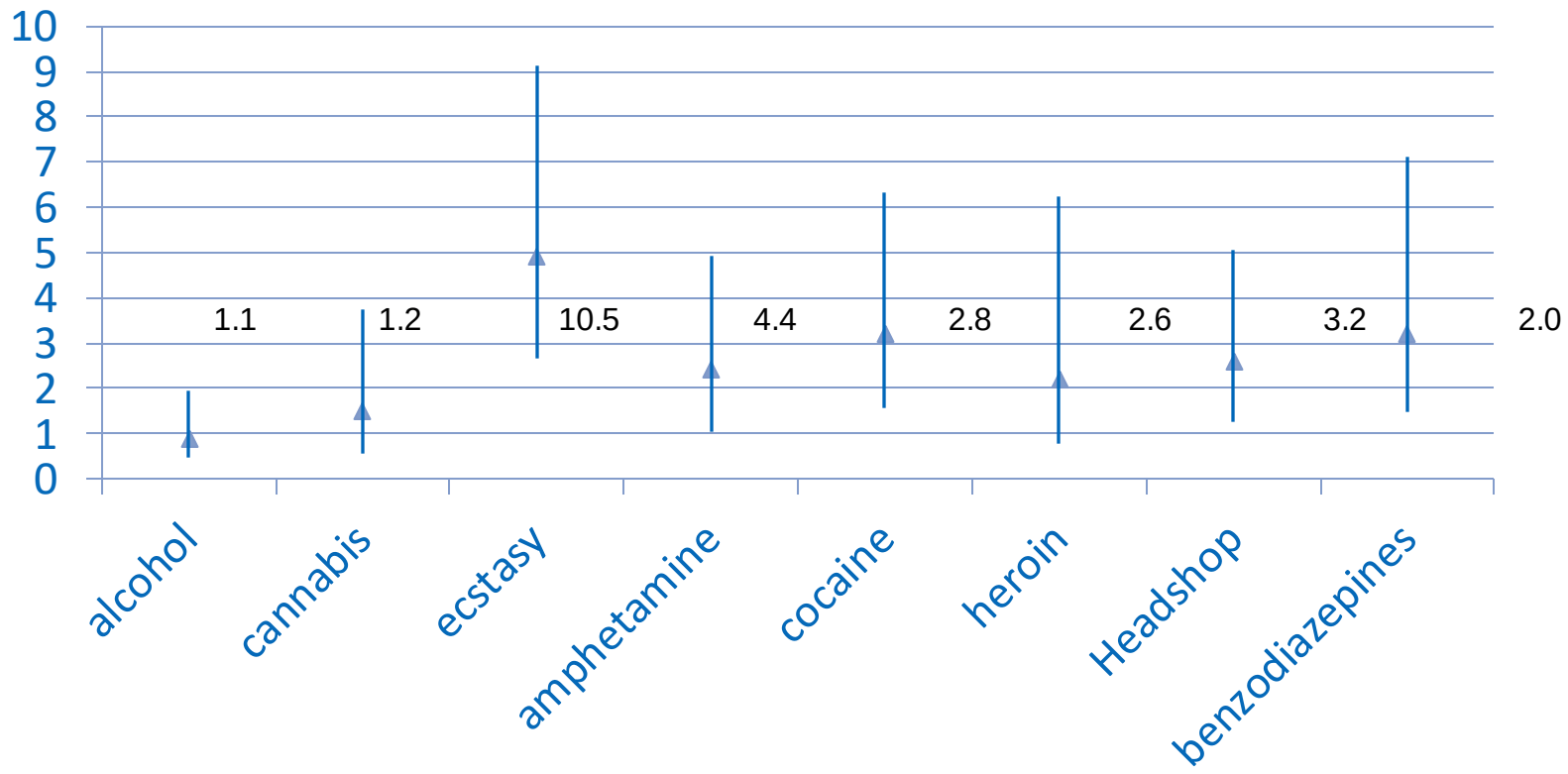
Ultra high risk of psychosis on committal to a young offender prison: an unrecognised opportunity for early intervention

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

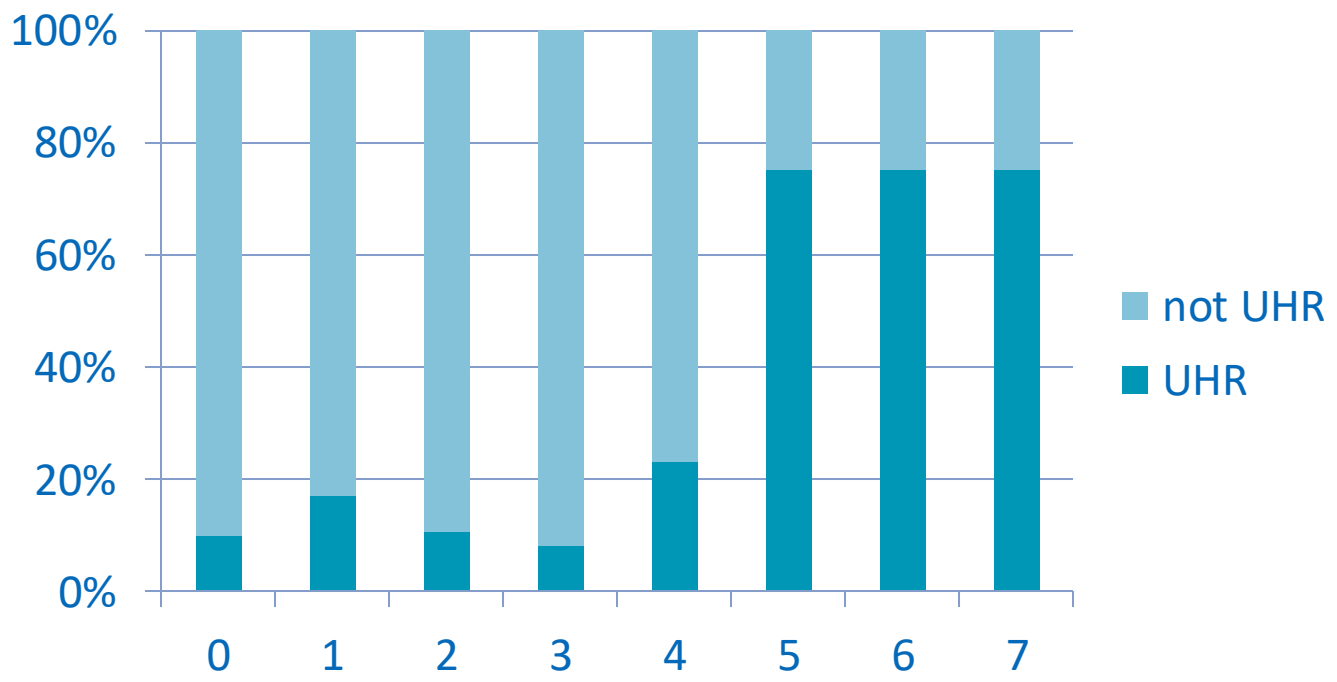
Abstract

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 $R_0S=1$

Conjecture

Psychosis in sentenced prisons is a stable equilibrium $R_0S=1$
Psychosis prevalence in prisons is the equilibrium between susceptibility (UHR) and exposure to

Conjecture

Psychosis in sentenced prisons is a stable equilibrium $R_0S=1$
Psychosis prevalence in prisons is the equilibrium between susceptibility (UHR) and exposure to
(a) Intoxicants – cannabis, stimulants, others

Conjecture

Psychosis in sentenced prisons is a stable equilibrium $R_0S=1$
Psychosis prevalence in prisons is the equilibrium between susceptibility (UHR) and exposure to
(a) Intoxicants – cannabis, stimulants, others
(b) Violence threat of violence (which is also related to drugs in prison

Conjecture

Psychosis in sentenced prisons is a stable equilibrium $R_0S=1$
Psychosis prevalence in prisons is the equilibrium between susceptibility (UHR) and exposure to
(a) Intoxicants – cannabis, stimulants, others
(b) Violence threat of violence (which is also related to drugs in prison
Diversion cannot reduce it

Conjecture

Psychosis in sentenced prisons is a stable equilibrium $R_0S=1$
Psychosis prevalence in prisons is the equilibrium between susceptibility (UHR) and exposure to
(a) Intoxicants – cannabis, stimulants, others
(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