The Regulation and Quality Improvement Authority

Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons

OCTOBER 2021

Glossary

AD:EPT	Alcohol and Drugs: Empowering People through Therapy
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
CJINI	Criminal Justice Inspection Northern Ireland
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CSU	Care and Supervision Unit
DoH	Department of Health
DoJ	Department of Justice
EMIS	Egton Medical Information System
FMCN	Forensic Managed Care Network
GP	General Practitioner
HBW	Hydebank Wood
HiP	Healthcare in Prison
HMP	Her Majesty's Prison
HNA	Health Needs Assessment
HSC Trust	Health and Social Care Trust
HSCB	Health and Social Care Board
IMB	Independent Monitoring Board
KPIs	Key Performance Indicators
NEXUS	Services and support to people who have been affected by sexual violence
NIAO	Northern Ireland Audit Office
NIPS	Northern Ireland Prison Service *Referred to, throughout this report, as the Prison Service*
NPM	National Preventive Mechanism
OBA	Outcomes Based Accountability
OST	Opioid Substitution T
PACE	Police and Criminal Evidence
PHA	Public Health Agency
PICU	Psychiatric Intensive Care Unit
PIPEs	Psychologically Informed Planned Environments
PSST(s)	Prisoner Safety and Support Team(s)
QNPMHS	Quality Network for Prison Mental Health Services
RQIA	Regulation and Quality Improvement Authority
SAI(s)	Serious Adverse Incident(s)
SEHSCT	South Eastern Health and Social Care Trust *Referred to, throughout this report, as the Trust*
SPAR	Supporting People at Risk
SPAR EVO	Revised Version of SPAR

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews and reporting against four key outcomes:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

Membership of the Expert Review Team

Professor Andrew Forrester	Professor of Forensic Psychiatry, Cardiff University
Mr Mick Burns	Former Co-Commissioner with NHS England and NHS Improvement
Ms Theresa Nixon	Former Director of Assurance with RQIA
Dr Leanne Morgan	Clinical Lead, RQIA
Mr David McCann	Assistant Director of Improvement, RQIA

Membership of the Project Team

Emer Hopkins	Interim Director of Improvement, RQIA
David McCann	Assistant Director of Improvement, RQIA
Leanne Morgan	Clinical Lead, RQIA
Wendy McGregor	Acting Assistant Director Improvement Director, RQIA (Expert Advisor)
Helen Hamilton	Project Manager, RQIA
Richard Gamble	Support Project Manager, RQIA

The RQIA are very grateful to the Health and Social Care Board, the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust for contributing their time and providing evidence to support the review, especially during the COVID-19 pandemic.

The Expert Review Team would wish to recognise the enthusiasm and positivity of ground level staff and their clear value base. They were particularly impressed with the relational style of the frontline staff, who were representing the Prison and Healthcare in Prison.

Contents

Foreword

As the Mental Health Champion for Northern Ireland and a Professor of Mental Health Sciences, it gives me great pleasure to introduce the report prepared by the Regulation and Quality Improvement Authority (RQIA) following the review of services for vulnerable persons detained in NI prisons. The RQIA review was jointly commissioned by the Department of Health (DoH) and Department of Justice (DoJ) in response to a number of suicides in prisons in Northern Ireland and following a prisoner ombudsman investigation into an incident of serious self-harm in 2016. This report is of particular interest to me as a trauma researcher focusing on mental illness and suicidal behaviour in NI.

I am keen to promote the needs of people in our prisons who are at risk from suicide and self-harm, and those who have mental health issues. These individuals often have complex needs, a history trauma and/or have lived through significant adverse childhood experiences, factors which often contribute to them being in custody. In light of this, the challenges facing prison and prison healthcare staff, particularly in the context of the unique circumstances of Northern Ireland, are considerable. I therefore commend the commitment shown by the Northern Ireland Prison Service (NIPS) and the South Eastern Health and Social Care Trust (SEHSCT), as reflected in this review conducted by RQIA, in supporting prisoners who are at risk or have mental health issues. This is particularly evident in the progress that has been made in terms of partnership working, the introduction of SPAR Evolution, wellbeing rooms at each establishment, therapeutic settings and a commitment to being trauma-informed. It is clear that NIPS and SEHSCT have worked collaboratively with the Public Health Agency and Health and Social Care Board to improve services and to protect those who live and work in our prisons during the pandemic, all within the constraints of existing resources.

However, RQIA has established that healthcare in prison is significantly underfunded in comparison to other regions within the United Kingdom, despite the NI population having higher levels of mental illness. As a result, prison healthcare services are under considerable pressure and presently it is a challenge to meet the needs of all those within its care who are at increased risk of self-harm and suicidal behaviour or have mental health issues.

This report describes the mental health challenges faced by those who reside within our prison population, as well as those faced by the dedicated NIPS and SEHSCT staff, and identifies the mental health and emotional wellbeing needs that need to be addressed. There is a clear need to ensure that people in prison with a mental illness can access high quality treatment and care.

I commend DoH and DoJ for commissioning this review and I am assured of their commitment to work together to improve the outcomes for prisoners who are at risk and those who have mental health issues. The RQIA report identifies the need for a government led strategy, accompanied by additional funding, to improve outcomes for people at risk of suicidal behaviour within the prison system. It is vital that the report's recommendations are fully implemented.

I would like to thank RQIA, and each and every person who participated in this review. Your experience, expertise and collective voice has the potential to change the lives of vulnerable people in our prisons, and the positive impact will be felt throughout society.

Professor Siobhan O'Neill
Mental Health Champion

Executive Summary

Northern Ireland has a 25% higher prevalence of mental ill-health than the rest of the United Kingdom[1]. This higher level of need is reflected within the prison population[2]. Between 2012 and 2019, there were 18 suicides and 5,217 recorded incidents of self-harm within Northern Ireland prisons[3]. During the same period, it was highlighted in a number of prison inspection and review reports that the care of vulnerable people in custody required significant improvement[4,5].

In September 2016, the Prisoner Ombudsman published a report which was highly critical of the care provided to a vulnerable prisoner who, in June 2014, sustained life-changing injuries as a result of self-harm inflicted during a period of detention in Maghaberry prison[6]. In November 2016, following the deaths of five prisoners in the preceding 12 month period, the Northern Ireland Ministers for Justice and Health announced that there would be a review into services provided to vulnerable people in Northern Ireland prisons[7]. Although work commenced it did not progress to completion. A rapid assessment of this initial review work, undertaken by the RQIA in January 2019, determined that there was a need for a fresh independent review.

The Criminal Justice Inspection Northern Ireland/RQIA Safety of Prisoners 2019 report acknowledged progress in addressing some of the issues but identified an ongoing need for better governance and partnership-working between Northern Ireland Prison Service and the South Eastern Health and Social Care Trust[8].

In July 2020, the RQIA was jointly commissioned by the Department of Health and Department of Justice to undertake a Review of Services for Vulnerable Persons Detained in Northern Ireland Prisons. This review was undertaken from December 2020 to February 2021, during which time the organisations faced specific challenges posed by the COVID-19 pandemic.

Aims / Objectives

The review aimed to:

- Hear the views and experiences of vulnerable people in custody.
- Assess the arrangements for the needs assessment, planning and commissioning of services.
- Assess the quality of services provided to vulnerable people in custody.
- Assess the effectiveness of strategies, policies and procedures which are designed to deliver care and treatment to vulnerable people in custody.

Methodology

We conducted a thematic analysis of the recommendations from previous reports and used this to develop a framework against which the quality of commissioning and service provision could be assessed.

The Expert Review Team gathered evidence to inform its assessment through a variety of methods:

1. We met with prisoners[i] and heard their views.
2. We met with Independent Monitoring Boards.
3. We distributed questionnaires to all relevant stakeholders.
4. We conducted interviews with planning and commissioning staff from Health and Social Care Board and Public Health Agency.
5. We met with management teams and front-line staff from Northern Ireland Prison Service and South Eastern Health and Social Care Trust.

Findings

At the outset of the review, we heard from a number of prisoners who provided a valuable insight into the experiences of vulnerable people detained in custody. These individuals were largely complimentary of frontline staff but were keen to express their view that there are considerable challenges within the system; many of which were evident to our Expert Review Team during fieldwork.

Whilst it was clear that the Prison Service and the South Eastern Health and Social Care Trust have made great efforts and commendable progress, particularly in relation to Supporting People at Risk Evolution, partnership-working and governance, they can only continue to improve within the constraints of existing resources. Healthcare in prison in Northern Ireland is significantly underfunded in comparison to other regions in the United Kingdom. Equally, the needs assessment, planning and commissioning arrangements require substantial improvement. Existing services are under considerable pressure, with demand greatly exceeding capacity. Waiting times for urgent and routine mental health assessments fall significantly short of national standards. There is a lack of specialist support for people with personality disorder and for those with specific vulnerabilities such as learning disability and autism. Some acutely mentally unwell people are being looked after within the Care and Supervision Units rather than receiving appropriate inpatient treatment. Waiting times for transfer to mental health beds are unacceptably long.

During the course of the review, we encountered a number of very capable and committed staff across both the prison service and within healthcare in prison. The Expert Review Team was impressed by their compassion and dedication to making things better for people in custody. In particular, Safer Custody arrangements and recent improvements within the Addiction Service are a testament to the commitment of these talented individuals. Equally, the Health and Wellbeing Engagement work and initiatives such as Towards Zero Suicide demonstrate the potential of collaborative efforts to lessen the mental health challenges faced by the prison population. However, in order to achieve improved and sustained outcomes for vulnerable people in custody there needs to be a co-ordinated effort across both the criminal justice and health and social care system.

[i] As a consequence of the Covid-19 pandemic engagement was limited to a small number of prisoners across each prison site; all engagement was conducted virtually.

Conclusion and Recommendations

A government-led strategy is needed to improve the quality and accessibility of mental health services in order to reduce the risk of self-harm and suicide within the prison population. Going forward, the planning and commissioning of services must be based on sound needs assessment and bench-marking; and should be underpinned by robust accountability and reporting arrangements for assuring the quality of services delivered.

Prison mental health and addiction services should have adequate capacity to meet the needs of the prison population and should ensure that prisoners are provided with the appropriate specialist treatment within acceptable timescales. The prison environment and support available should be conducive to the needs of those with personality disorder. Segregation in the Care and Supervision Units should be used only for the shortest time possible and as a last resort. Whilst a longer-term strategy is required to increase the number of mental health beds across the region, medium-term options should be appraised and solutions implemented to reduce delays in transfer to the appropriate inpatient setting. Equally, links between prison and community services need strengthened in order to improve transition of care to other services upon release from prison.

The 16 recommendations outlined in this report, if fully implemented, will deliver the necessary improvements in services and support available to vulnerable people in custody; this should lead to better outcomes including the avoidance of harm. Recognising that this is a challenging undertaking in a complex system with limited resources, sustained success will require commitment at all levels from across the system. In partnership with Criminal Justice Inspection Northern Ireland, RQIA are committed to monitoring the quality of care provided to people in custody and, where necessary, will work with providers of services to support improvement.

Section 1: Introduction

1.1 Background and Context

A decade ago, Dame Anne Owers' Review of the Northern Ireland Prison Service (2011), acknowledged the applicability of the European Convention on Human Rights to people living in custody[9]. It emphasised the duty of care owed to prisoners by the State and, in advocating a human rights approach, presented a compelling argument for the need to protect and support those prisoners who are most vulnerable.

All people detained in custody, by virtue of being deprived of their liberty, are considered vulnerable[10]. However, prisoners with mental health concerns are appreciably more vulnerable and are at increased risk of self-harm and suicide. The needs of these prisoners can be complex. Many have a history of adverse childhood experiences, substance misuse and significant mental illness[11]. Some may have additional needs such as those with learning disability, autism, attention deficit hyperactive disorder (ADHD) and acquired brain injury[12,13].

It has been prominently highlighted in a number of prison inspection reports, most notably in Criminal Justice Inspection Northern Ireland (CJINI)/RQIA Safety of Prisoners 2014, that the care of people in custody required significant improvement[14]. Media attention surrounding the deaths of prisoners and a serious incident of self-harm investigated by the Prisoner Ombudsman, drew further attention to an urgent need to review and improve the model of care and delivery[15].

In November 2016, Claire Sugden, Minister for Justice, and Michelle O'Neill, Minister for Health, announced that there would be a joint review led by the Department of Justice (DoJ) and Department of Health (DoH) into services provided to vulnerable prisoners. The review, focusing on the care provided to prisoners with mental ill-health and at increased risk of self-harm and suicide, was intended to form an action under the 'Improving Health within Criminal Justice Strategy'[16].

The review commenced in 2017 following the establishment of a review team comprising representation from the Northern Ireland Prison Service (NIPS), South Eastern Health and Social Care Trust (SEHSCT), the Health and Social Care Board (HSCB), the Public Health Agency (PHA) and the Probation Board for Northern Ireland. Unfortunately the work did not progress to completion and in December 2018, the DoH requested that the RQIA undertake a rapid assessment of the work undertaken to date. In early 2019, the RQIA rapid assessment determined that there was a need for a fresh independent review.

Since then, there have been a number of independent reports into mental health provision within the prison service. In May 2019, the Northern Ireland Audit Office (NIAO) published a report, 'Mental health in the criminal justice system', which delineated the extent of the problem, identifying that there had been 18 suicides and 5,217 recorded incidents of self-harm amongst the Northern Ireland prison population since 2012[17].

The CJINI/RQIA Safety of Prisoners 2019 inspection report acknowledged progress in addressing the issues but highlighted a need for better governance and partnership-working between the NIPS and SEHSCT, the provider of healthcare in prison[18].

Recognising an ongoing need for improvement, the DoH and DoJ jointly commissioned the RQIA to undertake the Review of Services for Vulnerable Persons Detained in Northern Ireland in July 2020.

This review was undertaken from December 2020 to February 2021, during the COVID-19 pandemic. Despite the specific challenges posed by the pandemic, each organisation (HSCB, NIPS and SEHSCT) remained committed to supporting the review.

1.2 Terms of Reference

RQIA drafted the Terms of Reference, agreed by a Steering Group of DoH and DoJ policy officials, to undertake Review of Services for Vulnerable Persons Detained in Northern Ireland:

1. To assess the effectiveness of strategies/policies, services and operational procedures in place to deliver care and treatment to individuals with mental ill-health at risk of self-harm or suicide in Northern Ireland prisons.

2. To assess the effectiveness of arrangements for needs assessment and planning and commissioning of services delivered to this group within Northern Ireland prisons.

3. To assess the effectiveness of arrangements for assuring the quality of services delivered to this group within Northern Ireland prisons.

4. To seek the views and experiences of service users in relation to the effectiveness of services provided.

5. To report on the findings and make practical recommendations to improve outcomes for vulnerable prisoners in Northern Ireland.

Exclusions

Excluded from this review are ‘services for children and young people under the age of 18’

Definition of a Vulnerable Person

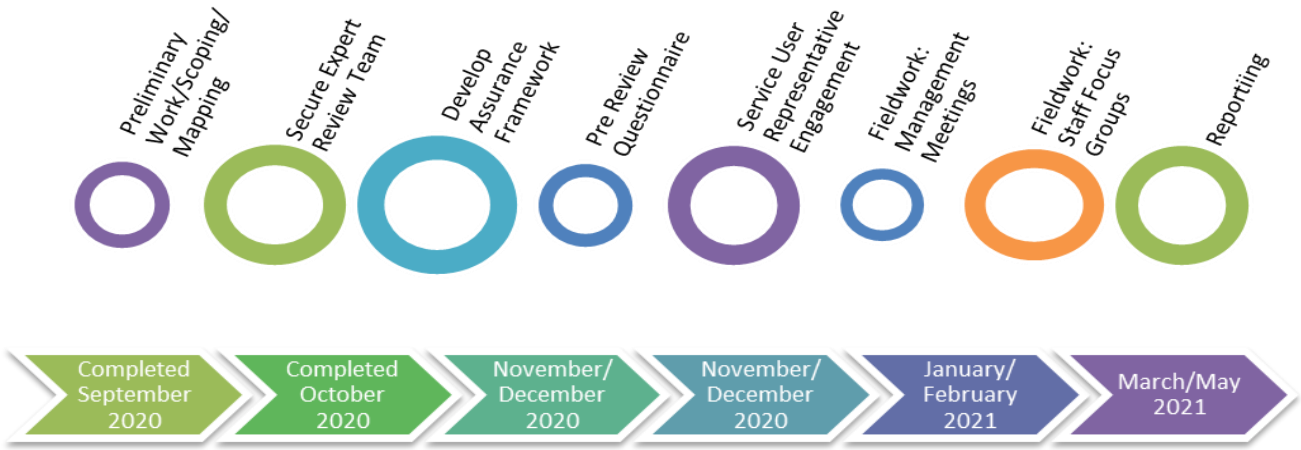
The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007[ii] states that any person "detained in a prison, remand centre or young offenders centre" is considered to be a vulnerable adult.

The aim of this review was to focus on people who are more vulnerable because of mental health concerns and who are at increased risk of suicide or self-harm.

Therefore it was agreed with the DoH and DoJ that for the purpose of this review, a 'Vulnerable Person' is defined as:

"a person with mental ill-health who is at risk of self-harm or suicide within Northern Ireland prisons".

1.3 Review Methodology



RQIA used a PRINCE project management approach to underpin this review. The review utilised a range of methodologies, agreed by our Expert Review Team, to obtain supporting information to inform our assessment:

- A preliminary scoping exercise was conducted, informed by the RQIA Rapid Assessment of the initial review.
- We undertook a review of the literature on governance to identify key themes and areas of focus.
- We completed a mapping exercise of previous recommendations from previous reports.
- We conducted a thematic analysis of these recommendations in order to inform the development of an Assurance Framework.
- We utilised our Assurance Framework in order to design and issue structured questionnaires to HSCB, PHA, NIPS and SEHSCT.

[ii] https://www.legislation.gov.uk/nisi/2007/1351/2007-05-17

- We analysed information returned to us by each of the organisations and used this to develop Key Lines of Enquiry for meetings with each of the organisations.
- We designed and disseminated an online survey to Prisoner Advocacy Groups.
- We met with the Independent Monitoring Board for each of the prison sites.
- We used structured focus groups to engage with and hear the views and experiences of prisoners across all prison sites.
- Our Expert Review Team conducted meetings with relevant senior and front-line staff from HSCB, PHA, NIPS and SEHSCT.
- We utilised our Assurance Framework to methodically analyse the information gathered through our meetings, structured questionnaires, focus groups and survey responses in order to determine our key findings and recommendations.

Assurance Framework

The Assurance Framework for this review is an evidence-based tool, which was developed by the RQIA and agreed by the Expert Review Team. It provides 87 indicators by which the quality of services can be assessed and is aligned to NICE guidance, and a number of existing frameworks:

- NICE guideline (NG66): Mental Health of Adults in Contact with the Criminal Justice System
- RQIA Inspection and Review Framework
- Seven Pillars of Governance
- The Five Quality Standards for Health and Social Care
- Victoria Clinical Governance Framework

The Assurance Framework is also underpinned by recommendations from the following reports:

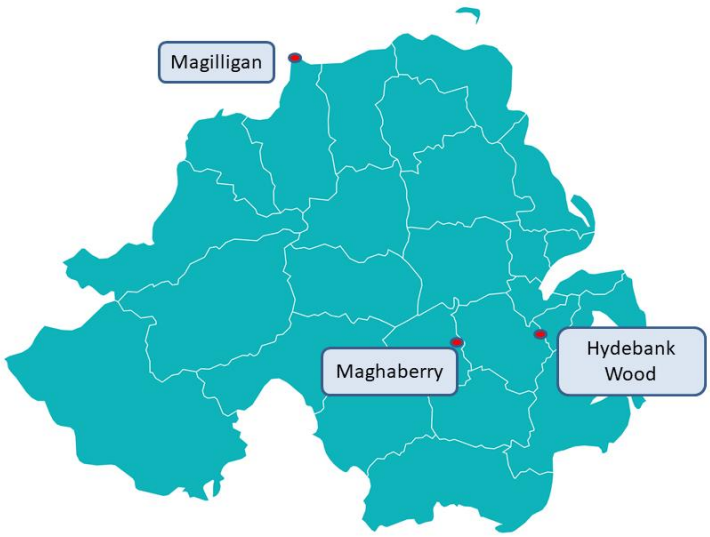
- The Safety of Prisoners held by the NIPS: CJINI/RQIA, Nov 2019
- Hydebank Inspection Report: CJINI, December 2019
- Hydebank Inspection Report (Ash House): CJINI, December 2019
- Maghaberry Inspection Report: CJINI, April 2018
- Magilligan Inspection Report: CJINI, June 2017
- Royal College of Psychiatrists report on Prison Mental Health in Northern Ireland, November 2018
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) Northern Ireland Report 2017

Section 2: Prison Services in Northern Ireland

2.1 Northern Ireland Prison Service

The Northern Ireland Prison Service (NIPS, also referred to as the Prison Service) is an agency within the DoJ. It is responsible for the operation and delivery of services within the Northern Ireland prison system. The overarching aim of the prison service is to improve public safety by reducing the risk of re-offending through the management and rehabilitation of offenders in custody. The Prison Service has responsibility for the welfare of people in prison. As prisoners spend the majority of their time alongside frontline prison staff, the interactions and approaches adopted by staff are fundamental to their wellbeing. In recognition of this principle, the Prison Service has committed to becoming a trauma-informed organisation and has implemented training on trauma-informed practice and adverse childhood experiences for staff[19]. Equally, there have been improvements in the prison environment in recent years which has seen the introduction of therapeutic spaces and wellbeing rooms to support prisoners with mental ill-health.

Currently, there are three prison sites in Northern Ireland; Maghaberry, Magilligan and Hydebank Wood College (incorporating Ash House). The current maximum capacity is 2,091.



Maghaberry Prison is the largest and most complex of the three prisons operated by the Prison Service[20]. It is the only high-security male prison in Northern Ireland and also operates as the remand prison for the majority of adult male prisoners who are on remand. It accommodates a range of sentenced prisoners such as those serving a life sentence, indeterminate and extended custody prisoners, and those serving short sentences.

Magilligan Prison is a medium security prison holding sentenced prisoners usually received on transfer from Maghaberry Prison[21]. The aim of Magilligan is to provide safe, secure and decent custody with a focus on pre-release preparation, risk management and resettlement. A small number of male prisoners who are on remand are accommodated at the Magilligan site instead of Maghaberry.

Hydebank Wood Secure College accommodates young male offenders between the ages of 18 and 24[22]. New committals who are aged 18-20 years are committed to Hydebank Wood, whereas those aged 21 and older are committed to Maghaberry.

Ash House is a stand-alone residential unit within Hydebank Wood Secure College campus adjacent to the young men's accommodation. The prison accommodates all of Northern Ireland's female prisoners[23].

2.2 Healthcare in Northern Ireland Prisons

Healthcare in prison has evolved differently in Northern Ireland compared to the rest of the United Kingdom. This is, in part, due to the 'Troubles' which had a significant bearing on the criminal justice system prior to the Good Friday Agreement in 1998. The threat to security services from terrorism in Northern Ireland meant that for a long time, security not healthcare had been the enduring operational priority[24]. However, there has been a considerable shift in focus towards healthcare over the last decade.

On the 1 April 2008, responsibility for the healthcare of prisoners in Northern Ireland transferred from the NIPS to the Department of Health, Social Services and Public Safety (DoH). A key driver for the transfer of responsibility was recognition of the need for parity with healthcare in the community. At the point of transfer, SEHSCT was commissioned by the HSCB to provide primary care, mental health and addiction services to all prisoners in Northern Ireland. Secondary and tertiary care services are provided through all five HSC Trusts.

Whilst responsibility for healthcare transferred to the DoH in 2008, the transfer of staff from the DoJ to the DoH occurred later in 2012. This transition was described as challenging and had an adverse effect on staff morale, recruitment and retention[25]. It coincided with a significant rise in the prisoner population which resulted in overcrowding and deterioration in the predictability of the prison regime.

A CJINI inspection of Maghaberry in May 2015 found that the prison was unstable and unsafe[26]. This highlighted a need to develop sustainable clinical governance arrangements in order to rapidly improve the quality of patient care. This need had formed the basis of the Prison Reform Project which, established by SEHSCT in October 2014, aimed to drive the cultural change required to improve health outcomes, embed improvement methodology and develop the workforce. The project was chaired by the then Chief Executive of SEHSCT and sought to implement an outcomes based accountability (OBA) approach, providing the foundations for the development of a three year strategy to address addiction and self-harm in prison. SEHSCT have made progress since 2015, as has been acknowledged in recent prison inspection reports[27,28].

Underpinning this progress, the number of staffing posts has increased and, within the constraints of allocated resources, a public health and wellbeing approach has been implemented. Similarly, there have been improvements in safety within the prison environment which are likely to have had a positive impact on prisoner wellbeing; a CJINI inspection of Maghaberry in 2018, found that the prison "felt safer and levels of violence were much reduced and lower than [is usually seen] in similar prisons in England and Wales[29]".

Healthcare services in Northern Ireland are commissioned by the HSCB under the direction of the DoH. The commissioning model in Northern Ireland drew criticism from both the Donaldson Report in 2014 and Bengoa's 'Systems, Not Structures: Changing Health and Social Care' in 2016[30,31]. Donaldson described the system as underpowered, highlighting the limitations of a provider-commissioner split which has added complexity and cost to the process yet lacks the sophistication of a more evolved model[32]. Following an internal review, it was decided that there would be the closure of the HSCB; this is due to occur on 31 March 2022, at which point the current system of commissioning will be superseded by a new integrated care system planning model[33].

RQIA has a statutory responsibility for the regulatory oversight of health and social care in Northern Ireland's prisons and mental health and learning disability facilities[34]. It is one of four organisations in Northern Ireland designated as a National Preventative Mechanism (NPM) by the United Kingdom government to ensure the protection of the rights of individuals in places of detention.

2.3 Northern Ireland Prison Population

Average daily prison population 2019-2020[35]

- The overall average daily prison population increased by 4.7% during 2019/20 to 1,516.
- The male population was 1,442 and the female population was 74.
- The remand population increased from 436 in 2018/19 to 492 in 2019/2020 and was at its highest level since reporting began.
- Prisoners aged between 30 to 39 years of age made up the largest proportion (34.4%) of the average daily immediate custody prison population.
- Prisoners aged between 18 and 20 years of age constituted 3.1% of the total prison population.
- 'Violence against the person' offences accounted for the largest proportion of all principal offence categories (34.2%).

Vulnerability amongst the prison population

The Northern Ireland population has a 25% higher prevalence of mental ill-health than the rest of the United Kingdom[36]; reflecting the intergenerational trauma and enduring social deprivation of a post-conflict society. The prevalence of mental ill-health and intellectual disability within the Northern Ireland prison population, however, is poorly understood[37].

Determining the true prevalence of these vulnerability factors has been challenging due to the absence of a robust system for data collection and monitoring within the healthcare in prison setting, which has led to incomplete data and conflicting statistics[38]. The 2021 Health Needs Assessment (HNA) was underway but was not yet complete at the time of fieldwork. A copy of the draft report was not available for inclusion in this review; the following statistics relate to the previous HNA.

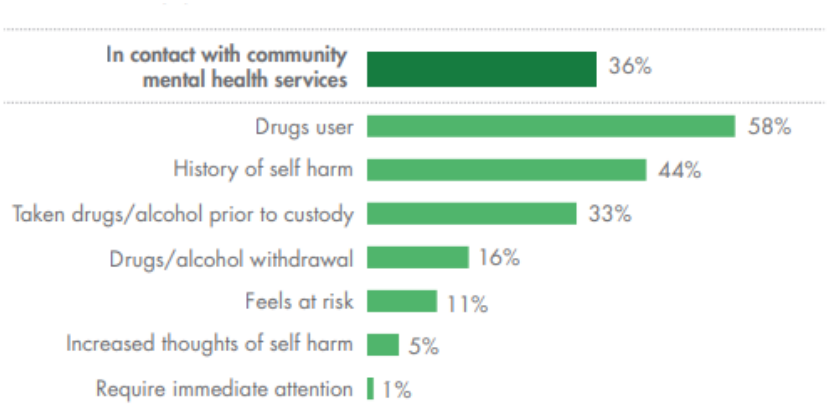
The 2016 HNA of mental health in Northern Ireland Prisons found that 29% of newly committed prisoners reported experiencing depression in the past; 6% reported current anxiety symptoms and 6% reported psychosis[39]. It found low rates of self-reported personality disorder (2%); this is in contrast to high-quality studies, which estimate the prevalence of personality disorder in the prison setting to be much higher, at approximately 65%, when diagnostic tools are used[40,41,42]. Prescription rates for people in prison are higher than in the general population and prescribing data for Northern Ireland prisons indicates that 45% of prescriptions were for anti-depressant medication; many of which have been started in the community. Women in prison were found to have a higher incidence of mental ill-health, a higher rate of referral to mental health services and higher rates of prescribed medication[43].

Numeracy and literacy levels are known to be lower in the prison population with 30% of Northern Ireland prisoners estimated to have either a learning disability or learning difficulty in comparison to 6.7% of the general population[44].

The prevalence of acquired brain injury is known to be significantly higher in the prison population. O'Rourke et al found a 79% prevalence rate for previous traumatic brain injury amongst women prisoners in Northern Ireland, with 38% of women self-reporting six or more previous injuries[45]. The majority of injuries were sustained as a result of either physical abuse during childhood or intimate partner violence.

Prevalence of risk factors at committal

Committal and the days following committal constitute a high-risk period for evolving mental ill-health, self-harm and suicide[46]. For this reason, an adequate risk assessment is essential to determine the need for ongoing care.



Prevalence of self-reported risk factors at committal. Source: Northern Ireland Audit Office: Mental Health in the Criminal Justice System (May 2019)[47]

An analysis of first night committals between May 2014 and September 2018 shows that over one third (36%) of prisoners reported that they were in contact with community mental health services at the time of committal[48]. 58% had a history of substance misuse. 44% reported a history of self-harm, 5% reporting increased thoughts of self-harm and 1% required an immediate mental health assessment[49].

The HNA in 2016 found that whilst only 5% of newly committed prisoners self-reported self-harming behaviour, self-harm accounted for 49% of Maghaberry mental health referrals[50]. 45% of Supporting People at Risk (SPAR)[iii] case conferences were due to individuals reporting thoughts of suicide; 16% of conferences were due to suicide attempts or statements of intent to commit suicide. 25% (255) of all incidents in Northern Ireland prisons in 2014 were related to self-harm or overdose, and 68 out of 83 Serious Adverse Incidents (SAIs) occurring between 2012 - 2016 were due to self-harm including attempted or completed suicide[51].

The scale and complexity of vulnerability amongst the prison population serve to highlight the challenges facing staff and the need for high-quality mental health and addiction services within the prison setting.

[iii] The Supporting People at Risk (SPAR) approach helps staff identify, at an early stage, symptoms or behaviours that suggest a prisoner may be in personal crisis and in need of additional and immediate support and care. The emphasis is on individualised care of the prisoner and engagement to understand what is causing the distress.

Section 3: Findings

3.1 The Views and Experiences of People in Custody

First and foremost in this review, are the views of those detained in custody; their lived experience is invaluable in identifying areas of good practice and highlighting areas of concern.

Structured focus groups were conducted with prisoners across all prison sites; due to COVID-19 these were held virtually. Six to eight participants from each site were identified by the prison service. We sought to hear their views and experiences regarding the care and support provided to prisoners with mental health problems who are at increased risk of self-harm and suicide. Although this engagement was with a small sample of the prison population, the Expert Review Team found that it provided a useful insight as prisoners talked openly and candidly about their own personal experiences and also about what they had observed in relation to others.

Most prisoners were very complimentary of the staff who work within the prison service; they were keen to highlight the dedication and commitment of prison officers to supporting vulnerable people in custody. In particular, they acknowledged the good work of the Prisoner Safety and Support Team and expressed an appreciation for their accessible and approachable manner.

"Prison Officers go the extra mile to support us."

"During COVID, Safety and Support stepped up to try and keep our spirits up. They also offer good support to prisoners in isolation. They are very good."

Prisoners also commended the work of in-reach support services such as AD:EPT(Alcohol and Drugs: Empowering People through Therapy), which was described as an invaluable therapeutic resource.

Although the majority of prisoners spoke very positively about frontline prison staff, some raised concerns about what they perceived as a lack of compassion. They felt that this was due to a lack of training and hence understanding of mental health issues which has led to some prisoners feeling unsupported and, at times, unfairly blamed for their problems.

One prisoner described it as:

"If you are depressed you are seen as lazy,
if you are anxious you are paranoid,
if you are badly behaved, you are attention-seeking"

Prisoners were also keen to highlight what they perceived as significant deficits within healthcare in prison. They were of the view that issues such as self-harm and suicide could be prevented by an increased commitment to investing and improving healthcare services for vulnerable people in custody.

They described an overstretched system, an over reliance on peer support and a situation where vulnerable people were being left without appropriate specialist input, only being attended to when their mental health reaches crisis point.

One prisoner captured it in this analogy:

"a broken window will be left alone but as soon as someone hurts themselves there is reaction"

A number of themes were identified which painted a concerning picture of service provision across all prison sites. Prisoners spoke of significant delays in accessing mental health appointments. They perceived that there was a lack of capacity within the mental health team to deal with the needs of the prison population. We heard about the lack of provision for psychological counselling, specifically trauma counselling, and the absence of specialist support for people with a diagnosis of personality disorder. Prisoners spoke of delays accessing addiction services and also raised concerns about medication being stopped or reduced on committal, leading to what was described as widespread agitation and behavioural issues. Prisoners also highlighted the lack of suitable infrastructure for urgent psychiatric assessments, stating that during COVID-19 it was not an uncommon occurrence for these to be conducted on the landing, where there is a lack of privacy and dignity.

We were told of prisoners becoming acutely mentally unwell and being transferred to the Care and Supervision Unit (CSU), due to the lack of availability of a suitable alternative; some felt there was a need for a prison inpatient facility. They also highlighted a lack of support for people when they leave custody; it was reported that many re-offend and re-enter the prison system.

These accounts were corroborated by the Independent Monitoring Board (IMB) for each prison site. The IMBs relayed concerns around the cessation of medication, overreliance on peer support, inadequate access to mental health input, suboptimal psychology provision and the use of the CSU for acutely unwell prisoners due to a shortage of regional secure beds. Our engagement with Advocacy Groups further reinforced concerns that there is sub-optimal support for people when they leave prison; they detailed the lack of community provision for mental health and addictions support, and inadequate arrangements for accommodation provision and the receipt of benefits. One practical suggestion was that the sharing of healthcare discharge plans with services, which offer prisoners support prior to release, could remedy some of these deficits.

3.2 Strategy for Improving Outcomes for Vulnerable Prisoners

The delivery of effective care to vulnerable people in custody requires a strong government-led strategy for improving outcomes, underpinned by a vision that is shared by all stakeholders, including commissioners and providers.

The 2019 DoH/DoJ strategy for 'Improving Health within Criminal Justice', acknowledges the challenges faced by the prison population[52]. Action 5: 'Health promotion and ill-health prevention' makes a commitment to developing a suicide and self-harm strategy.

Whilst it considers the potential for in-reach counselling services and referral pathways for self-harm, it does not address the issue of lack of provision of psychological support for those with personality disorders, nor does it acknowledge the need for greater capacity within existing mental health and addiction services. Although the strategy seeks to improve the diversion of mentally unwell individuals away from the criminal justice system and into more appropriate healthcare settings, it does not consider the issues of capacity, or of waiting times affecting transfer of mentally unwell prisoners to forensic secure beds.

The strategy is intended to be broad and wide-ranging, focusing not just on mental health within the prisons, but more generally on improving the health of those who come into contact with the criminal justice system. As such, it lacks a clear vision for improving outcomes for vulnerable people in custody. This was evidenced by the diverging accounts of the strategic vision presented to us by commissioners and providers during fieldwork.

The most closely aligned vision was that of the HSCB/PHA; aspects of the DoH/DoJ strategy for 'Improving Health within Criminal Justice Strategy' are reflected in the HSCB/PHA 10 Point Plan, which has a work stream specific to addressing the healthcare needs of vulnerable prisoners. The strategic vision of the NIPS however, was described as being one of person-centred approach; whereas the SEHSCT describe their vision as one of a health improvement ethos. Whilst both these visions aim to implement improvement at an individual level, the differing emphasis has resulted in a lack of focus at a prison population level. It is evident that a clear strategic focus is now needed in order to improve mental health outcomes for vulnerable people in Northern Ireland prisons.

Recommendation 1 **Priority 3**

DoH and DoJ should clearly communicate the vision for improving outcomes for people in prison who are at increased risk of self-harm and suicide. This may be encompassed in a new or updated strategy and should be fully embraced and implemented by all stakeholders: NIPS, SEHSCT, HSCB and PHA.

3.3 Needs Assessment, Planning and Commissioning

Effective needs assessment, planning and commissioning arrangements are essential to ensure that services are high-quality, accessible and provide evidence-based care which meets the needs of the population.

Needs assessment

Needs assessment forms a key aspect of the commissioning of services. It should take into consideration the current health and social wellbeing of the population, while also assessing the likely future need. Improvement and investment arrangements for healthcare in prisons in Northern Ireland should be primarily identified by the HSCB/PHA through needs assessment, in addition to local and regional planning processes.

A Population Needs Assessment was undertaken in Northern Ireland prisons as part of the initial work on the Review of Vulnerable Prisoners in 2017. Data sources included CJINI inspection reports, previous health needs assessments and prison population statistics. Despite forming a crucial step in the commissioning process, the authors acknowledged that there was conflicting information and statistics; as a result, a limitation of the needs assessment was that data could not be "totally relied upon to develop and commission services".

Underlying the challenges in needs assessment has been the lack of a robust system for data collection within healthcare in prisons. The current electronic Egton Medical Information System (EMIS) provides limited yearly data and lacks the capability for more nuanced data extraction and analysis. It is hoped that the new regional electronic health records system, Encompass, will provide a much-needed solution. However, it is likely that it will be a number of years before this is implemented and embedded; in the interim an improved arrangement for data collection and analysis is required.

Notwithstanding the lack of a robust data collection system, available sources of healthcare information are wide-ranging and, in addition to EMIS, include:

- committal assessments, including mental health assessment
- SPAR Evolution data
- referral to the Prisoner Safety and Support Team and ongoing monitoring
- Towards Zero Suicide project; including the Lived Experience, Carers and Advocates Group
- data on waiting lists and waiting times for healthcare in prison services
- monitoring from the Peer Mentor Support initiative
- CSU monitoring
- Transfer Directional Orders monitoring
- 10,000 Voices interviews post committal

Whilst there is data collected at a provider level, it was noted that this is not always shared between providers or made available to commissioners. Self-harm data, for example, is monitored by the Safer Custody Forum within the prison service but is not routinely monitored by commissioners. It is noted that there are a variety of sources that are underutilised and, as a result, the dashboard does not provide the metrics necessary to support the quality assurance or development of services. An up-to-date health needs assessment should go some way to mitigating this deficit.

An up to date HNA was underway at the time of this review and has an anticipated publication date of mid-2021. Undertaken by a HNA partnership comprising the HSCB, PHA, SEHSCT and NIPS, the HNA incorporates a theme of Mental Health and Learning Disability and is intended to provide valuable information regarding the needs of vulnerable people in prisons.

Recommendation 2 **Priority 2**

Commissioners (currently the HSCB) and its provider (SEHSCT) should work together and with NIPS to define and agree the metrics needed to inform an ongoing assessment of need.

A robust system for regular data collection and analysis, utilising all relevant sources of information, should be developed and implemented as an interim measure ahead of the introduction of Encompass. In the absence of a reliable electronic system, consideration should be given to harvesting data manually.

Planning and commissioning of healthcare in prison

The HSCB and the PHA have specific planning and commissioning arrangements in place for healthcare within the criminal justice system. A multidisciplinary planning team comprising senior nominated representatives from HSCB, PHA and DoH seeks to deliver on the Service Budget Agreement by way of a Ten Point Plan.

Derived from the Improving Healthcare in Criminal Justice Strategy 2019, the Ten Point plan outlines key deliverables, one of which is specific to the needs of vulnerable prisoners:

1. Improve performance reporting and management systems including electronic notification systems to primary care.
2. Effective arrangements should be in place to develop and implement a health and social well-being strategy for prisoners.
3. Review of Service Specification – prison mental health and learning disability services in-line with Bamford.
4. Effective arrangements should be in place to develop care pathways for prisoners for both inside and outside of prisons.
5. Address the healthcare needs of vulnerable prisoner.
6. Ensure that there is evidence of service user engagement across all sites
7. Review service delivery and specification for specific services (a) ophthalmic services / (b) AHP services.
8. Regional learning quality and safety of existing services in prison
9. Review of health protection and screening procedures across all sites.
10. Renewed focus on prescribing information and medicine management/optimisation across primary care and prisons.

The Planning and Commissioning Team, whilst specific to healthcare in the criminal justice system, including prisons, has a very broad planning and commissioning portfolio. Its members have responsibility for many aspects of health and social care delivery within their respective roles. The Expert Review Team considers that this reduces the amount of time and focus that is dedicated to what should be a priority area. It also means that there is a lack of specialist expertise to effectively plan, commission and monitor the quality of these services.

The requirements of the SEHSCT as a provider are outlined in a service delivery document. Due to legacy arrangements, there is no service specification document for healthcare in prison, which poses challenges for instructing the delivery and monitoring of service provision. There are advantages to developing a service specification that go beyond the end document; the Expert Review Team consider that the very process of developing a specification ensures that there is a consistent delivery model that is clearly understood by all stakeholders.

A renewed commissioning model presents an opportunity for a new way of working. There is an overall migration transition process in place across all HSCB Directorates. HSCB Commissioning Leads are working with their DoH counterparts to confirm final arrangements in the latter part of 2021-2022.

Good Practice Example: Forensic Managed Care Network

The Forensic Managed Care Network for Northern Ireland (FMCNNI) was established in June 2019. Aligned to Action 2.5 of the Joint Criminal Justice Strategy 2019, it forms Action 6.2 of the Department of Health Mental Health Action Plan 2020. It aims to facilitate the co-ordination of multi-agency working across Health and Social Care (HSC) services, Criminal Justice Agencies (CJA) and third sector organisations in order to ensure continuity of regional service co-ordination, co-operation and planning. In both Action Plans and within the 10 year Draft Mental Health Strategy (2021-2031) there are cross-cutting and relevant actions in relation to pathways, outcomes, research and training and education.

The network encompasses mental health and learning disability/ intellectual development disabilities services across Northern Ireland. In partnership and collaboration with the Scottish Forensic Network, the Royal College of Psychiatrists Quality Network for Forensic Mental Health Services and Irish National Forensic Mental Health Services, its overarching aims are to:

- Bring a consistent approach to the planning and commissioning of high quality, accessible and effective treatment and care for those who require Forensic Mental Health and Forensic Learning Disability/Intellectual Development Disability Services.
- Improve outcomes for those who require Forensic Mental Health and Forensic Learning Disability/ Intellectual Development Disability Services.
- Ensure involvement of service-users and carers in all developments.
- Promote more formal collaborative working between Northern Ireland, the rest of the United Kingdom and the Republic of Ireland.
- Support, sustain and develop the workforce.
- Address teaching, training and research needs.
- Promote and build on good practice.

Funding was allocated in September 2020 to recruit a Forensic Network Manager, Clinical Director and associated support staff to the Health and Social Care Board in 2021-2022 to build on partnership working, strengthen strategic oversight and accountability and co-produce regionally effective models of care for people who require Mental Health and Learning Disability/Intellectual Developmental Disability Forensic Services. Working across all HSC services and the prisons, the Forensic Managed Care Network has the potential to positively shape future service delivery by informing commissioners of priority areas of need, promoting good practice examples and making evidence-based recommendations.

In light of the complexity of providing high-quality joined-up services for the criminal justice population, there is a need to strengthen the levels of expertise which input into the regional commissioning process. There is an opportunity for the Forensic Managed Care Network (FMCN) to provide this expertise. The chair of FMCN previously sat on the HSCB/PHA Improving Health within Criminal Justice Team, which has oversight of healthcare in prison commissioning. A number of individuals participate in both prison commissioning and the FMCN. Terms of Reference for FCMN have recently been amended to enhance the sharing of expertise.

Recommendation 3 **Priority 2**

The DoH and HSCB should define the future arrangements for the planning and commissioning of healthcare in prison. These arrangements should be founded on the development of a regional service specification which is based on a robust needs assessment and has the specific requirements and standards to enable the monitoring of services for people who are vulnerable in custody. The Forensic Managed Care Network should develop a Healthcare in Prison sub-group as part of its governance structures in order to provide expert advice to this process.

3.4 Funding for Healthcare in Prison

Robust systems and processes for the planning, commissioning and delivery of services are important to ensure optimal use of resources. However, for services to be high-quality and to adequately address the needs of the population they require sufficient funding and investment. Funding for healthcare in prison should be based on an agreed formula, which reflects the specific needs of the Northern Ireland prison population.

The allocated budget for healthcare in prison is £8.5 million per year. This budget is derived from legacy arrangements following the transfer of responsibility for healthcare in prison from DoJ to DoH. This historical negotiated figure has been uplifted on an annual basis and is augmented by non-recurrent funding; non-recurrent funding for 2020-2021 amounts to £350,000 for transformation projects. In addition, the PHA Health Improvement division provides approximately £120,000 of annual funding for health improvement initiatives (of which £48,375 is recurrent).

In comparison with healthcare in prison budgets in England and Wales, the Expert Review Team have determined through bench-marking that the Northern Ireland budget for healthcare in prison is significantly less per head of the prison population; this equates to a short-fall of approximately £4 million per year. This disparity has arisen because the funding for healthcare in prison has been determined by a historical figure, supplemented by an annual uplift, rather than being founded on a meaningful formula or needs assessment. The precise figure for mental health funding had not been delineated at the time of fieldwork but one can extrapolate that it falls below par. All of this occurs in spite of a higher demand for mental health provision within the general Northern Ireland population. The increased level of need is such that there is an argument for even greater funding to be provided within Northern Ireland prisons, not less.

Therefore, it is crucial that bench-marking augmented by robust needs assessment informs the commissioning of prison mental health services going forward; the Expert Review Team consider that it is likely a significant funding uplift is required.

Recommendation 4 **Priority 1**

Commissioners (currently the HSCB) and providers (SEHSCT) should benchmark Northern Ireland's healthcare in prison services with prison healthcare services in the rest of the United Kingdom. Where deficits are identified through benchmarking, a needs assessment should inform additional funding arrangements.

3.5 Quality Assurance

Strong governance and accountability arrangements are required to assure the quality of care provided to service users and to enable continuous improvement. Within the prisons, partnership working and joint governance arrangements between NIPS and SEHSCT are essential to support the safety of vulnerable prisoners.

It was highlighted in previous CJINI/RQIA inspection reports that challenges in partnership-working had affected joint oversight and quality assurance of prison and healthcare in prison[53,54]. The Expert Review Team noted the enhanced relationship between NIPS and SEHSCT and acknowledged the progress that has been made in improving governance arrangements. A number of joint strategies and procedures, including those implemented rapidly with support from the PHA in response to COVID-19, exemplify the value of this improved relationship:

- Joint Suicide and Self-harm Risk Management Strategy
- Joint Management of Substance Misuse in Custody Strategy
- Joint Supporting People at Risk Evolution (2019)
- Joint COVID-19 checklists for isolation units (new committal), isolation units (existing population), shielding arrangements
- COVID-19: Prisons and Places of Detention (PHA)
- Prison Service Contact Tracing Procedures
- Joint Operational Arrangements for Preventing and Managing Outbreaks of COVID 19 in Prisons (NIPS/PHA/SEHSCT)

Furthermore, revised governance structures are said to provide better oversight of service delivery and facilitate implementation of joint recommendations from inspection reports and Death in Custody investigations. It was considered by the Expert Review Team that this oversight mechanism could be strengthened further by the introduction of a joint traffic light monitoring system, which would facilitate an assessment of progress.

Quality assurance of healthcare services is said to be augmented by bench-marking and peer review. In recent years the SEHSCT has joined the Quality Network for Prison Mental Health Services (QNPMHS) and has undergone peer review on two occasions in 2018 and 2019.

During fieldwork, SEHSCT stated that they benchmark their performance against standards outlined in NICE Guidelines NG 57: Physical health of individuals in prison and NG 66: Mental health of adults in contact with the criminal justice system[55,56]. Whilst NICE guidelines provide nationally agreed standards, the Expert Review Team considered that this could be augmented through more formal benchmarking with other services.

At a commissioner level, monitoring arrangements exist by way of quarterly meetings between HSCB and SEHSCT. These were described as presenting an opportunity to consider strategic progress on the Ten Point Plan and to reflect on all issues within healthcare in prison. In addition to quarterly monitoring meetings, the HSCB monitor resources and seek assurances by a variety of other means:

- SAIs and complaints
- needs assessment information
- discussions with wider stakeholder groups
- service user engagement
- advocacy groups
- bespoke direct professional engagement on a needs basis

During fieldwork, it was stated that there is a move away from monitoring service activity and towards an outcomes-based approach with the development of scorecards and Key Performance Indicators (KPIs). The Expert Review Team considered that this was the right direction of travel with the potential to support continuous improvement within services; however, at the time of fieldwork KPIs were not yet fully developed. Greater efforts are also being made to involve service users, utilising a 'you said – we did' approach to planning services. However, it was noted that commissioners do not engage with the IMBs, which represents a considerable omission given that the IMBs can provide a unique insight into the needs of prisoners and the impact of gaps in service provision.

Whilst an improved relationship between the HSCB and SEHSCT is to be acknowledged and commended, present arrangements lack robust mechanisms for accountability. In the absence of a defined service specification and fully-developed comprehensive KPIs, the information shared between SEHSCT and HSCB appears to be selective. The Expert Review Team identified that key issues regarding service provision, such as a lack of capacity within mental health and addiction services, had not been fully relayed to the HSCB, representing a missed opportunity to obtain much-needed additional funding.

Accountability arrangements between the HSCB and DoH are further complicated by a lack of objective distance, with both parties forming part of the multidisciplinary Planning and Commissioning Team. Instead of providing oversight and accountability, the Expert Review Team identified that there was a significant reliance on the DoH to provide input into the commissioning process. The Expert Review Team considered that delineating the role and function of the DoH in the commissioning process has the potential to become even more challenging following closure of the HSCB; a factor that needs to be considered during reconfiguration of the commissioning model.

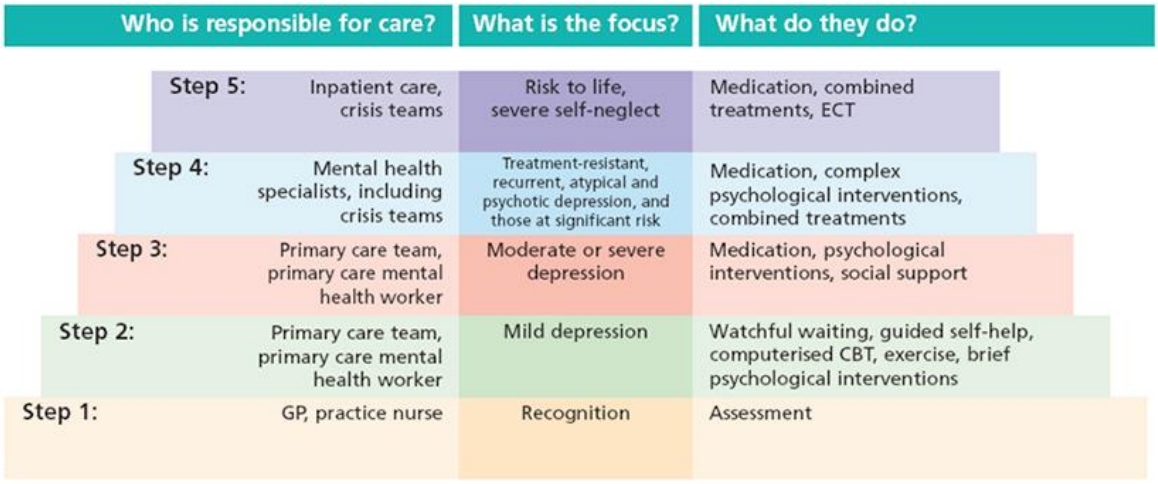
Recommendation 5 **Priority 2**

The DoH and HSCB/PHA should review their oversight arrangements to ensure that there are clear lines of reporting to support oversight and accountability for both the commissioning and provision of services. This should be facilitated by introduction of a traffic light dashboard to facilitate joint oversight and monitoring of key performance indicators at both commissioner and provider level.

3.6 Services for Vulnerable People in Custody

Model of healthcare

Crucial to improving outcomes for vulnerable prisoners, is an evidence-based model of healthcare, which meets the needs of those who are considered to be at increased risk of self-harm or suicide. Commissioners and providers describe a stepped-care model within the healthcare in prison.



The stepped-care model for mental healthcare provision was originally developed by NICE and was adopted in Northern Ireland following the Bamford Review[57]. Forming part of the Regional Mental Health Care Pathway, its underlying principle is that treatment is provided in accordance with need[58]. Those with milder mental health conditions are offered effective interventions such as psychological support, whilst those with more severe presentations are offered specialist psychiatric treatment; care can be stepped up and stepped down accordingly.

The prison mental health stepped-care approach is perceived to offer equivalence to provision within the community as it is essentially the same model of care. It should be noted that the principle of equivalence pertains to offering the same standard and quality of healthcare but does not require the service model to be identical. The internationally agreed position is outlined in the United Nations Standard Minimum Rules for the Treatment of Prisoners (also known as the Mandela Rules) which stipulates: "The provision of healthcare for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status[59]".

The Mandela Rules also state that healthcare in prison teams should "encompass sufficient expertise in psychology and psychiatry". The prison setting has its advantages in terms of delivering a model of healthcare that meets needs and improves outcomes. For example, prison mental health services are co-located which can provide greater opportunity for psychiatrists and psychologists to work together to oversee care arrangements that are tailored for the individual.

However, delivering high-quality care in the prison setting is not without its challenges. The needs of the prison population can be multiple and complex and the threshold at which specialist input is required may be lower[60,61]. The model of care must be effective at delivering the right level of specialist support for all individuals who need it, not just those with the most severe and enduring mental illness. There should be an all-illness model which provides services at all levels of the stepped-care model, without diagnostic exclusions; this necessitates that there should also be access to appropriate psychological interventions for trauma and personality disorder.

Additionally, the needs of vulnerable groups such as people with learning disability, autism, ADHD, acquired brain injury, and cognitive impairment arising from dementia, should be taken into account. Trauma-informed mental health services which are integrated with other psychological and social support services and offer support for individuals with specific vulnerabilities have been implemented in an attempt to meet the needs of vulnerable prisoners in England[62]. Such a model could be considered in Northern Ireland within a service specification framework. The collaborative process of commissioners and providers working together to develop a service specification has been described by our Expert Review Team as invaluable in ensuring that services are high-quality and meet the needs of the prison population.

Regardless of the model of healthcare, accessibility is crucial in ensuring effective service delivery. Although Maghaberry is piloting a seven-day service delivery model, Magilligan and Hydebank Wood continue to offer a five-day service; a disparity of which commissioners were unaware. We were advised by the SEHSCT that although there is no formal seven day service in Magilligan and Hydebank, mental healthcare is provided over the weekend on a bespoke basis for those with complex needs. The Expert Review Team note that the pilot service in Maghaberry is intended to be evaluated and consider that this could be used to inform a formal extension of the service across the other sites. At present, the SEHSCT are only funded to deliver a five-day mental health service and have piloted a seven-day service in the absence of commissioning. Whilst a seven-day service is required to meet the needs of prisoners, it will need to be adequately resourced.

Recommendation 6 **Priority 2**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to develop a service specification for an integrated model of care for mental health provision within the prison service; this should be informed by a robust needs assessment taking into account the needs of vulnerable people in custody. Underpinned by the right to health, there should be equitable seven-day provision across all prison sites.

Good Practice Example: Health and wellbeing engagement during COVID-19 pandemic

The COVID-19 response within the prison service required that new committals isolate for a period of 14 days and that all prisoners adhere to social distancing measures implemented to reduce the risk of COVID-19 transmission. Recognising the potential for a negative impact on mental wellbeing, the Health and Wellbeing Engagement Team, supported by members of healthcare in prison and AD:EPT, led an engagement initiative designed to lessen the mental health challenges associated with COVID-19 across the prison sites. A joint group with representatives from NIPS, SEHSCT, PHA and HSCB worked together to ensure good levels of activity for prisoners in isolation areas. Activities for prisoners included:

- Quarantine and landing engagement sessions provided an opportunity for prisoners to talk and also reduced feelings of loneliness and isolation associated with the pandemic
- Post-quarantine interviews enabled prisoners to share their experience of quarantine and talk about the impact on their mental health and wellbeing
- 'Good to talk' groups in Braid House provided an opportunity for prisoners to talk about their wellbeing and discuss coping strategies
- FAB News newsletter which is co-produced provided entertainment, quizzes and puzzles for prisoners
- WhatsUp – Non-Digital Social Media Platform
- Weekly quiz, competitions and bingo
- Relaxation and Mindfulness groups
- Distraction packs, colouring books, exercise mats

The engagement work and activities undertaken within the prisons during the COVID-19 pandemic serves to highlight the commitment of prison and healthcare in prison staff to improving prisoner wellbeing amid challenging circumstances and within the constraints of limited resources. Such improvement work demonstrates a welcome focus on the mental wellbeing of prisoners and has the potential to be further developed and embedded during the pandemic and beyond.

Healthcare pathway supporting vulnerable prisoners at Committal

All people who enter custody should be seen within 24 hours of committal by a primary care nurse who has received training in mental health presentations. This appointment includes an initial health screen to assess for immediate physical and mental health needs. There is a further comprehensive healthcare assessment within 72 hours of committal, which informs care planning, risk assessment and continuity of care.

Information is corroborated by accessing the Northern Ireland Electronic Care Record, Police and Criminal Evidence (PACE) information and any health records from previous episodes in prison.

Information from healthcare assessments is recorded on the EMIS system. All prisoners have a face-to-face triage appointment with a member of the Mental Health Team within five days of committal; the purpose of this is to identify those who require onward referral to the prison mental health service and to agree and implement a care plan.

Referral pathway into mental health services

Referrals into prison mental health services occur through a variety of means. Referrals can be from the mental health triage within five days of committal, from the healthcare in prison team, through the Supporting People at Risk (SPAR) Evolution approach or from the Prison Safety and Support Team (PSST).

Criteria for referral to the healthcare in prisons mental health team are:

- known to mental health services in the community
- diagnosis of severe and enduring mental illness
- committed on a charge of murder or manslaughter
- complex needs associated with mental illness and emotional ill health or Learning Disability
- engaging in self-harming behaviours whilst in custody or are considered high risk of self-harm and/or suicide
- expressing suicidal ideation whilst in custody
- ongoing symptoms of common mental health disorders such as depression or anxiety, following treatment from General Practitioner (GP)/Primary Care services within the prison
- significant change in presentation (e.g. bizarre behaviour, withdrawing from activity or evidence of self-neglect)

There is presently no option for self-referral, which presents a significant barrier in terms of access to specialist support. Access is instead reliant on an adequate assessment of need and a robust triage system; this may lengthen the time from presentation to being seen by the appropriate professional and risks that some prisoners may slip through the net.

A paper-based triage of referrals is normally conducted within one working day. A referral management system is used to record, monitor and manage all requests to access prison mental health services. Mental Health Team Leads triage new referrals daily from Monday to Friday. This process includes a review of available Northern Ireland Electronic Care Record and, where appropriate, information is sought from services within the community. Prisoners are either allocated an appointment or signposted to other agencies. An outcome decision is recorded. Outcomes include: allocation for assessment, transfer of care from mental health services in the community or signposting to other agencies.

Trust timescales for appointments differ significantly to the QNPMHS Standards[63]:

- **Urgent:** appointment within 10 days (QNPMHS: 48 hours)
- **Routine:** appointment within nine weeks (QNPMHS: 5 days)
- **Emergency/Crisis:** where crisis intervention is necessary, a mental health assessment is arranged on the same day in Maghaberry, seven days per week. However, it is worth noting that Hydebank Wood and Magilligan do not provide a weekend service; therefore assessments at the weekend occur within 48 hours.

As part of the stepped-care model, patients assessed as requiring care at steps 1-3 (recognition, mild and moderate depression) are looked after by the primary care team. This includes members of the primary care nursing team, occupational therapists and GPs. Interventions include medication, psychological therapies and social support.

Those requiring care at steps 4-5 or who are known to community mental health services are referred to the mental health team for assessment.

If it is deemed through triage that a mental health assessment is not required, then there may be signposting to alternative forms of support such as community and voluntary in-reach services within the prisons; examples include NEXUS, Action Mental Health, Barnardo's Family Matters programme, Start 360, prison listeners, and the chaplaincy.

Recommendation 7 **Priority 2**

The SEHSCT should update policy and procedure for allocating mental health appointments to align with the Quality Network for Prison Mental Health Services Standards and ensure live monitoring of performance. This process should consider the feasibility of a pathway for self-referral.

Availability and accessibility of services

Available and accessible services are essential to ensure that care and treatment is delivered in the right place at the right time by the right professional. The capacity and capability of services is dependent on recruitment, training and development to ensure that there are sufficient numbers of staff with the right skill mix to deliver effective care.

The QNPMHS conducted a peer review of mental health services in Maghaberry Prison in June 2019 and noted low staffing levels, increased workload and poor morale. The report made a number of recommendations in relation to the capacity and capability of the prison mental health team. It recommended that there should be a review of the staff members and skill mix of the team and that capacity management plans should be devised to ensure continuity of service provision in the event of leave or sickness.

Resource constraints aside, recruitment and retention of healthcare in prison staff can be difficult. Acknowledging the challenges that staff face, the Expert Review Team considers that in parallel to any drive to improve capacity, there should be ongoing recognition of the dedication and commitment of staff, and continued development of rewarding roles and career pathways within healthcare in prison.

Mental health service

The mental health and addictions service is overseen by a Service Lead supported by three mental health and addiction leads across the three prison sites. The prison mental health team comprises psychiatrists, mental health nurses, a psychologist, cognitive behavioural therapists, occupational therapists and speech and language therapists. Psychiatry provision comprises one whole-time equivalent (WTE) consultant forensic psychiatrist and one part-time (0.4 WTE) staff grade forensic psychiatrist covering three prison sites.

Waiting times for mental health assessments

Urgent assessments are required for individuals who are in a mental health crisis, who have rapidly escalating needs or presentation or who are at risk of immediate harm to self or others. The QNPMHS Standards states that urgent assessments should be undertaken within 48 hours and routine assessments within five days[64]. The waiting times for both urgent and routine appointments across all prison sites fall significantly short of these standards. It should be noted that this is also the case for regionally agreed targets, which allow considerably longer timescales (urgent appointments within ten days; routine within nine weeks).

When the QNPMHS undertook a peer review of mental health services in Maghaberry Prison in 2019, the review team found that response times to referrals were still being conducted within regionally agreed timeframes and not the standards laid out by the QNPMHS; a recommendation was made that timescales for appointments should be changed to comply with QNPMHS standards. It should be noted that despite this recommendation to comply with national standards, SEHSCT are only commissioned to deliver within the regionally agreed timescales.

Urgent mental health assessments

In 2020, 23 out of 187 (12.3%) prisoners in Maghaberry who were referred for an urgent mental health assessment were seen within the QNPMHS standard of 48 hours. 120 out of 187 (64.2%) were seen within the regional target of ten days. 33 are noted to have served their time before being seen. However, the data does not indicate whether this was within the nine week timescale.

In 2020, 1 out of 2 (50%) prisoners in Magilligan who were referred for an urgent mental health assessment were seen within the QNPMHS standard of 48 hours.

In 2020, 9 out of 132 (6.8%) prisoners in Hydebank Wood who were referred for an urgent mental health assessment were seen within the QNPMHS standard of 48 hours.

Routine mental health assessments

In 2020, 8 out of 344 (2.3%) of prisoners in Maghaberry who were referred for a routine mental health assessment were seen within QNPMHS standard of five days. 90 out of 344 (26.2%) were seen within the regional target of nine weeks. It is noted that 195 served their time before being seen. However, the data does not indicate whether this was within the nine week timescale.

In 2020, 2 out of 48 (4.2%) of prisoners in Magilligan who were referred for a routine mental health assessment were seen within the QNPMHS standard of five days. All (100%) were seen within the regional target of nine weeks.

In 2020, 9 out of 70 (12.9 %) of prisoners in Hydebank Wood who were referred for a routine mental health assessment were seen within the QNPMHS standard of five days.

Review appointments

Unlike new appointments, there are no targets for timeliness of review appointments; as is the case for the community mental health services. It should be noted that during the course of this review, the RQIA escalated concerns to the SEHSCT about delays in review appointments for three prisoners, who came to our attention during prisoner engagement. Following escalation, the three individuals were promptly reviewed. However, the Expert Review Team are concerned that this is only a small snapshot of unmet need, encountered during a focus group session. Given the absence of data and monitoring of waiting times for review appointments, there is a deficit in assurance around the accessibility of mental health services for the prison population as a whole which must be addressed.

Recommendation 8 **Priority 2**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to review the capacity and capability of the mental health service to ensure that waiting times for urgent and routine mental health assessments meet the Quality Network for Prison Mental Health Services Standards. Specifically, this should include a review of the number of staff members and skill mix of the mental health team. Data should be routinely collected on waiting times of all mental health appointments including review appointments.

Accessibility of addiction services

Provision for addiction treatment within the prison service has improved following the recruitment of a consultant addictions psychiatrist and the introduction of prolonged-release injections to treat opioid dependence. Beneficially, the Addiction Service has also expanded its remit to provide care and treatment for those with a history of alcohol misuse. The team work closely with AD:EPT (Alcohol and Drugs: Empowering People through Therapy), a service delivered by Start 360, who are an independent organisation providing therapeutic services across the three sites.

In addition to an addictions psychiatrist, the service is provided by specialist nurses and GPs with a special interest in addiction. However, whilst three specialist addictions nurses have been appointed by the SEHSCT, we were told by frontline staff that at the time of fieldwork only one nurse was currently working. As stated in the SEHSCT policy, induction on to Opiate Substitution Therapy (OST) is dependent not only on the criteria set out in the United Kingdom Guidelines on Drug Misuse and Dependence 2017 but also on the availability of appropriately trained nurses and prescribers across the prison sites; as such, any lack of nursing capacity presents a considerable challenge[65].

Demand for OST is described as significant; the waiting time for an addictions appointment was seven months at the time of fieldwork with 90 individuals on the waiting list. Whilst this represents an improvement, it is clear that many prisoners are still waiting too long to be seen. Not only does this perpetuate a demand for illicit drugs within the prisons, it also means that some prisoners will experience acute withdrawal symptoms. This falls short of expected standards when it comes to both best practice and human rights.

Recommendation 9 **Priority 1**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to review the current capacity and capability of the addiction service to meet the needs of prisoners who require treatment and support for addiction. Urgent consideration should be given to increasing the number of specialist nurses in order to increase Opiate Substitution Therapy provision and to shorten waiting times.

Clinical psychology provision

The United Nations Standard Minimum Rules for the Treatment of Prisoners (also known as the Mandela Rules) stipulate that healthcare in prison teams should "encompass sufficient expertise in psychology and psychiatry[66]". A community-equivalent stepped-care model requires adequate access to psychological interventions, the need for which is known to be greater within the prison setting.

There is one newly appointed part-time (0.6 WTE) clinical psychologist who provides psychological treatment across all prison sites. At the time of fieldwork, due to sick leave, provision was limited to just one day per week across all sites delivered by a part-time (0.2 WTE) locum psychologist. The majority of psychology referrals were described as being for prisoners with a diagnosis of personality disorder. It was stated that referrals are made sparingly, which indicates that the service is under-utilised; this is even more apparent when one considers the estimated prevalence of personality disorder within the prison population. The Expert Review Team considers that not only is the current provision insufficient to meet the needs of those with personality disorder, it is also insufficient to meet the needs of those with common conditions such as anxiety, depression and obsessive compulsive disorder (OCD). The effective delivery of a stepped-care model requires sufficient psychology input to provide care to those with both common and more complex conditions; it is clear that the present provision falls short of what is needed.

In addition to clinical psychology input, there is one WTE cognitive behavioural therapist who provides support for mental illness, trauma and adverse childhood experiences. Healthcare in prison also has a link with the regional trauma network. It was reported that all new staff receive training in trauma awareness at induction and there are plans to roll this out to existing staff. Despite this positive development, specialist psychology interventions for trauma appear to be lacking.

Recommendation 10 **Priority 2**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to review the current capacity and capability of prison psychology services to effectively deliver a stepped-care model that meet the needs of vulnerable prisoners. Consideration should be given to introduction of a specialist psychology service which offers therapeutic intervention for those with a history of trauma and personality disorder.

Specialist input for personality disorder

Personality disorder is known to be highly prevalent within the prison setting; both international and United Kingdom studies estimate that when diagnostic criteria are applied, approximately two thirds of prisoners will meet the threshold for diagnosis of at least one type of personality disorder[67,68]. Whilst not a homogenous group, people with personality disorder often have a history of childhood trauma. Given the higher incidence of conflict and intergenerational trauma in Northern Ireland, which has been compounded by socio-economic deprivation, the prevalence of personality disorder within the Northern Ireland population is expected to be as high, if not higher, than the rest of the United Kingdom[69,70]. People with personality disorder often have difficulties in regulating their emotions; this can impact on their behaviour and may be the reason underlying their conviction and subsequent committal to prison. They are also known to be at increased risk of self-harm, suicidal behaviour and other co-morbid mental health conditions. If we are to rehabilitate offenders and reduce the incidence of self-harm and suicidal behaviour within the prison population, it is important that the needs of prisoners who have an underlying personality disorder are identified and addressed. Any effective intervention requires a co-ordinated effort across both prison and healthcare in prison, supported by additional resource as necessary.

NICE guidance [NG66] on 'Mental health of adults in contact with the criminal justice system' states that providers should ensure that staff are able to identify the common features and behaviours of personality disorder and use these to inform the development of programmes of care, whilst ensuring that interventions are supportive, facilitate learning and coping strategies[31]. The Northern Ireland Regional Care Pathway for Personality Disorders offers advice and guidance relevant for staff working in criminal justice agencies and forensic mental health services[71]. Whilst it explicitly states that people with personality disorders should not be excluded from HSC services by virtue of their diagnosis, there is no evidence that a care pathway for personality disorder has been implemented within Northern Ireland prisons.

We were informed during fieldwork that in the absence of a co-existing mental health problem, not only is it difficult to access support for individuals within the prisons, but it is also a challenge, through existing arrangements for exit planning, to gain access to mental health services for those with personality disorder within the community. These represent considerable deficits which require further exploration. The Expert Review Team welcome that the Draft Mental Health Strategy 2021-2031 includes an action to "create a personality disorder service and enhance the specialist interventions available for the treatment of personality disorder in Northern Ireland[72]". If implemented, this will improve therapeutic provision for personality disorder within the community which in turn should reduce offending behaviour and lead to fewer people with personality disorder entering the prison system[73].

There is an identified misconception within the prison service that the Mental Health (Northern Ireland) Order 1986 does not allow for treatment of personality disorder in the absence of co-morbid conditions[74]. However, there is an important nuance that needs to be recognised, which is that the legislation precludes detention for treatment (i.e. compulsory treatment) but does not preclude treatment on a voluntary basis. Therefore, the existing legislation is not a barrier to providing a much-needed service for the management of people with personality disorder within the prison system.

Given the prevalence and associated resource implications, it would not be feasible to provide therapeutic intervention to all prisoners who exhibit personality disorder traits. However, those with severe personality disorder, who are recognised to have complex needs or present with challenging behaviours, should be offered appropriate specialist support. This should take the form of evidence-based treatment programmes, designed to meet the needs of individuals and improve outcomes in terms of mental wellbeing, interpersonal relationships and rehabilitation. Alongside the provision of therapeutic interventions, consideration should also be given to how the prison environment impacts on those with a personality disorder diagnosis.

Psychologically Informed Planned Environments (PIPEs) have been demonstrated to be effective in maintaining gains made through treatment programmes within prisons in England and Wales[75]. They are specifically designed environments, within existing prison settings, which are staffed by prison officers who have received additional training in how to support those living with a personality disorder. They aim to offer a safe and supportive environment through the adoption of a consistent approach to respectful interaction between staff and prisoners, enhancing the quality of interpersonal relationships and facilitating personal development. PIPEs are not treatment programmes per se, but are instead designed to help prisoners maintain developments previously achieved through therapeutic intervention.

Prison-based psychological treatments alongside psychologically-informed planned environments have been demonstrated to be as clinically effective as treatment within National Health Service secure inpatient units, yet are significantly cheaper to provide. Investment in managing and treating prisoners with personality disorder is likely to reap wider prison system and societal benefits, through a reduction in self-harm, violent behaviour and re-offending.

Recommendation 11 **Priority 3**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to plan, commission and implement a therapeutic approach to personality disorder within the prison service. This should include the introduction of a specialist personality disorder service providing evidence-based treatment programmes. Commissioners (currently the HSCB) and providers (SEHSCT) should also work together with NIPS to consider the introduction of Psychologically Informed Planned Environments to help improve the management of people with personality disorder.

Specialist provision for specific vulnerabilities

Vulnerable groups, such as those with learning disability, autism, ADHD and acquired brain injury, may be overrepresented yet underdiagnosed within the prison population[76]. Adults with these conditions have higher impulsivity and, as a result, higher rates of self-harm and suicide[77,78]. They also tend to be marginalised groups who at increased risk of bullying, coercion and abuse within the prison system. Therefore, it is not only services that need to be designed to identify and provide care to these individuals, it is equally important that the prison environment is able to meet their needs. All Northern Ireland prison establishments have landings which provide dedicated areas for people who need additional support. This includes access to therapeutic spaces, staffed by prison officers who have received additional training.

We were told during fieldwork that all prisoners are now screened for learning disability on committal; others may be identified by other means such as speech and language assessment or concerns raised by prison and healthcare in prison staff. There are three nurses who are trained in learning disability; one on each site. There is an ongoing pilot on the Maghaberry and Hydebank sites where all new committals are offered a Speech and Language Communication Needs screen which aims to identify those prisoners who would benefit from additional support. Where required, 1:1 support is made available; training is also provided to prison and healthcare in prison staff. These initiatives are recognised to be of value, especially as the need for specialist input is likely to increase given the current restricted admissions pathway to Muckamore Abbey Hospital[iv].

ADHD is known to be significantly under-diagnosed and under-treated amongst the prison population and indicative of this, there are only small numbers of prisoners on ADHD treatment within Northern Ireland prisons[79]. We were told during fieldwork that whilst there is no specialist support for these individuals, there are plans in place to scope the potential for the introduction of a clinic for those who require ADHD treatment. Given the prevalence of this condition, this is a welcome development, which should help to address a significant unmet need.

[iv] Muckamore Abbey Hospital provides inpatient assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs or challenging behaviour. The hospital is currently closed to new admissions.

Dementia is reported to be an increasing problem due to a rise in the number elderly people entering the prison population following an increase in sentencing for historical offences. Maghaberry and Magilligan prisons have specific areas that have been designed for older prisoners and provide a dementia friendly environment. These environments have been developed to include a Men's Shed, raised beds for gardening activity and, in Magilligan, there is a facility for palliative care. Whilst staff receive dementia awareness training, there remains a lack of specialist provision for prisoners, such as memory clinics or social care support. Prisoners identified as requiring specialist input, are instead referred externally to memory clinics within HSC Trusts. Although the SEHSCT are not commissioned to provide social care services to the prison population, the Trust stated that they have adopted a pragmatic approach to meet personal care needs. Informal peer support "buddy systems" provide low levels of social care support within the prisons. Where it is identified that prisoners require more formal support with activities of daily living, this requires referral for a care package from the prisoner's host HSC Trust.

Foreign national prisoners are a particularly marginalised group who are at increased risk of harm within the prison system. In addition to their communication needs, they may have other vulnerabilities such as a history of trauma and a greater risk of psychiatric conditions. They may also have difficulties in accessing information and services, due to language barriers and under-referral. Additionally, they may find it more challenging to contact their family and may experience racism and isolation within the prison[80]. The introduction of virtual visits since April 2020, has increased the opportunity for all people in custody to maintain family links; this has been particularly beneficial to foreign national prisoners who have family members residing outside of Northern Ireland.

Whilst there is a lack of specialist support for these vulnerable groups, we were advised that staff take their needs into consideration and provide additional support to assist with communication and understanding, such as using easy-read versions for medication information. Similarly, there is provision for language tablets and the Big Word Telephone service for foreign nationals who require support with interpretation. We were told of the value of speech and language therapists in screening for communication difficulties which may result from previously undiagnosed autism spectrum disorders and brain injury.

Although it is encouraging that prison and healthcare in prison staff are committed to taking additional needs into consideration, in the absence of formal mechanisms to screen for conditions, to assess the need and commission services accordingly, there is a likelihood that there are prisoners from these vulnerable groups who remain unidentified and, as such, uncatered for. Robust needs assessment to inform the effective planning and commissioning of services is required in order to ensure that the needs of prisoners with specific vulnerabilities are met.

Recommendation 12 **Priority 2**

Commissioners (currently the HSCB) and providers (SEHSCT) should ensure that there is a robust screening and data collection system for specific vulnerabilities such as learning disability, autism, ADHD, acquired brain injury and dementia.

This data should be used to inform the needs assessment, planning and commissioning of specialist provision to ensure that services meet the needs of these vulnerable groups.

3.7 Safeguarding Vulnerable People in Custody

Strong systems for safeguarding are required to enable early intervention and support to protect prisoners at risk of harm either to themselves, to others or from others. There should be mechanisms in place to identify and support prisoners at risk of self-harm and suicide, alongside effective multidisciplinary working, information sharing and risk management systems to report, respond to and learn from incidents whilst implementing learning to mitigate risk.

Safer custody arrangements

The Expert Review Team note that there has been significant progress in improving the arrangements for safer custody within Northern Ireland prisons. Prisoner and Safety Wellbeing forms a key objective under the DoJ/NIPS Prison 2020 Strategic Framework. A Safer Custody steering group, comprising NIPS Directors, Governors and Safer Custody Leads, is responsible for the strategic development of safer custody policies, procedures and operational arrangements. It also provides effective oversight and scrutiny of safer custody functions and provides a mechanism to address recommendations from HMP/CJINI inspections, ombudsman reports and reviews.

Monthly Safer Custody Forums serve to monitor the implementation of policies and procedures, facilitate communication between stakeholders and ensure there are robust systems in place to monitor compliance. Data is monitored on a monthly basis and patterns and trends in relation to self-harm and violence including any contributing factors are identified and escalated.

The Expert Review Team were impressed by the achievements of Safer Custody Teams who have successfully integrated into the wider prison network and embedded improvements in prisoner safety in a relatively short period of time. The dedication of these staff members was evident and their commitment is to be commended. Within the prisons there are three such teams, one at each site. They seek to identify and support prisoners at risk in order to prevent self-harm, suicide and reduce violence in keeping with strategies and policies within the prison service. They comprise solely of prison service staff but they regularly liaise with mental health teams who provide support and guidance on a daily basis. Advice and support is also sought from primary care teams, the chaplaincy and organisations such as the Samaritans and Start 360 depending on the needs of the prisoner.

Safer Custody arrangements are underpinned by several strategies including NIPS/SEHSCT Suicide and Self-harm Risk Management Strategy, Anti-bullying Strategy, Substance Misuse strategy, and the Supporting People at Risk Evolution (SPAR Evo) approach.

Partnership working is facilitated by three weekly (bi-weekly during the Covid-19 pandemic) meetings between NIPS, the SEHSCT, the HSCB and PHA who have implemented a revised governance structure which will strengthen relationships.
The Safer Custody caseload and forums are multidisciplinary with SEHSCT providing meaningful input. Weekly Safer Custody meetings are attended by the Mental Health Team who discuss each case and provide advice on action points. Where required, Serious Case Reviews can be convened in order to implement multidisciplinary care plans for prisoners who are acutely unwell.

Supporting People at Risk Evolution (SPAR Evo)

The Joint Suicide and Self-harm Strategy has been operationalised through the Supporting People at Risk Evolution approach, which aims to identify and support those at risk of self-harm and suicide. The approach enables anyone to raise a concern about a prisoner's wellbeing, a risk assessment can then be performed and individualised person-centred measures put in place to monitor and mitigate risk.

The previous SPAR approach had been criticised by a number of prison inspection and review reports as being too process-driven, not person-centred, and lacking input from healthcare. We heard during fieldwork how it had inadvertently increased self-harm rates due to the unintended consequence of secondary gain for prisoners undergoing SPAR.

The new SPAR Evolution approach began implementation in 2018. It aims to be person-centred, address the underlying cause of distress and provide tailored support. The approach is multidisciplinary and includes family engagement and input from primary and mental healthcare teams where appropriate. Since the introduction of SPAR Evo, there has been a reduction in the numbers of people identified as "at risk". This reflects an improved and more targeted approach, where enhanced support is provided to those at increased risk of suicide and serious self-harm.

Whereas the previous approach was described as overly bureaucratic and laborious, SPAR Evo offers a more streamlined process, which is supported by technological solutions, whereby information is recorded in real-time on handheld devices. Staff also have access to personal history information which reduces the need to revisit traumatic events such as adverse childhood experiences. One drawback, however, has been that Magilligan remains on a five-day service model, which precludes the involvement of mental healthcare teams in SPAR Evo at weekends. It was also noted that although the process has significantly more healthcare input than it did previously, it is still led by the prison service and thus lacks the benefits of joint ownership. Nonetheless, it appears to be working well and, as part of wider harm reduction strategies, it is hoped that it will decrease the risk of serious self-harm and suicide amongst the vulnerable prison population. Encouragingly, data provided by the prison service has demonstrated a significant reduction in self-harm rates amongst female and young male prisoners in Hydebank Wood following the introduction of SPAR Evo; this corresponds to a reduction of 29% and 67% respectively.

SPAR Evo is due to be formally evaluated, which could present a valuable opportunity for the prison service to showcase their work and the progress that has been made. The Expert Review Team was of the view that this should be expedited and should be conducted as an external review, which would have the advantage of impartiality and independence.

Recommendation 13 **Priority 3**

The joint NIPS and SEHSCT Executive Group should jointly commission an external review of the SPAR Evolution approach. This should assess the effectiveness of input from healthcare in prison and evaluate outcomes for vulnerable people detained in Northern Ireland prisons.

Good Practice Example: Towards Zero Suicide Initiative

It is clear that for suicide prevention to be successful, it needs commitment from a range of involved multi-agency partners, not just from the prison service. Towards Zero Suicide (TZS) is joint initiative between SEHSCT and NIPS which launched in December 2019 and has been implemented across all prison sites. It is an evidence-based regional initiative which aims to exemplify a system-wide commitment to suicide prevention.

A TZS co-ordinator has been appointed to work with collaboratively with the Prison Service and other stakeholders in order to deliver training for staff in how to have difficult conversations with prisoners expressing suicidal thoughts (Safetalk training).

Although there have been some delays in progress due to the COVID-19 pandemic, there have been considerable early wins:

- There has been a significant uptake (90%) in the TZS training across healthcare staff
- TZS training has been placed onto the Trust E-Health Roster system; enabling tracking of staff who have undertaken training
- Training has been embedded within the induction programme for mental health staff and all existing healthcare staff are signposted to training
- All prison officers have received Safetalk training.
- TZS training is available at induction for all new prison officers and is delivered alongside training on trauma-informed practice and the impact of adverse childhood experiences.

While further work and evaluation is required, TZS serves as a good practice example of Quality Improvement within the prison service that could be scaled up and embedded to help further reduce the risk of suicide amongst the prison population.

3.8 Care and Supervision Units

There are three CSU within Northern Ireland prisons, which are located within Maghaberry, Magilligan, and within Hydebank Wood Secure College, where a new joint CSU (for women and young men) opened in October 2020.

CSUs exist to facilitate the separate accommodation of prisoners in circumstances where their behaviour or presentation makes them unsuitable for housing amongst the general prison population. The CSU is not intended to function as a therapeutic environment for prisoners who are mentally unwell but rather it is designed to be a segregation unit where prisoners are placed in isolation as a means to managing their behaviour. Whilst all prison sites have landings to provide additional support to prisoners with behavioural issues, at times the nature of the behaviour is such that a transfer to CSU is required. Legislative provision for the segregation of prisoners is set out by The Prison and Young Offenders Centres Rules (Northern Ireland) 1995 under Rule 32 which pertains to the restriction of association[81]. However, it should be noted that the decision to apply this rule should not automatically result in the relocation of a prisoner to the CSU and, in any event, there should be adequate safeguards in place. There is a CSU oversight committee at each establishment and NIPS HQ have oversight of all decisions to extend rule 32.

The United Nations Standard Minimum Rules for the Treatment of Prisoners, also known as the Mandela Rules, state that prior to imposing disciplinary sanctions it should be considered whether a person's mental illness or intellectual disability has been a direct cause of their conduct[82]; where this is the case, sanctions should not be imposed. Equally, the HM Inspectorate of Prisons Expectations state that prisoners with severe mental illness and at risk of suicide or self-harm should not be segregated except in clearly documented exceptional circumstances[83].

During fieldwork, we heard about the underlying reasons for transfer to the CSU and the safeguarding arrangements that are in place. Decisions to transfer prisoners to the CSU are largely undertaken by prison staff in response to severe behavioural issues and concerns around concealment of illicit drugs; it is not common practice for the mental health and addictions team to assess prisoners prior to transfer. Instead, all prisoners in the CSU are reviewed by the primary care team within two hours of transfer. Front-line mental health staff expressed a desire to assess prisoners prior to decisions being undertaken in order to identify triggers for behaviour and to assess if there might be any underlying mental health issues requiring treatment. This is not routinely performed and, if implemented, would be dependent on the capacity of the mental health team, which is known to be limited. However, it should be noted that there is an obligation to provide safeguards for those who present with mental illness or intellectual disability. One safeguard should be an assessment of the suitability of individuals for the CSU; this would have benefits in allowing earlier identification of underlying issues and help determine whether a placement in the CSU is appropriate. In England and Wales, an algorithm to assess suitability has been developed and is undertaken as part of an 'Initial Segregation Health Screen' performed by a doctor or registered nurse within two hours of placement[84]. A similar algorithm should be developed and implemented in Northern Ireland.

In addition to an initial assessment, prisoners in the CSU are reviewed daily by the primary care team. However, they are not reviewed by mental health or addiction teams unless already on their caseload. The addictions team expressed concerns around prisoners, who are not on their caseload, experiencing acute withdrawal symptoms within the CSU and the resulting impact on their physical and mental wellbeing. Concerningly, we also heard examples of acutely unwell prisoners being looked after in the CSU whilst awaiting transfer to an acute mental health bed within HSC. During fieldwork, the Expert Review Team heard repeated claims from Healthcare in Prison staff that the CSU is the best environment for acutely mentally unwell people within the prison. This is contrary to established best practice which states that those suffering from severe mental illness should be cared for and treated within a hospital environment by suitably qualified staff[85]. Of particular concern, was the lack of awareness amongst commissioners regarding the extent of the problem, indicating that the issue of CSU placement for mentally unwell patients is not receiving the focus it warrants. The HSCB informed us that this had been impacted by the suspension of commissioner visits to prison since March 2020 due to COVID-19 and, compounding this, the issue had not been escalated.

A clear underlying factor impacting on the use of the CSU is the lack of a suitable alternative; primarily the lack of regional forensic secure beds, compounding a shortage of acute mental health beds across the region. In 2020, 23 prisoners who left prison by Transfer Directional Order to transfer to an acute bed in a psychiatry setting, had spent time in CSU; of note, six were transferred directly from CSU. Of great concern, is the waiting time for transfer. The average waiting time in 2020 was 40 days, ranging from 1–177 days. Of those transferring directly from CSU, the average waiting time was 22 days, ranging from 7–48 days, meaning that some prisoners are kept in segregation for prolonged periods of time. Notwithstanding the fact that is not an appropriate therapeutic setting, it raises very serious questions about a breach of human rights.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) Northern Ireland Report 2017 recommended that prisoners suffering from extreme mental illness should be transferred to hospital immediately[86]. This has been echoed in the recent Subcommittee on Prevention of Torture and Other Cruel Inhuman or Degrading Treatment report which states that prisoners with “severe mental-health conditions should not be placed in segregation units as an alternative to normal accommodation; instead, such prisoner patients should be treated in a closed hospital environment, suitably equipped and with sufficient qualified staff to provide them with the necessary assistance[87]”. The use of segregation for mentally unwell prisoners within Northern Ireland prisons warrants closer examination.

Coinciding with this review is a ‘Review into the Operation of Care and Supervision Units in the Northern Ireland Prison Service’ which is jointly undertaken by CJINI in partnership with RQIA and Education and Training Inspectorate. The Terms of Reference are of notable relevance to the care and treatment of vulnerable people in custody[88]. The Expert Review Team welcomes an in-depth review of this aspect of the service.

Recommendation 14 **Priority 1**

Commissioners (currently the HSCB) and Providers (SEHSCT) should develop an algorithm to assess the suitability of individuals placed in the CSU as the result of an operational decision taken by NIPS. The algorithm should be applied by a doctor or registered nurse within two hours of placement in the CSU. Where it is identified that a prisoner is mentally unwell, they should be assessed by the mental health team; appropriate arrangements should be made for the immediate transfer of those who are severely mentally unwell to an acute mental health bed within HSC. For those who are mentally unwell but do not require an acute mental health bed, an appropriate care plan should be formulated and implemented by SEHSCT.

3.9 Arrangements for Transfer to Services within HSC Trusts and the Community

The interface between healthcare in prison, services within HSC Trusts and the community can impact on whether prisoners receive the appropriate level of care at the right time. Waiting times for transfer to beds in HSC Trusts are affected not just by transfer arrangements but also by bed capacity; meanwhile, care in the community is determined by the availability and accessibility of services to people who have been in prison. Although these services themselves are outside the scope of the review, they are important factors to be considered when determining how arrangements for transfer may be improved.

Regional capacity for prisoners requiring forensic secure bed

The regional bed capacity for prisoners requiring forensic psychiatric care is limited; this is in the context of regional bed pressures across all acute mental health beds which frequently operate beyond maximum capacity.

Prisoners requiring an acute mental health bed are transferred to Shannon Clinic. Shannon Clinic is a regional medium secure inpatient unit situated on the grounds of the Knockbracken Healthcare Park, Belfast HSC Trust. The clinic has a capacity of 34 beds which are commissioned for psychiatric treatment for patients with a history of offending behaviour who require treatment and rehabilitation in a secure therapeutic environment. Where a bed at Shannon is unavailable or not indicated, suitability for an alternative bed within the Trusts' acute mental health wards and Psychiatric Intensive Care Units (PICUs) is determined by the prison forensic mental health team. There is presently no provision for low secure inpatient psychiatric care in Northern Ireland. Although there are 17 low secure beds at Six Mile Ward at Muckamore Abbey Hospital, these are commissioned specifically for people with learning disability. In any case, Muckamore Abbey is currently restricting admissions pending the resettlement of existing inpatients.

The number of forensic secure beds in Northern Ireland falls significantly below equivalent bed numbers per capita in comparison to the rest of the UK; Shannon presently offers about one third of what is required[89]. We were informed during fieldwork that proposals were being considered to increase the number of secure beds, primarily focusing on the need for low secure provision.

In May 2021, the Health Minister gave approval to the policy direction set out in these proposals. This will enable a full business case to be progressed with a more detailed consideration of options and recommendations to improve regional service provision, bed capacity and outcomes for peoples requiring forensic mental health and forensic learning disability/intellectual development disabilities services.

Effective bed allocation and patient flow requires a clear pathway of care from admission to discharge; of relevance we heard of the impact of delayed discharges, due to lack of community provision to support resettlement. The Expert Review Team heard how waiting times for transfer into a secure bed is impacted not just by bed availability, but also by variation in practice across Trusts as some mental health teams insist on reassessing prisoners for suitability for PICU even when an assessment has already been performed by the prison forensic mental health team. This unnecessary duplication occurs despite a standardised Regional Protocol and may reflect differing perceptions of risk between the host HSC Trust and prison mental health team. Whilst it is understandable that HSC Trust mental health teams may wish to undertake further assessments to plan admissions and consider the suitability of ward environments, duplicating referral and gatekeeping admissions only leads to a delay in transfer and treatment.

A potential medium-term solution to these chronic issues is the establishment of a single point of access for PICU and acute inpatient beds. One HSC Trust providing a dedicated service could remove some of the barriers in terms of bed capacity and unnecessary reassessment for suitability. Similar models have been piloted elsewhere; South London Mental Health and Community Partnership[90] is a new innovative collaboration between three leading mental health Trusts. It provides an example of a combined prison referral pathway which offers a single point of entry and aims to reduce delays in hospital transfer. In the longer term, a concerted government-led effort to increase the number of regional secure beds and address issues with provision in the community impacting on delayed discharges is required.

Recommendation 15 **Priority 3**

Commissioners (currently the HSCB) and providers (all HSC Trusts) should collaborate to identify options for expediting the transfer of prisoners who are acutely mentally unwell and require admission to appropriate hospital services. One option should be a single point of entry for access to PICU and acute mental health beds.

Planning for release and ongoing care within the community

The immediate period following release from custody represents a high-risk time for people with vulnerability factors. The transition from institutional to community living can be stressful, there may be poor engagement with healthcare and other services and there is strong evidence that this is associated with an increased risk of suicide[91]. Robust systems and processes for identifying needs, linking with external agencies and planning care within the community are essential. 'Through-the-gate' liaison with external agencies is well-established within NI prisons; engagement is led by Prisoner Development Units in each prison and includes input from probation services.

Even with this in place, it can be challenging to achieve stability and rehabilitation for this population, given the high incidence of unemployment and homelessness that exists amongst former prisoners; not helped by short-notice release dates for the remand population and chronic difficulties in securing suitable accommodation.

Unfortunately the lack of accessible provision for conditions such as personality disorder within the community and the time-consuming nature of making contact with multiple external agencies makes this all the more the challenging. Therefore, robust transitional arrangements are essential in order to prepare for discharges from prison and to facilitate the sharing of information with the relevant agencies. The prison addictions team must liaise with community addiction teams to ensure that prisoners have ongoing access to OST following release; this is supported by AD:EPT who conduct pre-release planning. The mental health team must handover to community mental health teams to ensure all the relevant information is shared and that ongoing needs can be met. We were told during fieldwork that the healthcare in prison team also makes contact with the GP to provide a discharge summary and details of outstanding referrals that are required to be made to outside organisations; this indicates that some arrangements are not in place prior to release. A contributory factor is that the date of release is decided by the courts, which can afford healthcare in prison teams very limited time for discharge planning; this is a particular problem for prisoners who have been placed on remand and can be released at short notice.

There is a significant need for better community services for vulnerable people who have previously entered the prison system. Such a deficit in provision may increase the risk of reoffending amongst some prisoners and is unlikely to serve society well. A clear direction is outlined in a recent public consultation for the new ten year Mental Health Strategy which aims to improve mental health outcomes for people in Northern Ireland, including community services for vulnerable people at risk of mental ill health such as those who have been detained in custody[92]. Community services were outside the remit of this review; however, effective arrangements for discharge planning, information sharing and onward referral to available services might help mitigate the risk of suicide and self-harm amongst former prisoners. Furthermore, building relationships between providers and the different agencies is crucial in order to develop a mutual understanding of how to meet the needs of this vulnerable population; all the more important when one considers the stigma that can exist towards people who have formerly been in prison.

Recommendation 16 **Priority 2**

Commissioners currently the (HSCB) and its provider (SEHSCT) should work together with NIPS and all relevant stakeholders, including the probation service, to ensure that there are robust systems in place for referral, liaison and information sharing to facilitate planning for ongoing care in advance of a prisoner's release date.

Section 4: Conclusion and Recommendations

4.1 Conclusion

This review is the first to look at the planning and commissioning of prison mental health services since the Dame Anne Owers' review one decade ago. Since then, there has undoubtedly been progress, particularly in relation to SPAR Evolution, partnership-working and governance. However, despite these commendable improvements, there remain considerable challenges in meeting the needs of vulnerable people in prison.

Healthcare in prison is significantly underfunded in Northern Ireland in comparison to other regions in the United Kingdom. Equally, the needs assessment, planning and commissioning arrangements require substantial improvement. Existing services are under considerable pressure, with demand greatly exceeding capacity. Waiting times for urgent and routine mental health assessments fall significantly short of national standards. There is a lack of specialist support for people with personality disorder and for those with specific vulnerabilities such as learning disability, ADHD and dementia. Some acutely mentally unwell people are being looked after within the CSUs rather than receiving the appropriate inpatient treatment. Waiting times for transfer to mental health beds are unacceptably long.

During the course of this review we encountered some very capable and enthusiastic staff across both the prison service and healthcare in prison. The Expert Review Team were impressed by their compassion and dedication to making things better for people in prison. In particular, Safer Custody arrangements and recent improvements within the Addiction Service are a testament to the commitment of these talented individuals. Equally, the Health and Wellbeing Engagement work and initiatives such as Towards Zero Suicide demonstrate potential to address the mental health challenges faced by the prison population. But to truly improve outcomes for vulnerable people in custody there needs to be a concerted and co-ordinated effort across the system. Outside the scope of this review, but no less important, is the need for better liaison and diversion to ensure that mentally unwell people do not enter the criminal justice system in the first place and also the need for better community services to support those who leave prison to reduce the risk of harm and reoffending. It is clear that such a whole-system approach requires political commitment and leadership.

A specific government-led strategy, accompanied by additional funding, is essential to improving the quality and accessibility of mental health services in order to reduce the risk of self-harm and suicide amongst vulnerable prisoners. Going forward, the planning and commissioning of services must be based on sound needs assessment and bench-marking; and must be underpinned by robust accountability arrangements which assure the quality of services delivered.

The prison environment and the support available must be trauma-informed and take into account the needs of people with personality disorder. Segregation in the CSUs should only be used for the shortest time possible and as a last resort.

There is a need for a regional strategy to increase acute mental health and forensic inpatient provision so that the CSU is used only in exceptional circumstances and that those with acute mental ill-health are looked after in the appropriate therapeutic environment. The State has a duty of care to maintain and uphold human rights standards for people in prison.

The RQIA are also mindful of their responsibilities as a member of the National Preventative Mechanism and as a regulator of healthcare to safeguard the rights of service users within places of detention. Despite a clear need, the RQIA does not have its own funded prison inspection programme, however, it is committed to developing a programme of inspection for healthcare in prison, in partnership with CJINI, should funding be secured. Where services fall short of the minimum standards, the RQIA will work with providers to support improvements in the standard of care provided.

The views and experiences of prisoners have provided us with a detailed insight into the challenges faced by those living within Northern Ireland prisons. It is intended that the 16 recommendations outlined in this report, if fully implemented, will facilitate improvement in the services and support available to vulnerable people in custody. It is our sincere hope that any subsequent review team will hear more examples of high-quality service provision and less of a system under considerable strain.

4.2 Summary of Recommendations

The recommendations have been prioritised in relation to the timescales in which they should be implemented, following the publication of the report.

Priority 1 - completed within 6 months of publication of report
Priority 2 - completed within 12 months of publication of report
Priority 3 - completed within 18 months of publication of report

Recommendation 1 **Priority 3**

DoH and DoJ should clearly communicate the vision for improving outcomes for people in prison who are at increased risk of self-harm and suicide. This may be encompassed in a new or updated strategy and should be fully embraced and implemented by all stakeholders: NIPS, SEHSCT, HSCB and PHA.

Recommendation 2 **Priority 2**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together and with NIPS to define and agree the metrics needed to inform an ongoing assessment of need. A robust system for regular data collection and analysis, utilising all relevant sources of information, should be developed and implemented as an interim measure ahead of the introduction of Encompass. In the absence of a reliable electronic system, consideration should be given to harvesting data manually.

Recommendation 3 **Priority 2**

The DoH and HSCB should define the future arrangements for the planning and commissioning of healthcare in prison. These arrangements should be founded on the development of a regional service specification which is based on a robust needs assessment and has the specific requirements and standards to enable the monitoring of services for people who are vulnerable in custody. The Forensic Managed Care Network should develop a Healthcare in Prison sub-group as part of its governance structures in order to provide expert advice to this process.

Recommendation 4 **Priority 1**

Commissioners (currently the HSCB) and providers (SEHSCT) should benchmark Northern Ireland's healthcare in prison services with prison healthcare services in the rest of the United Kingdom. Where deficits are identified through benchmarking, a needs assessment should inform additional funding arrangements.

Recommendation 5 **Priority 2**

The DoH and HSCB/PHA should review their oversight arrangements to ensure that there are clear lines of reporting to support oversight and accountability for both the commissioning and provision of services. This should be facilitated by introduction of a traffic light dashboard to facilitate joint oversight and monitoring of key performance indicators at both commissioner and provider level.

Recommendation 6 **Priority 2**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to develop a service specification for an integrated model of care for mental health provision within the prison service; this should be informed by a robust needs assessment taking into account the needs of vulnerable people in custody. Underpinned by the right to health

Recommendation 7 **Priority 2**

The SEHSCT should update policy and procedure for allocating mental health appointments to align with the Quality Network for Prison Mental Health Services Standards and ensure live monitoring of performance. This process should consider the feasibility of a pathway for self-referral.

Recommendation 8 **Priority 2**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to review the capacity and capability of the mental health service to ensure that waiting times for urgent and routine mental health assessments meet the Quality Network for Prison Mental Health Services Standards. Specifically, this should include a review of the number of staff members and skill mix of the mental health team. Data should be routinely collected on waiting times of all mental health appointments including review appointments.

Recommendation 9 **Priority 1**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to review the current capacity and capability of the addiction service to meet the needs of prisoners who require treatment and support for addiction. Urgent consideration should be given to increasing the number of specialist nurses in order to increase Opiate Substitution Therapy provision and to shorten waiting times.

Recommendation 10 **Priority 2**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to review the current capacity and capability of prison psychology services to effectively deliver a stepped-care model that meet the needs of vulnerable prisoners. Consideration should be given to introduction of a specialist psychology service which offers therapeutic intervention for those with a history of trauma and personality disorder.

Recommendation 11 **Priority 3**

Commissioners (currently the HSCB) and providers (SEHSCT) should work together to plan, commission and implement a therapeutic approach to personality disorder within the prison service. This should include the introduction of a specialist personality disorder service providing evidence-based treatment programmes. Commissioners (currently the HSCB) and providers (SEHSCT) should also work together with NIPS to consider the introduction of Psychologically Informed Planned Environments to help improve the management of people with personality disorder.

Recommendation 12 **Priority 2**

Commissioners (currently the HSCB) and providers (SEHSCT) should ensure that there is a robust screening and data collection system for specific vulnerabilities such as learning disability, autism, ADHD, acquired brain injury and dementia. This data should be used to inform the needs assessment, planning and commissioning of specialist provision to ensure that services meet the needs of these vulnerable groups.

Recommendation 13 **Priority 3**

The joint NIPS and SEHSCT Executive Group should jointly commission an external review of the SPAR Evolution approach. This should assess the effectiveness of input from healthcare in prison and evaluate outcomes for vulnerable people detained in Northern Ireland prisons.

Recommendation 14 **Priority 1**

Commissioners (currently the HSCB) and Providers (SEHSCT) should develop an algorithm to assess the suitability of individuals placed in the CSU as the result of an operational decision taken by NIPS. The algorithm should be applied by a doctor or registered nurse within two hours of placement in the CSU.

Where it is identified that a prisoner is mentally unwell, they should be assessed by the mental health team; appropriate arrangements should be made for the immediate transfer of those who are severely mentally unwell to an acute mental health bed within HSC. For those who are mentally unwell but do not require an acute mental health bed, an appropriate care plan should be formulated and implemented by SEHSCT.

Recommendation 15 **Priority 3**

Commissioners (currently the HSCB) and providers (all HSC Trusts) should collaborate to identify options for expediting the transfer of prisoners who are acutely mentally unwell and require admission to appropriate hospital services. One option should be a single point of entry for access to PICU and acute mental health beds.

Recommendation 16 **Priority 2**

Commissioners currently the (HSCB) and its provider (SEHSCT) should work together with NIPS and all relevant stakeholders, including the probation service, to ensure that there are robust systems in place for referral, liaison and information sharing to facilitate planning for ongoing care in advance of a prisoner's release date.

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The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street,
Belfast
BT1 4LS


Tel: 028 9536 1111


Email: info@rqia.org.uk


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