



Health and Criminal Justice conference

Responding to learning disability, addressing addiction and improving mental health among offenders

Wednesday 24 September 2008
Glenavon House Hotel, Cookstown

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Acknowledgements

This conference was developed by the Health Promotion Agency for Northern Ireland (HPA), the Northern Ireland Prison Service (NIPS) and the South Eastern Health and Social Care (HSC) Trust. Advice on the event was provided by the Department of Health, Social Services and Public Safety (DHSSPS), Probation Board for Northern Ireland (PBNI), Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO) and the Youth Justice Agency.

Foreword

This report is a record of the Health and Criminal Justice conference that took place at the Glenavon House Hotel in September 2008. Held six months after the South Eastern HSC Trust took over lead responsibility for healthcare in prisons, this conference was a valuable opportunity for health service and prison staff to come together with colleagues from the many other organisations that carry out valuable work with offenders. It gave us the chance to explore the learning from recent experience as well as some of the shared challenges ahead.

Shared challenges

Shared challenges are the key concept in this era of joined-up working, where we pool our expertise, experience and resources to provide value for money and ensure more effective and caring treatment of offenders. We are committed to caring for offenders in a holistic way across the system, improving their healthcare while tackling more of the factors that contribute to offending and ill health in the first place.

Taking a whole-person approach to health can not only improve the health and wellbeing of the individual, it can also help reduce the risk of reoffending, and help them break out of the cycle of the criminal justice system in which repeat offenders find themselves. We can also better support prison and community-based staff to do their best for offenders in a way that reduces the risk of compromise to their own health and wellbeing. Staff training is an important part, as are ways of working at organisational level to make staff feel supported. Our three organisations are collaborating on a health-promoting pilot at Hydebank, which aims to address some of these issues.

Resettlement

One of the themes of the conference was how we bridge the gap between custody and community, and better share information across organisations, to ensure that good work in prison translates into effective and caring resettlement. That is very much an area of priority for us at this time.

The challenge also arose of the risk that our criminal justice legislation can result in, for example, those with mental health or learning difficulty issues being sent to prison and kept there inappropriately.

The conference recognised the need to ensure that the health and criminal justice sectors become more joined-up, not only to benefit wider society but also to ensure a person-centred approach to the health of individual offenders.

We therefore take great pleasure in recommending to you this report of the Health and Criminal Justice conference. It is an important reminder to those who were present on the day, and those who were not, of the things we must keep doing – or start doing – to improve health within the criminal justice system.



Dr Brian Gaffney
Chief Executive
Health Promotion Agency for Northern Ireland



Robin Masfield
Director General
Northern Ireland Prison Service



John Compton
Chief Executive
South Eastern Health and Social Care Trust

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Background

The health of offenders is affected by varied and complex factors, and therefore requires a coordinated response from both prison and community resources. Offenders are more likely to come from lower socioeconomic groups and have poor levels of education – factors that are inextricably linked with ill health. Offenders spend more time in the community than in prison, yet many offenders do not have a GP.

Mental health disorders

Offenders are significantly more likely than those in the general population to have mental health disorders. There are clear links between poor mental health and reoffending, and mental health problems can increase the difficulties many offenders find in coping with demands that leaving prison places on them. These problems are exacerbated where drug use and mental health problems coexist. Alcohol and drug misuse tends to be common among offenders and, according to the Northern Ireland Drug Misuse Database, between April 2006 and March 2007 one in eight of those presenting for treatment for problem drug misuse was referred by probation services or prison.

Recent research has also focused attention on the issue of prisoners with a learning disability or learning difficulty. People with learning difficulties are more likely to be excluded from activities and opportunities than other prisoners; they are more likely to be victimised than other prisoners; and they are more likely to need more support and assistance than other prisoners. So it is important to make sure that we can identify and meet their needs.

Offender health

The HPA, the Northern Ireland Prison Service, and the South Eastern HSC Trust hosted a one day conference to bring together the organisations that contribute to offender health and wellbeing, to raise awareness of offender health issues, and identify how to improve outcomes in relation to offender health. This event also provided an opportunity for the Prison Reform Trust to launch its report on views of Northern Ireland prison staff on how

prisoners with learning difficulties and learning disabilities are identified and supported.

The objectives of the conference were to:

- raise awareness of the mental health, learning disability and addictions issues of offenders in Northern Ireland and examine the wide range of factors that impact on these;
- consider how current and developing services can be aligned to tackle the issues more holistically;
- consider how the criminal justice system can meet the needs of those with mental illness and personality disorder;
- identify how mental health can be promoted among offenders;
- consider what improvements can be made for those with learning difficulties and disabilities;
- provide an update on the developments in addiction services, current and planned, and consider how they can be further developed on a joined-up basis.

Programme

9.00am	Registration for parallel sessions
10.00am	Welcome Dr Brian Gaffney, Chief Executive Health Promotion Agency for Northern Ireland
10.05am	A prisons' perspective Robin Masefield, Director General Northern Ireland Prison Service
10.20am	No one knows. Learning disability in offenders: assessment and intervention Juliet Lyon, Director Prison Reform Trust
10.45am	Mental wellbeing and health problems among offenders Dr Andrew Fraser, Director of Health and Care Scottish Prison Service
11.10am	Break
11.40am	The challenges of working with offenders with addictions Denis Bradley, Consultant Northlands Treatment Centre
12.10pm	The transfer of lead responsibility for healthcare: implications for offender health John Compton, Chief Executive South Eastern Health and Social Care Trust
12.30pm	Questions and discussion
1.00pm	Lunch
2.00pm	Parallel sessions <ul style="list-style-type: none">• Learning disability: assessment and intervention• Managing mental illness• Promoting mental health• Addictions: treatment and brief interventions• Learning disability, mental health and addictions: making the links
3.30pm	Feedback plenary
4.00pm	Close

Welcome

Dr Brian Gaffney, Chief Executive
Health Promotion Agency for Northern Ireland

It is over two years since the HPA started working with the Prison Service to look at the issue of promoting the health of offenders. Our first joint initiative was a conference in Lisburn in September 2006. The focus was the development of a health promoting prisons approach. Feedback from that conference indicated that people wanted more opportunities like the conference to learn from, and share their experience with, others involved with offenders.

Themes

There was a particular demand for information around mental health issues, addiction and learning disability, and that is why we decided that they should be the themes of today's event. Feedback from the last time also indicated that people wanted to have more time for discussion, and you will see that we have organised parallel sessions with the opportunity to put forward your views and learn from each other.

Since the last conference, we and the Prison Service have been progressing plans, notably for the health promoting prison pilot at Hydebank Wood. We are hopeful that over the next 12 to 24 months we will be developing Hydebank Wood as a health promoting prison, which will make it one of the first in Europe, and put Northern Ireland at the forefront of using this model.

Implications of change

I am sure you are aware that lead responsibility for healthcare in prisons has now transferred to the South Eastern Health and Social Care Trust, and that is a major change in the ways things are organised around the prison service and healthcare. I am delighted that the chief executive of the Trust, John Compton, is here to talk about the implications of this change.

One of the key themes of this conference is how we address mental ill health and how we promote good mental health amongst

offenders. I don't need to tell you – it is part and parcel of your everyday work – that these issues are so complex that we need a wide range of organisations and individuals to be involved if we are to make progress. So I am delighted when I look at both the number of people attending the conference, and see how wide and varied the delegate list is.

Exclusion

There has been a lot of progress in terms of understanding offenders with learning disability or learning difficulty, or mental health disorder. We know that such offenders do have a much more difficult time and can be excluded during their time in prison, so I am delighted that the Prison Reform Trust is here to launch its report on prison staff views.

Once again, it has been a very positive experience for my agency to be working with the Prison Service over the past two years, and in developing the themes for this conference. We are also delighted that the South Eastern Trust has joined us as a lead partner in organising this event.

We are going to begin the conference with Robin Masefield. He has been the director general of the Prison Service since 2004. He has been connected with the Prison Service for a long time and we expect him to speak to us about the work that is going on and developments in the Prison Service, both in terms of healthcare and generally.

Presentations

A prisons' perspective

Robin Masefield, Director General
Northern Ireland Prison Service

What an audience... it is a tribute to the importance of the subject, and it is also a tribute to the work of the HPA and the Trust and many others and we, if you like, who have been very much in the front line with dealing with offenders and the wide range of needs which we are very familiar with and will be exploring today.

Joined-up-ness

Two years ago at the first HPA conference on prison health, I spoke of the need for joined-up-ness between the health and criminal justice sectors. I quoted the words on the Statue of Liberty. Today my text comes again from New York, from the West Side Story musical, some 50 years ago. The words of the song *Gee, Officer Krupke* are directly relevant. The self-confessed delinquent is suffering from classic dual diagnosis, indeed beginning with foetal alcohol syndrome. He comes into contact with a policeman, a judge, a psychiatrist and a social worker – only the voluntary sector is missing. In the words of the song, the Jets end up singing *Gee Officer Krupke, what are we to do?*

Today is about providing some answers to that very question. Paul Goggins and Michael McGimpsey have identified two key priorities for offenders – mental health and addiction services. Today the Prison Reform Trust rightly brings to that agenda a third key issue – learning difficulty and disability. Juliet Lyon is here to launch the PRT report on Northern Ireland.

Partnership agreement

Let us take stock of progress made in the past two years – the platform is undoubtedly stronger. The transfer of lead responsibility for prisoner healthcare was completed on 1 April

this year. The South Eastern Health and Social Care Trust are playing a lead role. A detailed partnership agreement is nearly finalised.

A needs analysis for addiction services has been completed and submitted to the Eastern Health and Social Services Board, and there is also an updated needs analysis covering wider healthcare issues. We have introduced a new management culture to facilitate modernisation. In partnership with the Trust, we are developing staff to undertake specialist roles and reviewing the skills mix.

Toxic environment

As Professor Roy McClelland said at our last conference, prisons are a toxic environment. I cannot deny that, but we are also working on physical improvements. Paul Goggins announced last December the building of 400 new prison places over a three year period. A 50 room unit has already opened in Magilligan, and a state-of-the-art accommodation block for 60 prisoners with integral sanitation opens in November this year; there will be a similar block for 120 prisoners in Maghaberry next spring, and a further 120 at Maghaberry following on after that. And, of course, the minister has announced the programme to replace the prison at Magilligan. In all three establishments, NIPS is refurbishing or indeed replacing the existing healthcare facilities.

It is essential not to forget our client base. Between 5,000 and 6,000 individuals come into prison every year. Many of them are vulnerable and damaged. To quote but one example, I spoke two years ago of the case of a female offender in her 40s with 127 previous convictions. She is back in custody now with over 160 convictions and/or offences.

Criminal Justice Order

The strategic landscape has changed, as well. As you know, the Criminal Justice (Northern

Ireland) Order 2008 received Royal Assent in May this year. The provisions for public protection sentences were implemented on 15 May 2008. To support the emphasis on public protection, the legislation requires the services to gear up their risk assessment and risk management, and to improve the programmes for addressing offending behaviour.

Those individuals who are given public protection sentences for sexual or violent offences will only be released by the parole commissioners if they can prove they are no longer a risk of serious harm to the community. Moreover, the MASRAM arrangements are being extended, beginning on 6 October 2008, to include certain violent offenders under the Public Protection Arrangements Northern Ireland. Again, the Criminal Justice Order requires the statutory cooperation of the agencies including health Trusts and Boards.

Bamford report

Similarly, since our last conference, we have had the final Bamford report. That placed an emphasis on change and modernisation of services, but also on greater recognition of the rights of the individual. There will inevitably be a tension between the emphasis on those rights and on those of the public in the Criminal Justice Order.

A further development is the *Health and wellbeing investment plan*, which targets a number of areas for development in relation to mental health services.

Greater funding

I spoke two years ago of the need to leverage greater funding for mental health services for those in custody. I do not want to steal John Compton's thunder, but we are beginning to get there, and that is hugely welcome. Specific proposals agreed between the Trust and the Prison Service are now with the Board.

These will bring in additional psychiatric services, better detoxification arrangements and enhanced substitute prescribing services, extended CBT provision, greater support for mental health nurses within establishments, and discharge coordinators linking to services in the community. As the Bamford vision states: "The involvement of the Health and Social Care Trust in leading prison healthcare should ensure the development of the

service in keeping with that in the community and facilitates seamless transfer of care across the interface between prison and the community."

Addiction services

Two years ago I referred to our plans for tendering addiction services from the non-statutory sector. That process has taken longer than I had hoped, but we plan later this year to issue those documents. That must be done in the context of the requirements of the Criminal Justice Order. It is important, too, to recognise the client base: there are some 150 prisoners in custody now whose main offence relates to drugs.

We are familiar with dual diagnosis, but I wonder if we need to address triple diagnosis from now on. The title of the report by the Prison Reform Trust, *No one knows*, is very apt. The Trust produced three reports – on the services in England, and Wales, Scotland, and Northern Ireland. It was not surprising that this one on Northern Ireland was the slimmest by far. That has to be an indictment of our knowledge, as well as a criticism of our services. We think we know our prison population; as Stephen Sondheim wrote 50 years ago, *Natchery we're punks*. But the song also says, *Deep down inside us there is good*.

Traditional boundaries

We now have the new Criminal Justice Order, new arrangements for programmes, new requirements for release and for recall. They will require us to work across traditional boundaries, to effect change in individuals. But there is, I believe, a real and emerging issue in relation to individuals with learning difficulties and disabilities. There is an onus on the authorities, and again as with personality disorder it cannot be left to those running the Prison Service, to ensure that individuals with low cognitive abilities, who may struggle to complete standard programmes, do not become consigned to an indefinite stay in prison. There is a powerful report due very soon from Anne Owers, the Chief Inspector of Prisons, which will shed further light on this issue.

I have taken a personal interest in dyslexia – we know that something like 30% of those coming into prison are assessed as having dyslexic tendencies. But do we know how many suffer

from ADHD, Asperger's, autism or indeed allergies? Do we have effective arrangements that allow the authorities in the criminal justice system to access the education records or the health details of such individuals, at least to enable us to look at how our services can better meet their needs?

A journey

We are on a journey, one that will benefit from the input of everyone in this room. It has already started. To give you another example, over the next six months at Hydebank Wood we'll be assessing individuals for learning disabilities and piloting improved interventions. The governor is also taking forward a partnership with Loughshore School. The Prison Service recognises that we, indeed society, need a wider range of inputs if we are to tackle the challenges. The challenges include addressing and balancing the needs of the individual and the rights of the public.

Doing nothing is not an option; the future requires a multi-disciplinary approach involving, not just the criminal justice and now the health sectors, but also increasingly the non-statutory sector. In short, we have a clearer handle on the West Side Story question, *What are we to do?* I hope today will for all of us be another step towards providing the answer.

No one knows. Learning disability in offenders: assessment and intervention

Juliet Lyon, Director
Prison Reform Trust

The Prison Reform Trust believes passionately that so many of the solutions to offending and crime, as well as to the overuse of imprisonment, lie in health. They also lie in education, in housing and in social services, of course. But in health you have so many of the solutions in relation to

treatment of addictions, care for the mentally ill, social care and work with people with learning disabilities.

Concerns

No one knows is a report about Northern Ireland and it is based on what staff here in the Prison Service told us. It was very clear from what they were saying that there were a number of concerns that many of them have had for a long period of time.

Throughout this programme, the Prison Reform Trust has been guided by a group of people with learning disabilities and convened by Key Ring. The Working for Justice group came and talked to Lord Keith Bradley, who is doing a review of court diversion for the mentally ill and people with learning difficulties. One of these young men was talking to Lord Bradley about his experience about going to court and he said, "I went to court and I was very frightened."

Community penalty

Nobody went with this young man and he had nobody to explain his needs or views or to explain to him anything about the proceedings. He said, "The judge said to me, 'You are getting a community penalty', and he gave me a big piece of paper." Now, this young man was completely delighted that he wasn't going to prison and that was the thing that was at the top of his mind. So he skipped out of court and went home and played football with his mates that night. The police came past and picked him up because he had broken his curfew.

Now that was just a vivid example of one thing. A word that someone didn't understand and no one explained – and he ended up in custody because he had broken his curfew; he had broken the conditions of his community penalty. That is just a stupid and mindless and thoughtless thing but it is the way that the system sometimes operates. It is a bad thing to happen to a young man like him who was very vulnerable, and thankfully is now being helped a lot by Key Ring.

Drive home

It is that kind of example that I really want to try and drive home because that is the reason to try and change things. It is not just about paper and policies, it's about individuals who get caught up in the system who can't manage it. Sometimes they are sent to prison but obviously

it is important to talk to people that are involved in probation, too.

What we have tried to do is to write a report that is broad and encompasses people with both learning disabilities and learning difficulties, and doesn't focus on one or the other. This is a quote: 'One of the most prevalent vulnerable groups amongst offenders comprises those who do not have intellectual disabilities formally defined but do have much lowered cognitive ability than do either the general population or the offending population.' We are, as we said, talking about a particularly vulnerable group here.

Learning difficulty

How many people are we talking about? At the moment, we think that about 20% to 30% of offenders have a learning difficulty or learning disability such that it interferes with their ability to cope within the criminal justice system. We also know that 7% of prisoners across the UK have an IQ of less than 70, and obviously if their IQ is that low they are going to find it very hard indeed to understand or cope with the system.

We know that almost a quarter of juvenile prisoners, the under 18 year olds, according to Harrington and Bailey have some form of disability and have an IQ of less than 70. So it is an even higher proportion when we focus on young people in the system. We are also talking about hidden disabilities. So although we are outlining the needs of a minority group, it is actually a very sizable minority. Research demonstrates that these people are at risk of reoffending because of their unidentified needs and consequent lack of support, and that they are unlikely to benefit from conventional programmes designed to address their offending behaviour.

Custodial sentence

I want to pick up Robin Masefields's point about the new indeterminate custodial sentence, because I think that this is a very critical issue. The chief inspector of prisons in England and Wales has a great expression, 'electric fence learning', and I think there is some electric fence learning around this for people here in Northern Ireland. One of the things that is very clear when we introduced the indeterminate sentence for public protection, the IPP sentence in England and Wales in April 2005, was that instead of netting the very few or the very dangerous people

that it was intended to target, actually the net was very wide.

There are thousands of people, over 4,000, serving an IPP in England and Wales. More than 600 of them are already over their tariff. We run an advice and information service at Prison Reform Trust, and we have had family after family phoning us and saying, for example, "My son has been given a sentence, he has been given three months for arson, but they say it is indeterminate and what does that mean?" The answer is, it could mean any length of time.

Parole system

With pressure on the parole system such as it is, with the scarcity of offending behaviour programmes such as it is, it is very hard for people to jump through the hoops required of them, so they are in this sentence, which is everyone's worst nightmare really. You are locked up and you are not quite sure what you have to do to prove your way out, and when you are told exactly how to demonstrate that you are no longer a risk, you discover that that means of demonstrating isn't open to you. I am talking generally now about all the prisoners in the system.

Now that legislation has just been amended as from April this year, you can no longer get an IPP sentence unless you are serving a four year sentence or more. That was amended in order to try and address this tidal wave of people that ended up being caught in this net, many of whom are mentally ill or have learning disabilities. The amendments came about through Lord Carter's report, which was issued in December 2007.

Specific tariff

I do understand that the tariff is two years in Northern Ireland, which is better than no specific tariff, but is still not long enough to prevent some of the abuses that I have drawn to your attention.

When you collect your copy of the *No one knows* report, I want to draw your attention to a reference on page 13 to this particular piece of legislation. We have submitted evidence to the Joint Select Committee on Human Rights, quite specifically drawing attention to the IPP sentence and saying that people with a learning disability aren't able to participate in offending behaviour programmes. They are quite specifically excluded

because the programme is not suitable for this group. So they are doubly disadvantaged and, if they are serving an IPP sentence, then they have no means actually to demonstrate they no longer present a risk.

Human rights

This was determined by the Select Committee as a straightforward abuse of human rights. I think it is hugely important for professionals who are going to be working with risk taking and very vulnerable groups of people to have antennae for this. We are waiting to see quite how the Government is going to respond, whether it will be something that will have to go to the European Court or whether it will be something that will be dealt with by the Equalities and Human Rights Commission.

Clearly, it is an important issue that has to be attended to. Many people with learning disabilities may get caught up in this new and indeterminate custodial sentence. It is vital either to adapt these offending behaviours' programmes or reconsider the sentence. At the very least, it is crucial for people in the field to monitor what is happening to these particular individuals as they hit this particular situation.

Solutions

People with learning disabilities are more likely to be targeted by other prisoners, and they are more likely to be bullied. They represent numerous difficulties for staff who often lack the specialist training for working with this group of people. There are specific implications, not only for offenders themselves, but also for a wide range of professionals and practitioners who work with them. That is what I was saying at the beginning – that there are solutions not only in criminal justice, but also in health and social care and education.

There are also important messages for the police prior to custody. The appropriate adult provision in police stations that we found when we were reporting on England and Wales was very patchy indeed. Often, needs went unidentified. Screening wasn't adequate. There were very limited referrals for clinical attention. Criteria for fitness to interview lacked clarity. There wasn't sufficient police training and awareness for them to pick up people who had a learning disability or learning difficulty when they reached the police station or on the point of arrest.

Diversion schemes

No one knows focuses primarily on prison, but it is important to think of the journey into prison. Similarly at court, local diversion and liaison schemes we found in England and Wales particularly, but also in Scotland and in Northern Ireland, seem to be very patchy and few people involved in these diversion schemes have social care expertise.

There are provisions for vulnerable witnesses and vulnerable victims, but these have not as yet been extended to vulnerable defendants. That could be something that could be done easily because the mechanism is already there.

Needs of offenders

The needs of offenders with mental health issues are prioritised over those with learning disabilities, so you get disadvantaged groups kind of competing. We found that people with learning disabilities seemed to get the very worst of all deals. Prison staff also felt that community based provision is not always accessible to offenders with learning disabilities or difficulties.

The report found that there was a lack of proper assessment prior to and within custody. Prisoners with learning disabilities and learning difficulties faced problems with communication, information, adjusting to prison and engaging with the full regime. There were obstacles to providing support, relating to lack of identification, staff awareness, resources and the systematic understanding across the prison estate.

Confidentiality

The information sharing across prisons was patchy, and familiarity with specific protocols for confidentiality was pretty mixed. Few respondents were familiar with the types of support that were available even within their own prison, and those who were aware of the support available were negative about the quality of that support.

People who have a learning difficulty or learning disability and leave prison are incidentally more likely to find resettlement tough, so whether it is finding money or housing, finding work, everything is doubly difficult. I think there is a lot of work to do on the resettlement end of things.

Bullying

The report looked at bullying and I want to read you quotes from three prisoners, all of whom

have learning disabilities: A prisoner in Scotland said, “I have been scared through bullying; I can hear people planning things and talking about it although it doesn’t necessarily happen. I am scared in the shower – there are no cameras and no officers. So if they are going to get you, they will get you alone and that is where it will happen. I have seen this happen.”

One woman said, “I hate seeing fights. I always run to my room and lock the door.” A young offender told us, “He (an officer) just started taking all my stuff out and throwing it around and I shouted at him to stop. He came at me, grabbed me and twisted me up. I did nothing and that actually shook me up.”

Abusive

I think there are very few occasions with staff being abusive, and I think there are very many more staff that want to help, but don’t know how to do it. One solution was suggested by a young offender who said, “You should have someone who comes to the wing to help you and then you would have help from just one person and that would be much better. If people see you getting help, then they might laugh at you and pick on you. There should be somewhere quiet where nobody can see you and you will find that people would use that a lot more and even one of the staff can do it, for about an hour.”

With some notable exceptions, most of the aspects of the prison regime had not been adapted for prisoners with learning disabilities or learning difficulties. Prisoners were excluded from activities or opportunities and, as I said earlier, primarily in relation to this new sentence from offending behaviour programmes.

Good practice

Respondents were not confident that the skills and expertise to support this group of people were available at their prison and specific disability awareness training was only available to certain staff. Respondents were able to cite examples of good practice and work of which they were proud, including support work with poor copers, one to one work and help for prisoners with dyslexia.

There is a set of recommendations in this report, based on the findings – some about policy and some about practice. I know that this audience is a very expert one, many of you are influential

in relation to policy. Some of you may be policymakers and others will be leading practice. I think much more could be done, and our sense from the research in Northern Ireland was there was a willingness to do it.

In conclusion, you will see from the recommendations in the report that there is a criminal justice journey to be followed. I think there is also a prior journey about prevention and a prior responsibility in relation to education, health and social services in identifying people who are beginning to get into trouble and steering them away.

Mental wellbeing and health problems among offenders

Dr Andrew Fraser,
Director of Health and Care
Scottish Prison Service

I am going to structure my talk around the work of the World Health Organization (WHO) which has done quite a bit of work in its Health in Prisons Project (HIPP) on mental illness and the UK perspective. There are a lot of very exciting things going on in England, and I would highlight the Mental Health Research Network led by Jenny Shaw in Manchester.

Mental illness

I am quoting here, from a chapter by Eric Blaauw and Hjalner von Marle from the Netherlands. These are what I would call standard statistics for mental illness. There is a concentration of severe mental illness in prison. In statistical terms, it is just 4%. Well, 4% is a lot, especially if you talk to people in our women’s prison about last weekend, for instance. They had over 400 people in the prison and it was quiet apart from two very disturbed prisoners who just completely turned the culture and the sentiment and the whole running of the prison on its head.

Mental illness might be in the minority and right through the system, but on the other hand there is the majority, I am quoting 89% with a depressive symptom, so mental illness is everywhere. Certainly, poor mental wellbeing is everywhere and it goes back to one statistic from *No one knows*: 7% of prisoners have an IQ less than 70, and between 22% and 27% have a whole range of problems and learning disabilities, and you have this dilemma between “it’s just a specialist thing” or “it’s a mainstream thing”. Both mental illness and learning disability are both – you cannot separate them out from the mainstream running of prisons.

Slovakia

Then we have the *Trencin statement* that was launched this year. Trencin is a place in Slovakia where we met and talked through prisons and mental health last year in the WHO network. It was a very hard-hitting statement about prisons and mental health. There is this theme about prisons being the new asylums, ‘a dumping ground for the mentally ill’. We do have a problem with the lack of, what the criminal justice system calls rather carelessly, ‘disposals’, but the rest of us call ‘care plans for people with mental illness’, and prison in my view all too easily becomes the bucket at the bottom when you sieve through all the other sieves.

Prisons have no waiting lists, prisons have a statutory duty to take who they are given, and as a result we are getting a lot of people who, by the way, have mental illness. But it is not as easy as that, it is much more profound a problem than that, so the *Trencin statement* really started to address and challenge that.

Rehabilitation

Are we becoming the 21st century asylums for the mentally ill? The point of mental illness and the treatment of mental illness, learning disabilities, and addictions and the creation of mental wellbeing is all about rehabilitation, and you cannot engage with a rehabilitation programme unless your head is screwed on properly. The *Trencin statement* looks at how institutions are seldom able to treat and care for acutely mentally ill prisoners, how vulnerability must be understood, and how personal planning is not just for the good of the staff, but also for the good of the person in front of you.

You asked me to talk about offenders, and I have really concentrated on prisoners because we know

more about prisoners. We also need to know what is about out there because these people have needs, too. People who are offenders in the community have very high needs, higher than the background population. They are approaching levels that you would expect to see in prisons but surprisingly have low levels of service use. Why is that? It’s probably because their mental health problems are in the shadows of their addictions. Also, there are very low expectations for what services can do for them.

Sick people

Prisons are the major source of referral to the secure mental health services. Sick people come into hospital from the community. Yes, they come in from general psychiatry. But prison is the major referral agency and we are the main valve because most of them come back to us.

I would like to come back to the issue that Robin raised about dual, triple diagnoses. We are talking about people with many layers of problems; we are not talking about people with mental illness in that box there and learning disabilities in that box there. The person in front of you has many problems and we have to layer them out and order them so that one goes before the other, and one type of service respects the other.

Separation

I did a review five years ago on drug addicted people and alcohol addicted people along with mental health problems. There is a separation of the services. They don’t speak to each other and they don’t seem to know what goes first (this is in the community). We have got to sort this. People are people and we have got to look and see primarily what they need, rather than what our services need to keep going.

Going back to the WHO guide: there is a very helpful chapter with a checklist of what can be done to support mental health in a prison environment. There’s not much about medical treatment, nursing or health care in this. This is about the process, it is about the environment, it is about the commitment of management and staff, it’s about leadership and how it starts at the top with the Government or the director. And lastly, it is about respect, it’s about being kind to people. So it’s the ethos of prisons that this chapter is driving at, rather than it needs to be a certain number of people with a certain amount of skill in your prisons.

Have hope

Hope is a very important part of mental health and mental illness. If you don't have hope, what is the point? We need to be able to induce hope in the people in front of us. Hope is absolutely a key aspect of beginning the process of becoming mentally well.

Finally, I want to flag up prison overcrowding and prison misuse. People are using prisons for the wrong reasons, the easy reasons, and prisons are being misused for people who are mentally ill. This is an issue which I passionately believe needs to be brought to the attention of people who use prisons too lightly, who treat mental illness too lightly and labels around mental illness too lightly, and who don't understand the damage that can be caused (try as we might to minimise it) to a human being's mental health by sending them to prison inappropriately.

The challenges of working with offenders with addictions

Denis Bradley, Consultant
Northlands Treatment Centre

If you look at a Bank of England £5 note, there is a photograph of a woman's head. It is a photograph of Elizabeth Fry. She was the first and probably the best known of the prisoner reformers. She was born in 1780 and she lived until 1845. She visited prisons, found them to be to be horrendous, and spent a great deal of her life trying to do something about it. She believed that when society couldn't or wouldn't face up to a problem, it had a strong inclination to dump those problems into prison.

Dumping ground

It was mentioned earlier in this conference that we are in danger of returning to the days of Elizabeth Fry. Society is again using prisons as a dumping ground. Those of you at this conference who are about to take over the health and welfare of prisoners might be well advised to know this reality.

Why is it happening again now? Why are we returning to some of the same conditions that Elizabeth Fry faced? The answer is probably complex, but if we were to identify two factors they would be: a) the growing fear of crime and: b) an imbalance between the victim and the perpetrator. These are two good and valid reasons and they should not be ignored. But it is possible to comment upon them. Firstly, every police service on these islands will tell you that there is definitely a growing fear of crime, even though the actual amount of crime has been dropping.

Fair society

On the second issue about the treatment of victims, it is interesting that the British prime minister appealed yesterday at the Labour Party conference for a fair society. I think there is a need indeed for a fair society, and there is a need to find a balance between holding victims in esteem and holding perpetrators or prisoners in esteem. That is not beyond the possibility of the human being. If you treat prisoners with respect, with dignity and decency, with proper care, that does not in any way diminish your ability to actively respect the people who have been hurt or damaged or frightened. We are capable of holding two things in balance at one and the same time.

But the issue that I am addressing here is that of alcohol and drug addiction and its impact on prisons and prisoners. Well, in the years between 1990 and 2000 in Ireland, we increased the amount of alcohol that we consumed. In fact, we doubled the amount of alcohol we consumed. We jumped in the league of consumption levels within Europe from pretty low down to one of the top.

Damage levels

Of course as we increased the amount of alcohol we consumed, we also increased the damage that was done at every possible level. There is a direct relationship between consumption levels and damage levels. The number of people that have ended up in prison as a result of over-drinking increased as other damage increased. A&E in hospitals saw an increase, the suicide rates saw an increase, mental illness saw an increase, social and marital breakdown and domestic violence all increased, as did the number of people who ended up in prison from an increase in consumption of alcohol.

Those who ended up in prison were those who were already vulnerable, those who were already

the most damaged. Added to that is an increase in heroin intake and an increase, particularly in cocaine. We know from public and health services it has been on the cards, and it is now clear that we are about to take all the problems that society cannot manage anymore and dump them into prison. That is where the people who are attending this conference are about to work, that is what is coming down the road.

Big questions

Can you handle it? Should you handle it? Those are the big questions. I am not too sure you should, but I am quite sure that you are going to have to. First of all, I think you should protest. Elizabeth Fry was not just a worker in prisons, she politicised her work, she protested to the politicians. Devolution of policing and justice is going to happen within the next few months. That means that prisons are going to be controlled by local politicians. Whoever becomes the local politician dealing with this issue should have his/her ear twisted and told not to turn our prisons into asylums.

Let's take an example. Someone who goes into prison under a two year tariff may not get out for a long, long time. The new Probation Board is going to pose the question: "Who is going to guarantee that this person will not misbehave again?" If I were asked that question, I would refuse to answer it. When you are dealing with addiction, you cannot give guarantees or simplistic prognosis. Those are the wrong questions and, if those are the questions you are asking, then what you are doing is throwing the key away. This is not good enough.

Local politicians

The second thing that we can do when devolution happens is put a bit of pressure on our local politicians to look at what services we are offering prisoners. There is a danger that the politicians will be told that everything is all right. The health service has now taken over the prisons, so they can relax. But they will not be told that health doesn't do addiction well. The health service has never done addiction well. Otherwise, why would the medical profession encourage AA to have been formed, and why would the medical profession refer so many people to AA and to independent organisations? If it is going to be dealt with by health, then who should deal with it? The nurse, the GP, the psychologist, psychotherapist? All of them? None of them?

The truth is that addiction is about as slippery as you can get because it's spiritual, mental, physical and social, all at the one time, and it needs all of those inputs at the appropriate levels. Are people going to get that in prison? Not at the moment. Should they? Well, there is certainly a captive audience. I think we could do it better and I think some people have done it better.

RAPT

I am a big supporter of RAPT (the Rehabilitation for Addicted Prisoners Trust) in England, an independent charity organisation servicing about 12 prisons. Their results look very good and their research looks very good. Why are we ignoring the research? Aren't we an evidence-led group of people? RAPT mainly does a 12-step programme with AA. It takes a wing, and works with people who are the most difficult but who have some motivation.

It is now a single mode of operation, but it is better than anything I have seen. Not perfect, but what is? We tried it here. I offered it to Paul Goggins but he decided to move past it into the bigger issue. I can understand that, but I say to any Government minister: "What is happening at the moment is not good enough".

More research

The opportunities are magnificent. The last thing we need is more research. I went into the internet to see what I could learn. It is full of reports. The internet yields a mountain of research, but I didn't discover the line that said, "Something was implemented because of the research". Nowhere did it say, "This was done because of the research" or "This was done because this was the evidence", and yet people will say they need more research. What we need do now is implement some of this research.

But we already know some things. We know that addiction is hard to treat. We know that it is hard to treat in its early stages, and even harder to treat in its later stages. We know that a lot of people who are in prison pass all the tests of addiction. We know that many of them are in the later stages of addiction. We know that they will be hard to treat because on top of, and running alongside, the addiction will be a plethora of other conditions and problems, eg marriage, social, psychological, behavioural, personality. We know that some therapeutic input is better than no therapeutic input. All the research shows that. We know that

the best therapeutic programmes are those that include aftercare for a minimum of at least two years.

Aftercare facilities

What do we know about our prisons? Well, we know they are trying. We know that there are programmes in there now when once there was nothing. We know that there are proposals for new types of programmes. We know that most or all of these programmes are not intensive or prolonged. We know that there are very few, if any, residential aftercare facilities in the whole of Northern Ireland. We know that prisons are going to offer light touch programmes that will last three to six weeks. I am sure in themselves that the programmes will be fine, but they are not enough. They will tick the bureaucratic boxes but they will not challenge or encourage the prisoner to the extent or to the depth that is possible and needed.

Prisons are facing great challenges but they are also being offered great possibilities. Addiction and how to deal with it is one of the great challenges. It holds a potential to block the parole and release system and so create a bottleneck within the prisons themselves. This happened to some extent in England and is more than likely to happen here. The other side of that is that prisoners are indeed a captive audience. And within the rhythms that are peculiar to prison life could be offered programmes and treatments that would help break the cycles of addiction and the cycles of reoffending.

The transfer of lead responsibility for healthcare: implications for offender health

John Compton, Chief Executive
South Eastern Health and Social Care Trust

I want to set the context of where health and social care is coming from in terms of the transfer.

Maghaberry is in the South Eastern HSC Trust area and this made it an inevitability that, in the new arrangements, the South Eastern Trust would be the lead organisation. From my point of view, I approach it with a degree of optimism that our Health and Social Care Trust is now directly involved in delivery of services to prisons. We are not going to solve the problems that exist in prisons overnight, but I think we can make a difference.

Political context

All the issues mentioned so far at this conference occur within a political context and it is important that is understood – both from the health perspective and from the prison perspective. That political environment is to some extent an expression of society's position and we equally have to understand that we are not an island and not isolated from that position. You might argue that just as society gets the health service it deserves or expects, it might also get a prison service it deserves or expects.

So from our point of view, looking at the service perspective, this is how the health side looks at the prison side. There are three large facilities, they do different things, and they have different roles. We are learning to understand the difference a little more clearly. The important thing from our point of view is that there is a client population which spans the age ranges. Those who find themselves in prison are a population, as I understand, of over 5,000 in a year. So there is a tidal movement during the course of a year of people who come in and out of prison. That is a challenge for us on the health side because we have a way of looking at certain services which are perhaps different to the way in which a prison might look at services.

10,000 employees

The South Eastern HSC Trust is an integrated hospital and community Trust providing over 200 services on a daily basis, eg mental health, hospital, community services, disabilities, children's services. On the full amount of services we spend more than £400 million, ie every day over 24 hours we spend over £1 million. We have 10,000 employees of whom just less than 8,000 are full time. We are an amalgamation of what were two former Trusts – Down and Lisburn, and Ulster Hospitals.

So what are the issues for us for a health organisation? What, if you like, is on my agenda? Well, safe and effective care. Increasingly, we live in a world where we are accountable for the actions that we take and the consequences of the actions. On some occasions, decisions are taken without regard to the individuals who have health and social care needs. We are required to live in financial balance, so we don't have open season on how to spend money. We are expected to be as transparent as we can in telling people what we are about, and we aim to be productive, innovative and caring.

Standards

How are we approaching working together? As a chief executive of a Health and Social Care Trust, it is my responsibility to set the standards of the organisation. We have a strategic partnership between the Northern Ireland Office, the Prison Service and ourselves. We are close to the final agreement. Our services are commissioned through the Eastern Health and Social Services Board (EHSSB). That has been something, I think, that has been challenging in terms of the prison side to understand.

There are two sides to the delivery of health care – those personnel who assess need and commission services, and those who deliver. We do the delivery. The EHSSB does the assessment and the purchasing. They have £6.2 million a year for services in prisons. We have a strong partnership board chaired by our director, and I think that works well and that people are beginning to learn how we approach and think about things. In a sense, this is about culture, it's about focus, about being practical, and it's about understanding.

Tortuous exercise

The transfer of lead responsibility for healthcare in prisons started in April 2007. Since then, our assistant director has been working well with the managers in Maghaberry, Magilligan, and Hydebank Wood. The transfer, for anybody who was involved in it, was a tortuous exercise – I make no apology for saying that. It was a tortuous exercise because you have two systems that frankly didn't really understand each other, but needed to understand each other. Perhaps the delay in the transfer, in hindsight, has turned out to be a good thing because people have made that movement and understand each other. The community that is

in prison is not the equivalent to the community that is outside. There is not a normal distribution. It is a community and a population with an abnormal distribution of healthcare needs, yet what someone in the prison community can reasonably expect from our services should be entirely the same level of service those outside prison get from the health system.

Compassion

Behind all of that, there has to be a genuine sense of compassion if we are really interested in helping people. The objective is to make their life a little bit better and, coincidentally maybe, to make society's life a little bit easier. I don't think we can have any other expectations than that.

So how do we do that? I think what we have been engaged in is looking around to see who does it well and what are the things that work. If someone has got it sorted out, go and find out where it is and do that. I think there needs to be respect between both sides. I am sure there will be times when we will perceive things differently, that is just a fact of life – but that doesn't mean you can't balance these two things. It is about people. Systems are the product of people, and if people are prepared to work together, then the systems will reflect that.

Resident address

It is a primary care service, as far as I can see, that is the principal drive here, that is what happens to most people, that is how they receive their services at home or as close to home as they can. Prison is not a home, but for a period of time it is a home life environment, it is the resident address of someone. The service has to be based on needs and assessment of needs.

Governance for us, and for the prisons, is a major concern to get right and we do need to understand the governance arrangements on both sides. We have different policies and we need to get those into harmony. For example, if we have a process by which we supervise prisoners whom we consider at suicide risk in the health system, and the prison service also has a policy by which it supervises prisoners at suicide risk, we need to make sure those policies are aligned.

Good service

Performance management is important in the health service. Ultimately, if it is working properly, it is simply reflecting what a good service should do. So when we measure a good service, it should be achieving. We have to measure our information systems, how we look at our workforce and, above all, how we communicate.

Primary care services operate 365 days a year and have to provide a full range of health services with person-centred planning. This is the language of health which may be unfamiliar to many of you, just as there is language you use which is unfamiliar to us. Person-centred planning simply means planning for the specific needs of the individual.

Need problem

We have the opportunity of some new investment in excess of £400,000 and that will continue. It is going primarily into mental health services because it is deemed as the single biggest area of need problem in prisons. This is consistent with the Bamford recommendations and with relevant PFA targets. How it is spent will be evidence-based and will take into account the recommendations of reviews and needs assessment.

The idea is to strengthen home treatment in prison through increased medical nursing cover and the provision of diversity of therapies. If you want to make improvements in mental health, the therapeutic environment in which people reside is important. A research report called *The lost 23* looked at the lost 23 hours in a day if you're admitted to an in-patient unit. It was worked out that for 60 minutes in a day you had therapy. What did you do for the rest of the 23 hours apart from when you were asleep? What did it contribute to your mental health and wellbeing? The environment and the way in which facilities operate and are structured is important to the therapeutic environment. We will have to work together to understand that and to see what is possible and what is not.

Risk management

We clearly need to strengthen psychological therapies. Specifically, we need to look at the issue of personality disorder. We know that one or two people with very acute difficulties can disrupt the whole focus that was mentioned in terms of the Scottish system. We need to

strengthen risk management through our clinical coordinators and, of course, look into the addiction services and, in particular, the learning that we have had from what is referred to as dual diagnosis.

We are getting to grips with what might be a reasonable way to approach addiction services. We also have interface issues. We have a criminal justice bill coming, and the implications of how we are supposed to deal with people with mental health problems when they leave our care in hospital and go into the community while we have governance and responsibility. There is a whole range of emerging issues and you could be overwhelmed and say, "This is all too difficult, we will never get all these sorted out", but actually one step at a time will get you there. This is about changing the system. It is about changing the purpose. It is not about a short term fix.

Commitment

To date, much work has been done – a lot of it quietly and unobtrusively – by both prison and health staff, and I would like to take the opportunity to publicly thank the prison staff who have worked with our staff. Effort, energy and commitment have been brought to bear, and that augurs well for the serious business of making the relationship between the prison service and health constructive and positive.

Finally, I hope I have left you with some sense of the direction we are going in, and what we might reasonably expect to do. I look forward to a similar type of conference in 12 to 18 months when we can talk about the progress we have made. Using the information from the two organisations and the skills of the staff with one focus will lead us to make our prisons more healthful institutions, not simply dumping grounds. Certainly one of the issues that we in health want to contribute to is the rehabilitation of prisoners.

Parallel sessions and feedback

Learning disability: assessment and intervention

Autism and early intervention for the prevention of offending

Eimear McCurdie,
Development Officer (Partnerships)
Autism NI (PAPA)

Many young people and adults with autism are excluded from peer groups who may find their behaviour disconcerting. This can lead to problems of frustration, depression, anxiety and anger. The by-product of this has been the increase in young people and adults with autism coming into contact with PSNI, the juvenile justice system and receiving Anti Social Behaviour Orders. The additional problems include bullying, being misunderstood and a higher risk of suicidal behaviour.

Autism NI (PAPA) works with a range of organisations to provide knowledge and awareness of the 'fundamentals of autism'. Due to the invisible nature of this disability, it has been deemed necessary to work with emergency service organisations, for example PSNI, juvenile justice, and Fire and Rescue.

The 'attention card' system piloted in the Western HSC Trust area, and also work with the NI Assembly detailing the need for expertise within the criminal justice system, has enabled the organisation to develop a training package with funding from the Eastern Health and Social Services Board's community grants scheme to assist and contribute to the recognition of autism, inform procedures and to provide information for parents.

From this previous work and research, the outcomes demonstrate that there is a need for a more active partnership between Autism NI (PAPA) and the emergency services.

Implementing dyslexia interventions: a person-centred approach

Janice McHenry,
Learning and Skills Advisor
Northern Ireland Prison Service

Who is affected by dyslexia? What is dyslexia? Why is it important to support offenders with dyslexic tendencies? NIPS Learning and Skills Branch response to *No one knows* report.

Three key messages:

- The management of learning disability, learning difference within the Northern Ireland Prison Service requires an inter-branch approach in order to effect change.
- Staff training is required at a number of levels; awareness raising for all staff and specialist training for teachers is needed.
- Dyslexia interventions should, where possible, be integrated within normal learning and skills delivery, with appropriate provision for individualised intervention according to need.

Feedback from discussion

Nancy Loucks (Chair)

This session emphasised a number of issues. The first issue is that training is very important to make sure that staff are aware of the issues and can recognise some of the signs of learning disability and learning difficulties. There needs to be staff awareness training across the board, not just limited to specialist staff or health care staff. It is something that has to be available for prison officers because they are the ones who are having the face to face interaction with the prisoners on a day to day basis.

The second issue concerned looking at what prisons actually do, in terms of how people are expected to obtain information and how they are supposed to progress through their sentence. For example, people have to fill out forms for absolutely everything, the fact that people are expected to look at leaflets and posters and so on to get information about the regime, the rules, and their rights and entitlements.

We need to try and make sure this information is visually appropriate. One of the things that Janice brought out was that, with Power Point presentation of information, the simpler in terms of language and visual aids it is the better, as it may otherwise be disturbing for some people. Having pictures to assist can be very helpful. That's not something that just benefits groups with learning disabilities and learning difficulties – it can benefit everyone, including those with low literacy levels and foreign nationals.

The third issue raised is to make sure that we take a multidisciplinary approach for people with learning disabilities and learning difficulties. It is not something that is just a health problem, it is not just psychology, it is not just education – it concerns everybody across the prisons and outside, in the courts and in the community: it is a multi-agency issue.

Managing mental illness

REACH project at Maghaberry Prison

Billy McKeown, Principal Officer
Northern Ireland Prison Service

REACH is a service that focuses on managing the needs of prisoners who are poor copers, or present with challenging behaviours often debated as a personality disorder. REACH is a dedicated unit within HMP Maghaberry that aims to improve prisoners' social functioning through a meaningful day concept. The project commenced in April 2007. It is a local initiative that has provided training for prison staff in the area of mental illness, and has helped foster improved staff/prisoner relationships.

Three key messages:

- Extraordinary effort by ordinary staff can make a difference.
- Effective therapeutic interventions can reduce self harm, improve prisoners' wellbeing, and help individuals learn to manage their difficulties more effectively.
- REACH can contribute meaningfully to a multi-agency approach in managing offenders, risk and resettlement into the community.

Meeting the needs of mentally disordered and personality disordered offenders in the community

Geraldine O'Hare, Forensic Psychologist
Probation Board for Northern Ireland

Mentally disordered offenders invariably demonstrate a wide spectrum of psychologically distressing symptoms and perplexing behaviours within criminal justice settings.

This presentation concerned the complex and pervasive nature of such difficulties and underlined the need for a systematic, coordinated, interagency approach with respect to both the initial assessment and subsequent proactive management of such individuals.

Three key messages:

- Mentally disordered and personality disordered individuals are commonly found within the criminal justice system.
- Current deficits in both mental health legislation and the provision of services in Northern Ireland have resulted in individuals with personality disorder being considerably disadvantaged compared to other jurisdictions within the United Kingdom and western European states.
- A comprehensive treatment and management strategy of such individuals is required in Northern Ireland. An absence of such an initiative will unquestionably result in both the unacceptable compounding of the inherent psychological disability of the sufferer, and is liable to increase the risk of harm to the public from such individuals.

Feedback from discussion

Dr Ian Bownes (Chair)

This session focused on the burning issue of people with mental disorders within prisons and, in particular, individuals who have a disorder of personality. Some of the figures that were presented highlighted the high prevalence of personality disorder within the criminal justice system. As you know, 13% of the community will have a categorical disorder personality, but within the prison system 60%–70% of individuals have that type of diagnosis.

This condition is distressing and disabling. Various initiatives within the criminal justice system, the REACH project at Maghaberry and initiatives within the probation service, were highlighted. These initiatives should be commended, but it was noted that there was a limited input from health to these initiatives and it was felt that here was an opportunity for health, in partnership with the prison service, to push forward a greater clinical input to these existing services.

It was felt that the existing services within prison require not only more input from health, but when individuals leave prison they need to have further assistance in terms of rehabilitation within the community, and there needs to be sister services within the community to manage these individuals.

It was also felt that one of the major problems in terms of managing people with personality disorder was the current provision or lack of provision within the Mental Health Order. Through Bamford, the Northern Ireland Mental Health Order is under review, and it is hoped that serious consideration will be given to utilising the Mental Health Order to assist practitioners who are managing people within the prison service, and managing people within the community in terms of the diagnosis of personality disorder. It is hoped that new mental health legislation will lead the way for a rational approach to managing these individuals.

Promoting mental health

Mental health promotion training with criminal justice staff: a practitioner's perspective

David Williams

Care Services Improvement Partnership (CSIP)

Mental health is a key factor in reoffending, and a large number of prisoners have mental health difficulties. These include problems like depression, anxiety, stress, loss reactions, and substance misuse which can result in self-harm and suicide.

Prisoner mental health is an important contributor to the stresses of the job of prison staff, having a huge impact on their day-to-day work. By promoting better mental health, prison staff and prison healthcare staff can use an evidence-based approach, which will build emotional resilience and diminish mental illness. This approach allows active promotion of a prisoner's mental health so that a problem has less chance of recurring and prisoners are better equipped to deal with life on release.

Three key messages:

- There is a need to reduce the medicalisation of low level mental distress.
- Prison staff are often approached by prisoners and / or know when something is "wrong" with a prisoner, but not what to do about it.
- In every prison there are numerous support services, not just healthcare, that will support individuals to address the causes behind their mental distress and find solutions to these.

It's healthy to talk: the Listeners' scheme in prison

Madge Dempsey,

Regional Prison Support Officer (NI)

Samaritans

Three key messages:

The Listeners' vision is of a prison environment in which

- people are able to explore their feelings;
- people are able to acknowledge and respect the feelings of others;
- fewer people die by suicide.

Listeners' values are based on the belief that being listened to in confidence, and accepted without prejudice, can alleviate despair and suicidal feelings. Listeners' initial training and subsequent support meetings, and ongoing training with Samaritans, promotes mental health in the Listeners themselves.

The mental health of a vulnerable/distressed /suicidal prisoner can be promoted and enhanced by confidential, caring support and non-judgmental listening by their trained peers.

Feedback from discussion

Deirdre McNamee (Chair)

This session looked at the potential within the prison setting of promoting positive mental health. Discussions arose around the learning from the models the two speakers shared with us, and how the CSIP work could be translated for us in Northern Ireland.

One of the issues that we identified was the lack of joined-up working in terms of transferring the models of good practice within the prison setting to when prisoners are resettled within the community. Sometimes this doesn't work very well and some of the learning could be taken from within the prison setting and transferred outside.

This issue is particularly relevant for prisoners from paramilitary backgrounds who may face a range of difficulties in terms of their resettlement, including the reality that they do not access services within the community. Better linking of the pathways in relation to how prisoners are resettled within the community was felt to be a major issue to be taken forward as a recommendation from the conference. Training for staff will enable them to be able to do their work better and support them in the future. The issue of recruitment and retention of staff, particularly at the minute, within the mental health sector was raised, and it was felt important to look at workforce planning.

Involving staff from the outset in any future developments was another point that was raised. Staff really need to be involved because they are the biggest resource within the prison setting. The health promoting prisons approach would be a good way to look at staff within the prisons and also how they link with the wider community.

Addictions: treatment and brief interventions

Treatment services: continuity of care

Briege Quinn,
Assistant Services Manager (Addictions)
Belfast Health and Social Care Trust

Three key messages:

- the importance of good communication and partnership working;
- the importance of ensuring an integrated care pathway with community prescribers;
- the importance of drugs education, especially regarding tolerance loss and risk post prison release.

Addiction, prison and influencing positive behaviour change

Kathy Goumas, Addictions Manager
Northern Ireland Prison Service

As responsibility for addiction services in prison prepares to transfer to the DHSSPS, there is an opportunity to develop services that are more comprehensive in responding to the needs of offenders with substance misuse and dependency problems. The need to be integrated within the agendas of both health and criminal justice is crucial and a multi-professional approach to the management of treatment and support for this sub-section of the offender population is being developed.

Three key messages:

- Addiction services need to be comprehensive in the range of services provided, be integrated within both the health and criminal justice systems, and support effective coordination of care to respond to the far-ranging and varied needs of the prison population.
- All staff within an organisation can play a role in influencing positive behaviour change if they are taught effective communication skills and supported to use simple skills and strategies that are aimed at increasing motivation and decreasing resistance.
- Experiences from the Swedish Prison and Probation Service offer interesting and important guidance on implementing a motivational interviewing, semi-structured programme that has enhanced how their clients engage with behaviour change interventions.

Feedback from discussion

Martin Cardwell (Chair)

This session explored the challenges around improving service delivery in a more joined-up fashion for those offenders with substance issue problems. It developed into a discussion that could be titled 'Safe and effective care' as was mentioned earlier on by John Compton. It focused on two main issues – client safety or risk management, and standards and governance.

Under risk management and client safety, the main challenge was around improvements in the planning and coordination of entry into services, both within and outside the prison setting. There were issues about improving communication between the statutory and voluntary agencies both inside and outside prison, and the various agencies in the community.

It was felt there needs to be more of a shared understanding of operational issues around the different array of services – interface issues, for example, in someone being released from prison and needing to be picked up in terms of treatment. So there is something there about systems and understanding the systems, and the differing operational issues between the different agencies.

Under standards and governance, points were raised about provision of training for prison officer staff and staff within the various agencies. There needs to be training in areas like detox and talking therapies. There needs to be support and supervisory arrangements for those staff as well. We also need protocols.

The point was made about the need for shared learning and opportunities for such learning. It was suggested that the Masaran approach was a good model for developing shared learning. However, another point raised was the difference in governance issues between the voluntary and statutory agencies, and how there are different requirements.

Learning disability, mental health and addictions: making the links

Inter-agency working to support those with multiple complex needs

Mal Byrne

Homeless Support Team, Extern

Three key messages:

- the importance of a holistic approach to assessment and intervention with this group;
- the importance of communication between agencies to ensure effective intervention, avoid duplication and maximise engagement;
- the use of the assertive outreach approach to client engagement which requires agency cooperation to be effective.

Progressing the Bamford vision

Dr Fred Browne

Shannon Clinic

Belfast Health and Social Care Trust

The Bamford review of mental health and learning disability made many recommendations for the development of policy, legislation and services for mentally disordered offenders. The main recommendations were summarised. The Government's response, *Delivering the Bamford vision*, was also described. In the section on forensic services, there were only four targets within the three year programme.

Three key messages:

- The Bamford review made many recommendations for developments over the next 10–15 years. It set out a principle-based vision for the development of comprehensive inter-connected services as well as a supporting legal framework.
- *Delivering the Bamford vision* supports the Bamford approach but contains less ambitious targets for the next three years. Most of these targets will soon be met.
- There has been substantial progress in the development of services for mentally disordered offenders over the last few years, but there is still a very long way to go. Perhaps the greatest challenge for everyone involved is the continuing development of cooperative relationships in working towards shared goals.

to be proactive and talk to MLAs about them, and together have a collective voice about the importance of care and resettlement. Equally, we should be talking to MLAs about the lack of resources for some of the most vulnerable people in our society who have these complex needs.

A further issue raised was unpredictable release from prison, particularly for male prisoners. An example given was about a prisoner release at 5 o'clock on a Friday with nothing there for them in terms of support. Sometimes they are met at the gate, not always, and often they are people who don't get the services they need, or end up in A&E. So there is a need to provide something for those people who are released quickly, sometimes in an unpredictable manner.

The final issue raised, which was also raised in the mental ill health parallel session, was the current mental health law. It is just unacceptable that we are sending people to England to get services. The length of time it takes is an issue for a start, but the fact is that we should be providing these services here in Northern Ireland.

Feedback from discussion

Dr Bill Lockhart, Chief Executive Youth Justice Agency

This session provoked a very active discussion. Questions asked included: Why was the Government's response to Bamford so weak? Why are there no judiciary at this conference? Why are we planning for 2,500 prison places, while Scotland is calling for a reduction by one third of places?

Part of the discussion related to the whole area of the principle of equality and making sure that anyone caught up in the criminal justice system, particularly in prisons, could get the same sort of health service and mental health service as people in the community.

It is important to make the case for care and resettlement, especially in the context of devolution of justice and policing for care and resettlement. Resettlement does work if it is properly planned and properly resourced. There are a lot of problems, so there is a need

Closing remarks

Robin Masefield, Director General
Northern Ireland Prison Service

You will all agree with me that energy, commitment and passion have shone through from the feedback from each of our five discussion groups.

Dr Gaffney echoes this view. This is the second conference we have had of this kind and I think there has been a huge development. There has been a very positive step forward since the first one two years ago in that we are now broadly in the same territory, we share many of the frustrations and, when we talk about them now, they are mutual frustrations. Maybe two years ago we were more on either side of the fence or within silos, but at least we now have a shared understanding and thank you all very much indeed for helping take us on that journey.

Bridging the gap

I want to pick up on a few themes. There is something about bridging the gap between custody and the community, both for individuals when they come into our care in the prison service and making sure we get the information that we need, but crucially about having it tied up when people go back into the community.

Two or three speakers spoke about training and development, and training sometimes implies we have not got the skills to do the job that we are asked to do. But virtually all of us in this room today share one thing in common: we are in the risk business, we have had a fair amount of experience at doing it, and yes, we have some failings, but yes, we have a lot of skill and professionalism which we demonstrate every day. There is a lot to build on in that regard. One of the themes of the conference was safe and effective care and I think this motif is one that we should try to bear in mind as we move forward.

Forensic network

There have been a number of references to training, and one in particular to the training of people who are not yet with us. Forensic psychology has been a hobby horse of mine for

a number of years and now we are getting wider recognition for the need for that. I very much welcome the development of a forensic regional network. It is coming onto the radar with the DHSSPS and I shall shortly be receiving a report on how forensic psychology applies within the prison service. I hope that we will be in a position to share that report with interested colleagues.

Research that has been done in the Northern Ireland context shows that an individual who has the problems we have been talking about (learning disability, personality disorder, addiction issues) will come into contact on average with 23 different people from seven different criminal justice organisations. That is not entirely surprising when you think about the process from police through to probation at the far end, but it highlights a need for joined-up-ness, and emphasises the point about having a patient-centred focus where you don't have to tell the same story to 22 other people before you get help.

Another victim

A further point was raised about the need to engage with Members of the Assembly. Certainly there is a need for an all-party group on mental health, and one of the actions that a number of us will take from today is making sure that we continue to lobby for it.

The reality is the people we are working with are human beings and for every week, for every month, for every year that there is a delay, the chances are increased of a death in custody, or someone going out into the community without these mental health issues being addressed and creating another victim on the streets. Let us address this issue and do all we can, including the joined-up working that we are rightly on the journey towards, to make sure that we make the care and resettlement that we have all agreed and signed up to as effective and safe as possible.

It only remains for me to thank Dr Gaffney and his team for taking the lead in today's conference, and to thank you all very much for your contribution to a successful conference.

Appendices

Advisory group members

Graeme Brown	NI Prison Service
Elaine Cole	Healthcare Unit Manager, HMP Magilligan
Pat Conway	Director of Services, NIACRO
Victoria Creasy (Chair)	Senior Manager for Public Health, Health Promotion Agency
Arthur Dick	Clinical Services Manager (Downshire Hospital), South Eastern Trust
Dave Eagleson	Governor, NI Prison Service
Dr Brian Gaffney	Chief Executive, Health Promotion Agency
Kathy Goumas	Addictions Manager, NI Prison Service
Dr Bill Lockhart	Chief Executive, Youth Justice Agency
Calum McDonald	Healthcare Unit Manager, Hydebank Wood YOC and Prison
Dr Ian McMaster	Medical Adviser in Mental Health and Physical Disability, DHSSPS
Michelle McMaster	Mental Health Promotion Coordinator, Health Promotion Agency
Trevor Patton	Healthcare Unit Manager, HMP Maghaberry
Eileen Richardson	Probation Board for Northern Ireland
Mark Wilson	Human Resources, NI Prison Service

Conference evaluation summary

Usefulness and impact on work practice

A questionnaire was provided to all participants as part of the delegate pack. Of the 212 participants who attended the conference, 82 completed the questionnaire. This is a response rate of 39%.

The most useful aspects of the conference, as reported by participants:

Parallel sessions allow for more open discussion	27
Wide variety of speakers	9
Information on prison system issues: mental health	8
Address problems and challenges facing prison service	8
Links between prison system and health service	5
All equally important	4
Denis Bradley presentation realistic and practical	4
Learn about positive work being done in area of mental health	3
Interagency perspective	2
Input which refocused energy and direction	1
Focusing on the enormity of the issue of learning disability in prisons	1
Awareness of prison based and community based support systems	1
Total number of responses	73

Participants' views (51 responses) on the impact of the conference on their work practice:

- increased knowledge, understanding and awareness of issues (31%)
- using contacts made through networking (14%)
- taking forward healthy prisons (9%)

Participants were asked to rate the conference overall, where a score of 1=poor and 5=excellent. Overall, the conference was rated very positively, with 79% of respondents giving a score of 4 or 5, and 99% giving a rating of 3 or more.

Conference rating, as reported by participants:

1	2	3	4	5	Total (n)
-	1%	20%	52%	27%	77%



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Department of

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AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**