HSP 18
Ymchwiliad i ddarparu gofal iechyd a gofal cymdeithasol ar yr ystâd carchardai i oedolion
Inquiry into the provision of health and social care in the adult prison estate
Ymateb gan Goleg Brenhinol y Seiciatryddion yng Nghymru
Response from Royal College of Psychiatrists in Wales

Health, Social Care and Sport Committee's inquiry into provision of health and social care in the adult prison estate

Written evidence from the Royal College of Psychiatrists in Wales

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The Royal College of Psychiatrists in Wales (The College) is the professional medical body responsible for developing and supporting psychiatrists throughout their careers, and in setting and raising standards of psychiatry throughout Wales.

The College aims to improve outcomes for people with mental disorders and the mental health of individuals, their families and communities. In order to achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; works with and advocates for patients, carers and their organisations. It also works on the promotion of health and safety in the community with other agencies, including local authorities, the police and probation services. The College has a vital role in representing psychiatric professional expertise to governments and other agencies.

The College would be very happy to provide any further evidence the Committee needs, in writing or in person.

Summary

In the 12 months to March 2019, there were 317 deaths in prison custody across the UK, up 18 from the previous year. Of these, 87 deaths were self-inflicted, up 14 from the previous year.

There were 26 self-inflicted deaths at prisons in Wales between 2010 and 2018. On average, a self-inflicted death is recorded at a prison in Wales every four months.

Self-harm incidents reached a record high of 55,598 incidents in 2018, a 25% increase from 2017. The number of incidents between October and December decreased by 7% to 14,313 since the previous quarter.

The number of self-harm incidents requiring hospital attendance increased by 5% on the previous year to 3,214 while the proportion of incidents that required hospital attendance decreased by 1.1 percentage point to 5.8%♦

Suicide rates have long been recognised to be higher in prison than in the wider community[1], but there had previously been some success in reducing these. There is consistent evidence that mental disorders are major risk factors for suicide inside prison[2]. Mental disorders are substantially more common among prisoners than the general population[3] (as are physical health disorders[4]). On top of this we know the numbers of prisoners self-harming is rising[5]. Untreated mental disorders, especially schizophrenia, personality disorders and substance misuse disorders, are also associated with serious risk of harm to others[6,7].

Rising deaths and other harms show there are failures in reaching prisoners who need general medical and specialist mental health care. The rises coincided with continuing growth in the prison population in conjunction with a very substantial cut in numbers of prison officers.

♦ Ministry of Justice: National Statistics (2019) *Safety in Custody Statistics, England and Wales: Deaths in Prison Custody to March 2019 Assaults and Self-harm to December 2018*

In this context, three things are crucial to the human rights of prisoners and to public safety:

- Reducing the numbers of people in prison, and most particularly numbers of people with mental disorder,
- Restoration of adequate prison officer numbers and
- Better assessment and treatment of those who are unavoidably imprisoned.

Figures recently obtained by the Wales Governance Centre show that there were 25 people transferred from prisons in Wales to hospital under section 48 of the Mental Health act 1983 in 2017. 11 people were transferred while unsentenced or untried and 14 were transferred from a Prison Service establishment in Wales after sentence. In total, there were 213 restricted patients detained in Wales in 2017.♦

Recommendations

- Fund extension of successful clinical models for diversion of people with mental disorders from the criminal justice system at the earliest possible stage in their careers

- Increase knowledge and abilities in the Criminal Justice System for safe diversion, such as through specialist drug courts, mental health courts or problem-solving courts.

- Restore prison officer numbers so that the prison officer: prisoner ratio is adequate not only for the basic safety of prisons, but also protection from dangerous, mind changing drugs and for prisoners to access mental health services in prison.

- Ensure that prison reform is informed by recommendations from the review carried out by NICE on the mental health of adults in the Criminal Justice System.

♦ Data were obtained via the Freedom of the Information Act 2000. Wales Governance Centre at Cardiff University & University of South Wales. Dr Robert Jones (2018) Imprisonment in Wales: A factfile

- Ensure that more prisons show a commitment to improve mental health provisions by committing to meet the standards set out in the Royal College of Psychiatrists' Quality Network for Prison Mental Health Services and the Enabling Environment Award Scheme.

- Separate and specific attention must be paid to the needs of substantial minorities in prisons, including young people in the Criminal Justice System, people with learning disabilities, black and minority ethnic groups, gay people and women if they are to receive equivalence of services. In addition, expertise is needed for the small minorities of people with gender identity issues.

- It is vital to provide more support to help prisoners maintain family relationships and other beneficial social interactions.

- The College is working to change attitudes and enhance skills among mental health professionals in the assessment and treatment of enduring mental disorders other than illness – including the personality disorders.

Detail

1. The appropriateness of prison for people with mental disorders or learning disability

1.1 Around ten years ago reports by Lord Bradley[9] and the Baroness Corston[10] clearly pointed the way towards more use of safe and appropriate diversion away from custody and, in carefully chosen cases, from the criminal justice system altogether. It is frustrating that implementation has not been sufficiently widespread.

1.2 There are adequate legal options for framing treatment in the community where an element of coercion may be helpful and necessary, including sentences other than imprisonment but these are not widely used.

1.3 Mental health legislation allows for Guardianship and, through the criminal courts, Guardianship Orders. These appoint someone – usually a relative or social worker - to oversee the person's care and ensure access to treatment. Use of these orders has been falling, possibly because of insufficient social care resources to oversee the orders.

1.4 Another alternative to prison is a Mental Health Treatment Requirement (MHTR), which may be added to a community or suspended prison sentence after conviction for a criminal offence. Just 652 (0.5%) community sentences in 2007 included an MHTR[11]. Our members say their use has changed little since then. Given that at least 3-4% of prisoners have a psychotic illness, 10-14% a major depressive illness and up to 2/3 have a personality disorder, opportunities are clearly being missed to divert people away from prison.

1.5 Research into Mental Health Treatment Requirements has shown that they are not used because of a widespread lack of knowledge about what they are and how they can be implemented, even by the courts[12]. In our experience, magistrates welcome input from psychiatrists in their training, but this tends to occur according to local links rather than systematically. The College would be happy to engage in extending this work.

1.6 Most people agree that anyone with psychosis who needs inpatient treatment should be in a hospital, whether or not an offender, but there are undeniable difficulties in treating people with personality disorders. Offenders with this condition are not always accepted by mental health services at all, despite being at least seven times more likely to die by suicide than those without mental illness[13]. A recent UK study of people attending general practices found that people with personality disorder were at least four times as likely to die by suicide as those with any psychiatric illness[14].

1.7 Given these vulnerabilities, the College is working to improve attitudes to treating personality disorders by supporting psychiatrists to equip them with the necessary knowledge and skills to work with such people.

1.8 The main barrier, however, to stopping people with personality disorder being inappropriately sent to prison is that suitable mental health services will not be available for a large proportion of them. Significantly more resources are needed for specialist community services. While this would mean new up front funding, ultimately it would be far less expensive than imprisoning these people.

- Whenever someone is detained on suspicion of committing an offence and mental disorder is also suspected, all parties in the process at all its stages should pay more attention to diversion options.

- In particular, for offenders with mental disorder, more work is needed to extend the use of the Mental Health Treatment Requirement in conjunction with community sentences, including clearing up uncertainty about the nature of the order, improving interagency collaboration and ensuring sufficient health and probation resources to fulfil real need.

- Additional resources for community treatment of many of the people who are currently being sent to prison, because there is nowhere else for them to go, would save significant amounts of money in the long run.

2. Identification and assessment of risk

2.1 Internationally, there has been a lot of research into improving identification of mental disorder among prisoners. A systematic review of published literature on screening tools[15] found a lot – 22 different ones – which is suggestive of how difficult it is to get this right.

2.2 There are several particular difficulties in identifying suicidal ideation on reception into prison, yet there is good evidence in general terms that this is a particularly risky time. First, there is generally no alternative to brief screening during the churn of reception into prison, but communication of suicidal ideation generally requires some trust between the person with the ideas and those who could help. Secondly, mental state is not fixed, and substantial changes in mental state can be observed even after just 3-4 weeks in prison. Fortunately, the prevailing tendency is for the initial distress to settle[17]. Screening should, therefore, not be regarded as a one-off event, but repeated at intervals.

2.3. A study of newly received male prisoners in Wales showed that the two historical issues which made it most likely that they were going to have severe depression after two months, were a history of mental health service use and a major change in their self-rated most important family relationship. While the two in-prison issues were 'not getting on with other prisoners' and 'not getting on with prison staff'[18, 19]. When men could 'get on', likelihood of severe depression after 4 weeks was much lower.

2.4 Even before staff reductions in prisons, it was hard for prison officers or clinical staff to build the kind of relationships that would ensure identification of most suicidal ideation. Now the chances of doing so are very substantially reduced.

2.5 Other prisoners may have an additional positive role to play – as Samaritans trained 'listeners'. This system is also threatened by prison officer reductions. It is likely that, as more prisoners are stressed by current prison environments, they will be less able to do this. With fewer prison staff they will have less access –

either to prisoners who they might otherwise be able to help or to their essential support and supervision for their role.

2.6 Gunn and colleagues[20,21] paved the way for calculation of service need for prisoners, through engagement of clinicians from relevant disciplines including but not confined to psychiatry, in a process of consensus decision making on placement need. This research fed into development of prison in-reach services. These are mental health services provided by the healthcare system but delivered in prisons, to identify health care needs and either facilitate transfer out of prison or provide out-patient services within prison, as appropriate.

2.7 An evaluation of in-reach services[22] showed that, while availability of mental health service personnel time available to prisoners had increased, only about 25% of prisoners with serious mental illness were being assessed and 13% taken into treatment. There was a much lower availability of service for people with personality disorder.

2.8 There is little mental health care available for prisoners with substance misuse disorders. The prison based Counselling, Assessment, Referral Advice and Throughcare (CARAT) triage system is the designated route to assistance, but fails to reach many problem users. One study found that over half of those who were dependent on alcohol, recognised the problem and wanted help were unable to access a CARAT worker[23]. It is likely that access is even worse now as these figures precede 2013 when prison officer numbers were cut, on average by 40-45% across the prison estate.

- There is no quick and cheap fix for risk assessments. Instead what is needed is adequate prison staff to identify problems when they arise and for there to be adequate services to refer people to when risks are identified.

3. The safety of the prison environment

3.1 If we continue to have too few prison officers for the number of people in prison, then it will be impossible to protect vulnerable prisoners from harming themselves - or from harming others. The risk to people with mental disorder is exceptionally high as they are more vulnerable to assault by others [24-26].

3.2 Too few prison officers are sufficiently trained to be aware of mental health problems and suicide risks, notwithstanding HM Chief Inspector of Prison's widely accepted perspective 'suicide is everyone's concern'[27]. The College's Quality Network for improvements in prisons found that only 17% of services could confirm that the majority of prison staff had received mental health awareness training.

3.3 When prisoners get on with each other and with staff they are less likely to be depressed. Some are better able to cope with their situation if sharing a cell with someone they know or can trust, but prison officers may be no longer able to assess fully if cell sharing is appropriate. There are also risks of bullying and physical harm.

3.4 Illicit drugs are rarely pharmacologically pure, so may have unexpected effects. Trade in illicit drugs brings additional risks of conflict and harm. Movement of illicit drugs can be controlled with adequate staff: prisoner ratios. High security hospitals have security similar to category B prisons and have largely eliminated illicit drug use. In these hospitals, education and advice are readily available to all. In addition, there are airport-style controls on entry for visitors *and* staff, who are routinely screened and searched with pat-down searches and X-rays of property. Trained dogs are brought in from time to time. Patients have random urine screens for drugs once a week. This tough approach would be possible in prisons given a sufficient workforce. Given the risks from illicit drugs, providing sufficient staff to control substances would be one of the most effective ways of improving prisoner mental health and safety.

3.5 Misuse of prescribed medication also puts vulnerable prisoners at risk of violence. Most prisons have programmes whereby prisoners hold their own medication. In a well staffed and controlled prison this is a good thing, in line with principles of supporting people to learn how to look after themselves in the community. With low staffing and failing controls, people with mental health problems who are prescribed psychotropic medication are very vulnerable to being bullied or attacked for their medication.

3.6 Coerced sexual activity is another recognised problem in prisons. HM Inspectorate of Prisons now routinely tries to gather information about this, but it is not known for sure whether people with mental disorder are particularly

vulnerable to sexual victimisation in prison. It is known that sexual victimisation has consequences for mental health and suicide attempts[28].

3.7 People with learning disabilities constitute an additional very vulnerable group in prisons[29] and more needs to be done to ensure they are protected.

3.8 A suicide in prison can have a big mental health impact on other prisoners and staff. Witnessing a suicide or serious suicide attempt is traumatic, whether it was seen or heard in a nearby cell. Suicide attempts in prison generally involve hanging, ligature tying or fire setting. It has been known for a prisoner to burn to death if there were insufficient staff to unlock his/her cell. The additional trauma of witnessing the suicide of another person at first hand may be a 'last straw' for prisoners who have already experienced much personal trauma. Sometimes people at risk of suicide are deliberately placed in a cell with another in an effort to reduce the risk. There is evidence that being very close to a suicide in prison does increase mental distress or ill health in the prisoner witnesses[30]. Such witnesses may need extra support.

3.9 To encourage prisons to offer better environments, the College has set up the *Enabling Environment Award.* This rewards organisations which create environments fostering wellbeing and good mental health. HMP Drake Hall is the first to receive an Enabling Environments Award for the prison as a whole.

- The safety of people with mental health conditions in prison cannot be secured until the ratio of staff to prisoners is corrected.

- All prisons should aim towards meeting the Enabling Environment Award scheme standard.

4. Access to specialist mental health services and other treatments/interventions

4.1 The Royal College of Psychiatrists Quality Network for Prison Mental Health Services enables prison mental health teams to measure their performance against nationally agreed standards, facilitating quality improvement and change through a model of openness and engagement.

4.2 The Quality Network for Prison Mental Health Services findings provide independent evidence of what our specialist forensic psychiatric members have said about the impact of cuts in prison staff on access to mental health services. They found that only 50% of services were able to ensure that patients are able to attend scheduled appointments. This creates an expensive waste of staff time and, more importantly, significant impact on the health of the prisoners.

4.3 In this context, it is perhaps unsurprising that the number of detentions and transfers under the offender provisions of mental health legislation seem to be falling whilst numbers of mental health detentions overall are increasing. This is almost certainly more evidence of failures to access vulnerable prisoners.

4.4 Prison staffing thus affects both equitable access to services and personal safety of all parties concerned – including staff. How many staff would be enough? Forensic psychiatrists and their colleagues have considerable experience in calculating appropriate staffing levels for secure hospitals – from high to low security. These calculations take account of staff time necessary to fulfil each of the classes of security requirement: perimeter security (the state of the building and its surroundings), procedural security (the systems for checking for weapons, drugs, visitor safety etc) and relational security.

4.5 Relational security is the most difficult type to understand and deliver. It is almost as relevant to prisons as to secure hospitals. Relational security depends on understanding personal boundaries and building sufficiently good relationships between staff and patients/prisoners for acquiring and collating information relevant to managing personal relationships. In prisons, this would help to ensure that prison staff are not compromised by prisoners – or compromise prisoners – and prisoners who could harm themselves or others are identified and managed appropriately. The Department of Health and the Royal College of Psychiatrists' Quality Network for Forensic Psychiatrists have put together a useful guide to relational security: *See, Think, Act*[31]. We believe this would be a useful tool for prison staff too.

4.6 Health service staff numbers have to be calculated to take account also of tasks specific to their roles as clinicians. Prison staff are also likely to have to calculate for some roles beyond immediate delivery of a safe environment.

- Accurate assessment of a safe ratio of prison staff to prisoners could be better informed by adoption of health service principles of calculation of staff: patient ratios necessary for delivering safety in secure hospitals

- Ensure that more prisons show a commitment to improve mental health provisions by committing to meet the standards set out in the Royal College of Psychiatrists' Quality Network for Prison Mental Health Services

4.7 In 2015, HM Inspectorate of Prisons (HMIP) published a review of substance misuse in adult prisons in England and Wales. Within its recommendations HMIP highlighted that a different approach in Wales was leading to "poorer outcomes for some prisoners" and that it was responsible for "inconsistency in substance misuse treatment between prisons in England and Wales" (HMIP, 2015: 14). An updated report published in July 2018 concluded that services in Wales continued to provide a "considerably less safe service" which persisted in creating "poorer outcomes" for prisoners held in Wales (HMIP, 2018: 22). The Welsh approach to opioid treatment was described as being "much harsher" than England's within an article published by The Economist in July 2018.♦

5. Maintaining family relationships

5.1 Too little is known about not only maintaining, but also improving the family relationships of prisoners, but the collective research evidence to date suggests that not only do they enhance prisoner well-being, but they also tend to improve in-prison behaviour as well as diminishing the risk of recidivism[32]. It is important to recognise, however, that prisoners often have difficult or changing relationships with their families and we have already referred to change in the relationship which they regard as most important to them being relevant to later depression in prison[18]. It is therefore vital that more is done to help prisoners maintain positive relationships

♦ The Economist (2018) https://www.economist.com/britain/2018/07/12/welsh-prisons-are-much-harsher-than-englands-onopioid-treatment

5.2 Prisons are, however, often designed to be difficult to access via public transport and most visiting hours are during the week in usual working hours. Most prisoners' families don't have their own transport so visiting is difficult and expensive.

5.3 An administrative issue is that family visits generally take priority over all other prison activities, including seeing healthcare professionals, education or work. Family visits may, thus, conflict with other essential prisoner needs as everything has to be done within short windows within the working day.

5.4 Family visits may lead to tensions, especially as violent offences are disproportionately more likely to have occurred either in the prisoner's family or in their wider social circle. Prisoners may, therefore, need mental health support following a visit; many more would benefit from family therapy. Some relevant programmes are offered to some prisoners, such as the Prisoners' Advice and Care Trust (PACT), but they have less impact than they might, because of difficulty ensuring that prisoners can access the service.

5.5 Sexuality in prisons is another very important consideration. Where prisoners were in stable relationships in the community, the lack of facilities for privacy between couples if this were deemed safe affects not only the prisoner, but also his or her partner. This could be construed as a human rights issue. Some prisons outside the UK do facilitate this. The little completed research in the area suggests that conjugal visiting impacts favourably on in-prison behaviour[32].

- Prisoners' families should be given support with transport arrangements and costs as family breakdowns can have a serious impact on the mental health of prisoners and their families.

- Prisoners need more access to services designed to resolve conflict with partners and other family members.

6. Welsh Language

6.1 The Welsh Affairs Committee has stated on two occasions, the first over ten years ago, that data on Welsh speaking prisoners is insufficiently limited, and that Welsh language prison services need to be improved.

6.2 Decisions regarding prisoner placement consider gender, age, type of offence, security category, capacity, length of sentence, and distance from home. There is a commitment to place prisoners from Wales in Welsh prisons, but no specific data is gathered on this. There are no prison places in Wales for women, young people between 18 and 20 years of age, or high risk prisoners. The Welsh language is not a specific consideration when deciding where to place prisoners.♦

7. Location of imprisonment

- 4,704 individuals from Wales are serving time in prison (based on their home address before being sent to prison);
- 37% of prisoners from Wales are held in prisons in England;
- There are prisoners from Wales in 104 of the 116 prisons in England (91% of all prisons).♦

8. Purposeful activity

8.1 Purposeful activities have consistently been associated with well-being in prisons. The Scottish Prison Service has published a useful review of purposeful activity in prisons[33].

8.2 Some activities, such as education, are associated with reduced recidivism[34]. The 2016 Coates review[34] shows that prisons in England and Wales are falling short in this respect.

♦ Welsh language commissioner (2018) The Welsh language in prisons. A review of the rights and experiences of Welsh speaking prisoners

♦ Wales Governance Centre at Cardiff University & University of South Wales. Dr Robert Jones (2018) Imprisonment in Wales: A factfile

8.3 We have received anecdotal reports that prisoners with a mental disorder or learning disability may be prevented by their condition from accessing or continuing in education or work in prison. In Wales, we are beginning a scoping exercise to seek accurate information on this.

8.4 We must reiterate the case that little purposeful activity can take place without adequate prison staff: prisoner ratios.

- Resource is needed for a full national study of whether people with mental health and learning disabilities are fully able to access education and employment opportunities, and to understand different needs where not.

9. Segregation/solitary confinement and appropriate use of restraint

9.1 There are some situations when it may be helpful for health or safety for a person to be held separately from all other prisoners and, indeed, hospitals occasionally use seclusion to this end. In hospital, however, this requires a specially designed room, a member of staff must be in constant attendance just outside it and regular formal reviews to check whether the seclusion remains necessary and, if so, what more could be done to end it.

- Prisoners known to have mental health problems should never be segregated without reference to the mental health team, and in these circumstances, mental health teams must prioritise an assessment.

- Where mental disorder is considered relevant to the segregation, and the prisoner cannot be settled within 24 hours it is likely that transfer to hospital will be needed.

- Long-term segregation for other reasons should be considered as an indicator for a mental health assessment.

10 Learning lessons for the future

10.1 There is already plentiful, consistent evidence and guidance on how to improve safety in all its aspects for offenders with mental disorder in the criminal

justice system. There have been phases when this has improved. We are currently in a phase when this is deteriorating.

10.2 While lessons may be learned from a single death in prison, changes should be driven by systematically collected data.

10.3 From all the evidence, much of it introduced above, specific indicators are that we need to:

- Reduce the prison population.
- Ensure particularly that we prevent people with mental disorder being sent to prison when they could be better looked after by healthcare providers.
- For those for whom prison is unavoidable, ensure there is *adequate prison staffing.* Adequate numbers and skills would be calculated on the basis of what is essential to ensure safety and what is needed to deliver programmes for change.
- Provide sufficient and sufficiently accessible specialist mental health assessment for prisoners, and, for those who need it in prison, appropriate treatment.

10.4 The Royal College of Psychiatrists is committed to working with all relevant agencies to enhance diversion services and deliver good medical and psychiatric care in prisons for those unavoidably there. We will train, support, evaluate, audit and feed cycles of improvement, but unless the government acts on the evidence, we will be able to do little more than highlight a situation which is unsafe for everyone – inside or outside prisons – and tragic for some individuals who do not survive their imprisonment.

10.5 Whilst often cited, effective, integrated electronic records between prison, inpatient, community and general practice would be hugely advantageous.

10.6 There is a precedent for success. The Government Home Office and Department of Health & Social Security appointed Butler Committee of 1975[37], which was set up to deal with a different sort of crisis – overcrowding in the high security hospitals and a lack of any other secure hospital services or expertise. All of its recommendations were ultimately fulfilled, the crucial issue being that the then government agreed new funding for clinical service development and,

although most developments came from health service initiatives, the joint working with the Home Office was vital. Now, too, the task must be shared across government departments.

10.7 It remains the case that many sources of 'Welsh only' justice data can only be accessed by Freedom of Information requests, a route that, while useful, limits the accessibility of such data to public debate at the broader level. But the stark evidence of specific Welsh challenges presented throughout this report highlight the importance of gathering and analysing up-to-date and accessible 'Welsh-only' imprisonment data. This report should, therefore, further convince the Ministry of Justice to fulfil its 2017 commitment to make 'Welsh-only' justice data more easily available to a wider audience.

References

1 Dooley E. (1990) Prison suicides in England and Wales 1972-1987. *British Journal of Psychiatry* 156: 40-45.

2 Fazel S, Cartwright J, Norman-Nott A, and Hawton K. (2008) Suicide in Prisoners: A Systematic Review of Risk Factors. *Journal of Clinical Psychiatry* 69: 1721-1731.

3 Fazel S and Seewald K. (2012) Severe mental illness in 33,588 prisoners worldwide: systematic review and met-regression analysis. *British Journal of Psychiatry* 200: 363-373. DOI: 10.1192/bjp.bp.111.096370

4 Fazel S and Baillargeon J (2011) The health of prisoners. *Lancet* 377: 956-965.

5 Hawton K, Linsell L, Adeniji T, Sariaslan A, Fazel S. (2014) Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide. *Lancet* 383 1147-1154.

6 Taylor PJ (2009) Psychosis and violence: stories, fears and reality. *Canadian Journal of Psychiatry* 53: 647- 659.

7 Taylor PJ and Estroff SE (2014) Psychosis, violence & crime. In *Forensic Psychiatry: Clinical, Legal and Ethical Issues.* J Gunn and PJ Taylor (Eds). CRC Press: Boca Raton, FL. 334-366.

9 Bradley K. (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.*

Department of Health: London. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf

10 Corston J. (2007) *A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system.* Home Office: London http://www.newsocialartschool.org/pdf/Corston-pt-1.pdf.

11 Solomon E and Silvesti A (2008) *Community Sentences Digest.* Centre for Crime and Justice Studies, King's College: London.

12 Khanom H, Samele C and Rutherford M. (2009) *A missed opportunity? Community sentences and the Mental Health Treatment Requirement.* Sainsbury Centre for Mental Health: London. http://www.centreformentalhealth.org.uk/

13 Schneider B, Schnabel A, Wetterling T, Bartusch B, Weber B, Georgi K. (2008) How do personality disorders modify suicide risk? *Journal of Personality Disorders* 22:233–45.

14 Doyle M, While D, ok PLH et al. (2016) Suicide risk in primary care patients diagnosed with a personality disorder: a nested case control study. *BMC Family Practice* 17: 106. DOI 10.1186/s12875-016-0479-y

15 Martin MS, Colman I, Simpson AIF and McKenzie K (2013) Mental health screening tools in correctional institutions. *BMC Psychiatry* 13: 275 http://www.biomedcentral.com/1471-244X/13/275

16 Grubin D, Carson D, Parsons S. (2002) *Report on new prison reception health screening arrangements: The results of a pilot study in 10 prisons.* Newcastle: University of Newcastle. (available to download through Google)

17 Walker J, Illingworth C, Canning A, Garner E, Woolley J, Taylor PJ and Amos T. (2014) Changes in mental state associated with prison environments: a systematic review. *Acta Psychiatrica Scandinavica.* 129: 427-236.

18 Taylor PJ, Walker J, Dunn E, Kissell AE, Williams A & Amos T. (2010) Improving mental state in early imprisonment. *Criminal Behaviour & Mental Health* 20: 215-231.

19 Williams H, Taylor PJ, Walker J, Plant G, Kissell AE, and Hammond A. (2013) Subjective experience of early imprisonment. *International Journal of Psychiatry and the Law* 36: 241-249.

20 Gunn J, Maden A and Swinton M (1991) *Mentally disordered prisoners*. Home office: London.

21 Maden A, Taylor C, Brooke D, Gunn J. 1995. *Mental disorder in remand prisoners.* London: Home Office.

22 Shaw J, Senior J, Lowthian C et al (2009) *A National Evaluation of Prison Mental Health In-Reach Services.* OHRN: Manchester. http://www.ohrn.nhs.uk/resource/Research/Inreach.pdf

23 Kissell AE, Taylor PJ, Walker J, Lewis E, Hammond A and Amos T. (2014) Disentangling Alcohol-related needs among pre-trial prisoners: a longitudinal study. *Alcohol and Alcoholism* 49: 639-644.

24 Walsh, E., Moran, P., Scott, C., McKenzie, K., Burns, T., Creed, F., Tyrer, P., Murray, R., Fahy, T (2003). Prevalence of violent victimization in severe mental illness. *British Journal of Psychiatry*, 183: 233-238.

25 Teplin, L.A., McClelland, G.M., Abram, K.M., Weiner, D.A. (2005). Crime victimization in adults with severe mental illness: comparison with the National Crime Victimization Survey. *Archives of General Psychiatry*, 62: 911–921.

26 Monahan J, Vesselinov R, Robbins PC and Appelbaum PS. (2017) Violence to Others, Violent Self-Victimization, and Violent Victimization by Others Among Persons With a Mental Illness. *Psychiatric Services* online 01/02/2017.

27 HM Chief Inspector of Prisons for England and Wales (1999) Suicide is everyone's concern. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/07/suicide-is-everyones-concern-1999-rps.pdf

28 Chen LP, Murad H, Paras M. (2010) Sexual abuse and lifetime diagnosis of psychaitric disorders: systematic review and meta-analysis. *Mayo Clinic Procedings* 85: 618-629.

29 Talbot J (2008) *No one knows. Prisoners' voices. Experiences of the criminal justice system by prisoners with learning disabilities and difficulties.* Prison Reform Trust:
London. http://www.prisonreformtrust.org.uk/Portals/0/Documents/No%20One%20Knows%20report-2.pdf

30 Hales H, Edmondson A, Davison S, Maughan B and Taylor PJ. (2014) The impact of contact with suicide-related behaviour on young offenders. *Crisis* DOI: 10.1027/0227-5910/a000292

31 Royal College of Psychiatrists (2015) *See, Think, Act.* http://www.rcpsych.ac.uk/pdf/STA_hndbk_2ndEd_Web_2.pdf

32 De Claire K and Dixon L. (2015) The effect of prison visits from family members on prisoners' well-being, prison rule breaking, and recidivism: a review of research since 1991. *Trauma, Violence and Abuse* DOI: 10.1177/1524838015603209

33 Scottish Prison Service (2014) *Delivering a strategy for purposeful activity in the Scottish prison service.* https://www.cot.co.uk/sites/default/files/consultations/Purposeful-Activity-Review-31-03-2014.pdf

34 Davis LM, Bozick R, Steele JL, Saunders J, Miles JNV. (2013) *Evaluating the Effectiveness of Correctional Education: A Meta-Analysis of Programs That Provide Education to Incarcerated Adults.* Rand Corporation: Washington DC.
Sponsored

35 Coates (2016) *Unlocking potential. A Review of education in prison.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/524013/education-review-report.pdf

36 Haney C. (2003) Mental Health Issues in Long-Term Solitary and Supermax Confinement. *Crime and Delinquency* 49: 124-156

37 Home Office and the Department of Health and Social Security (1975). *Report of the Committee on Mentally Disordered Offenders (the Butler Report)* Cmnd 6244. London: HMSO.