

**A comparative study of people transferred from prison to hospital under
the Mental Health Act (1983): their pathways and outcomes**

A thesis submitted to the University of Manchester for the degree of Doctor
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List of abbreviations

ACCT	Assessment, Care in Custody and Teamwork
CJS	Criminal Justice System
CMHT	Community Mental Health Team
CTO	Community Treatment Order
DSPD	Dangerous and Severe Personality Disorder
HCR20 v3	Historical, Clinical and risk items 20, version 3
HM	Her Majesty's
HMH	Hospital Managers Hearing
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison
IAFMHS	International Association of Forensic Mental Health Services
MHIT	Mental Health Inreach Team
MHRT	Mental Health Review Tribunal
Moj	Ministry of Justice
MSRAG	Medium Secure Recidivism Guide
NOMS	National Offender Management Service
NIHR	National Institute of Health Research
NHS	National Health Service
NR	Nearest Relative
OHRN	Offender Health Research Network
OPD	Offender Personality Disorder
PCLR: SV	Psychopathy Checklist Revised: screening version
SAPROF	Structured Assessment of Protective Factors
SMI	Severe Mental Illness
SOIOS	Severity of Index Offence Scale
S. MHA	Section of the Mental Health Act
UK	United Kingdom

Abstract

The University of Manchester, Sarah-Jayne Leonard, Doctor of Philosophy (PhD)

Thesis Title: A comparative study of people transferred from prison to hospital under the Mental Health Act (1983): their pathways and outcomes

Background: Little is known about the treatment pathways, transition and discharge of prisoner-patients detained in secure psychiatric services and how best to support and manage remittal back to prison. Remittals to prison now constitute just over 20% of discharges from medium secure services annually. Currently, there is no formal mental health care-pathway or national targeted post-discharge service for prison remittals in the United Kingdom, and there is need for formal guidance on follow-up and after care provision which may be appropriate for this group. This collection of studies aimed to produce essential data which would characterise prison remittals, their pathways through medium secure services and aftercare received post-remittal.

Method: A mixed methodological design was adopted which utilised both quantitative and qualitative data collection methods. A national prospective cohort study with a one year follow-up was conducted to identify factors associated with remittal to prison. All prisoner-patients discharged over a 6 month baseline period were included subject to Section 251 of the NHS Act (2006). Collection of demographic, clinical and criminological characteristics alongside ratings on 4 standardised clinical measures was informed by data extracted from medical case notes and telephone interviews with collateral informants. These data were compared across discharge destination for individuals discharged into the community and those remitted to prison. A concurrent qualitative investigation was conducted to further explore the identified key areas of interest. This involved a focus group interview and series of semi-structured interviews. Prison remittals were followed-up in the prison estate at 12 months post-discharge. Data were extracted from individual patient medical case notes to complete a proforma covering access to prison mental health services, treatment / care received post-remittal and incidents of self-harm / attempted suicide, readmission, and release into the community.

Results: There were 153 eligible prisoner-patients identified across 33 medium secure services. Comparative analysis revealed that prison remittals were 4 times more likely to have a primary diagnosis of personality disorder than community discharges and had a significantly shorter length of stay; patients with a length of stay of 6 months or less were 2 times more likely to be remitted to prison. Prison remittal scored lower for the presence of protective factors with the largest difference observed for presence of motivation for and attitudes towards treatment. Prison remittals were also rated as significantly higher risk of future violence and offending, with the largest difference observed for risk of future serious offending. Interview and focus group data allowed for exploration of how clinicians account for these observed differences and exposed the internal and external processes that guide prisoner-patient pathways through medium secure services. Overall, it appeared that different factors are taken into account depending on a prisoner-patients discharge destination, and many clinicians expressed their concern for the outlook of some patients post remittal. Eighty-nine prison remittals across 56 prisons were followed-up. It was identified that post-remittal aftercare is limited and that many patients present as vulnerable upon discharge, particularly those with a primary diagnosis of personality disorder.

Discussion: Evidence on the needs of prisoners requiring inpatient psychiatric care is improving and, through the data presented in this thesis, arguments for how best to respond to these needs can be further developed. It is hoped that this research will act as a platform for further development and consideration as to how best to manage prisoners who require secondary mental health care and the extent to which the medium secure estate can provide a proactive role in the care and rehabilitation of these individuals.

Declaration

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About the Author

I completed my Bachelor of Science degree in Psychology in 2010 at the University of Manchester and my Master of Research degree in Psychology in 2011 at the same institution. During both of degrees I also simultaneously undertook a variety of voluntary and contractual roles in clinical, health care and research settings. Between 2011 and commencing my doctoral programme in October 2013, I held the position of Independent Mental Health Advocate at the charity Stockport and District Mind. During this role I was predominantly based on a Psychological Intensive Care Unit which had a high proportion of prisoner-patient transfers. It was my role to assist patients to understand the legal provisions to which they were subject under the Mental Health Act 1983 and the rights and safeguards to which they were entitled. This experience encouraged my interest in patients' care pathways between mental health services and the criminal justice system, and my desire to conduct research which reduces the inequalities in access, care and treatment for underserved communities.

Published work during PhD candidacy

Price, O., Burbery, P., **Leonard, S.**, & Doyle, M. (2016). Evaluation of safeguards in forensic mental health: Analysis of a multicomponent intervention intended to reduce levels of conflict and containment in inpatient mental health settings. *Mental Health Practice*, 19(8), 14-21.

Doyle, M., & **Leonard, S.** (2016). The current state of violence risk assessment in England and Wales. In *International Perspectives on Risk Assessment*. Oxford University Press.

Presentations of this thesis during PhD candidacy

Oral presentations

- Leonard, S.,** Forrester., Shaw, J. (2018) Prison remittal from medium secure services Roundtable. Presented at *18th Annual Meeting and Conference of the International Association of Forensic Mental Health Services (IAFMHS)*. Belgium.
- Leonard, S.,** Sanders, C., Webb, R., Doyle, M., Shaw, J. (2018) Transfer and remission of mentally disordered offenders between prison and medium secure psychiatric services – clinician perspectives Presented at *18th Annual Meeting and Conference of the International Association of Forensic Mental Health Services (IAFMHS)*. Belgium.
- Leonard, S.,** Webb, R., Doyle, M. & Shaw, J. (2018). A national prospective cohort study of prisoner-patients discharged from medium secure services: one year follow-up of prison remittals. *Forensic Psychiatry Research Society meeting*. Oxford.
- Leonard, S.,** Webb, R., Doyle, M. & Shaw, J. (2018). Factors associated with prison remittal from medium secure service: a national prospective cohort study. Presented at the Royal College of Psychiatry Forensic Faculty Conference 2018. Nottingham.
- Leonard, S.,** Sanders, C., Webb, R., Doyle, M., Shaw, J. (2017) Transfer and remission of mentally disordered offenders between prison and medium secure psychiatric services – clinician perspectives Presented at *Prison Research Network Annual Conference (PRisonN)*. Leeds.
- Leonard, S.,** Alder, J., & Shaw, J. (2016). *Conducting forensic mental health research without consent: methodological and ethical implications*. Presented at *16th Annual Meeting and Conference of the International Association of Forensic Mental Health Services (IAFMHS)*. New York
- Leonard, S.,** Webb., Doyle, M., & Shaw, J. (2016). *Length of stay in medium secure services: 'prisoner patients' as a distinct population*. Presented at *The 25th BPS Division of Forensic Psychology Annual Conference*. Brighton.
- Leonard, S.,** Doyle, M., Shaw, J. & Singh, J. (2015). *Risk assessment in clinical practice - the UK results of the international risk survey (IRiS)*. Presented at *15th Annual Meeting and Conference of the International Association of Forensic Mental Health Services (IAFMHS)*; Risks, Rights and Responsibilities. Manchester.
- Leonard, S.,** Doyle, M., Webb, R. & Shaw, J. (2015). *A comparative cohort study of people transferred from prison to hospital under the Mental Health Act (1983)*. Presented at *15th Annual Meeting and Conference of the International Association of Forensic Mental Health Services (IAFMHS)*; Risks, Rights and Responsibilities. Manchester.

Poster presentations

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Leonard, S., Webb, R., Doyle, M. & Shaw, J. (2016). *Prison transfers to medium secure services: treatment pathways and length of stay*. Presented at 16th Annual Meeting and Conference of the International Association of Forensic Mental Health Services (IAFMHS). New York.

Leonard, S., Webb, R., Doyle, M. & Shaw, J. (2016). *Factors associated with length of stay in medium secure services for patients admitted from prison..* The Royal College of Psychiatry Forensic Faculty Conference 2016. Glasgow

Leonard, S & Alder, J. (2015). *Conducting forensic mental health research without consent: methodological and ethical implications*. Manchester Methods Fair 2015. Manchester

Leonard, S., Doyle, M., Webb, R. & Shaw, J. (2015). *A prospective cohort study of prisoners transferred to medium secure hospitals: their pathways and outcomes*. Presented at British Medical Association (BMA) Forensic Medicine Conference 2015: Medical Ethics and the Criminal Justice System. British Medical Association. London.

Other output during PhD candidacy

Leonard, S. & Shaw, J. (2018). Submission to 'Independent Review of the Mental Health Act: Interim Report'. On behalf of the Offender Health Research Network (see appendix A)

Thesis format

This thesis describes a mixed method study. It is written in the standard form, presenting sections in chapter format. Chapter 1 provides a literature review charting the relevant background to this research and the outstanding research questions within the field. Chapter 2 is the first of three methodology chapters which details the mixed methodological approach undertaken for this thesis. This chapter also provides an overview of the quantitative methodology adopted for Study 1, alongside associated governance and ethical procedures, and description of study sites. Three separate quantitative analyses are presented in Chapter 3 (pathways through medium secure care), Chapter 4 (factors associated with discharge destination) and Chapter 5 (sub analyses for those with severe mental illness). Chapter 6 is the second methodology chapter which describes the qualitative methodology adopted for Study 2, the findings of which are presented in Chapter 7. The third methodology chapter is presented in Chapter 8 which outlines the feasibility design adopted in Study 3. Descriptive findings for Study 3 are presented in Chapter 9. The final Chapter (10) presents a general discussion which integrates findings from all three studies, and considers these findings in relation to existing literature in the area. Strengths and limitations of the overall body of work are also discussed, alongside the clinical and policy implications of the study findings and potential directions for future research.

Chapter 1 Background literature and policy overview

This chapter provides an overview of the relevant service development and background literature for this study of prisoner-patients detained in medium secure services who are remitted to prison following treatment. In particular, the prevalence of mental disorder within the prison population will be considered, alongside current prison mental health service provision. Patient pathways through secure care will also be described, as will data and policy that is relevant to the remittal of individuals from medium secure services to the prison estate. For the purpose of this review, and throughout this thesis, a 'prisoner-patient' refers to an individual who has been transferred to medium secure services for assessment and/or treatment directly from the prison estate.

Note: Excerpts from this review have been previously published in 'Doyle & Leonard (2016). The current state of violence risk assessment in England and Wales. In J. Singh., S. Bjorkly, & S. Fazel, International Perspectives on Violence Risk Assessment (pp.308-327). Oxford University Press. Oxford. Some text has been updated for this purpose of this review, in line with policy updates and research findings between time of chapter submission and thesis submission.

1.1 Prison population and mental health

The United Kingdom (UK) prison population reached a record high of 88,179 in 2011, and at present it remains just below 83,000 (Ministry of Justice 2018). Within this population, there is a significant over-representation of people from socially excluded sections of society, who are more likely than average to experience adversities such as substance misuse, homelessness and poor educational achievement (Prison Reform Trust, 2013). It is well established that there are markedly higher prevalence rates of the whole spectrum of psychiatric disorders within the prison population, as compared to the general population (e.g. Fazel and Danesh, 2002; Singleton, Meltzer, Gatward, Coid & Deasy, 1998), and that the number of people with mental disorder being placed in prison establishments is steadily increasing (Dressing, Kief and Salize, 2009; Okasha, 2004).

The most recent large-scale study of psychiatric morbidity within prisons in England and Wales was conducted in 1997-1998 (Singleton *et al.*, 1998). This report indicated that 90% of the prison population had a mental disorder, whilst 70% had two or more diagnoses. Internationally prisoners are 2 to 4 times more likely to suffer from major depression or a psychotic illness than the general population, and 10 times more likely to be diagnosed with antisocial personality disorder (Fazel & Danesh, 2002); with 65% of male and 52% of female prisoners in the England and Wales classed as having a personality disorder (Ministry of Justice, 2010a). Such a substantial

prevalence of psychiatric disorder is known to be a risk factor for a number of adverse outcomes (Fazel & Seewald, 2012) such as suicide during imprisonment (Fazel et al. 2008), premature death once released into the community (Pratt et al., 2006) and increased rates of reoffending (Fazel & Yu, 2011). As such, ensuring adequate and proportionate treatment for prisoners with mental health problems has potential to elicit wider benefits, particularly in relation to the protection of the public. The mental health of offenders is therefore a critical priority area for policy changes for England and Wales (Department of Health, 2011).

Historically, the detection of offenders with mental health problems when entering the criminal justice system has been criticised as being ineffective (Steel et al. 2007), with many mental health problems going both undetected and untreated during imprisonment (Birmingham, 2003; Melzer et al. 2002). This trend was considered to be partially due to the typically chaotic nature of reception screening process upon arrival to prison (Edger & Rickford, 2009; Dressing, Kief, & Salize, 2009). Studies have reported that a degree of confusion persists among healthcare professionals over the purpose of the initial reception health screen, and there are concerns that the process relies overly on historical factors to prompt referral to prison-based mental health services, as opposed to the individual's current psychological adjustment (Offender Health Research Network (OHRN), 2008).

The government has committed to introducing a national Liaison and Diversion Service (Department of Health, 2014b). The aim of this service is to ensure that the mental health needs of offenders will be identified sooner and that appropriate support is allocated. These services have been introduced to police interview and custody suites and will aim to link into other parts of the Criminal Justice System, including prisons and probation services. It is anticipated that the availability of more Liaison and Diversion Services in the future should increase the volume of information available in relation to new arrivals at prison reception. However, it is clear that a lack of parity continues to exist in services for offenders with mental health problems compared with the general mental health population. A recent independent progress review has highlighted that there is little evidence to suggest that any changes to mental health screening on prison reception have been established and that the same processes are essentially taking place (Durcan et al. 2014). This failure to establish effective screening procedures continues to generate unreliable underestimates of the true prevalence of mental disorder in prisons. With the most commonly used estimate remaining that of Singleton et al. (1998), which is now 20 years old, the task of designing services and monitoring outcomes for prisoners who require mental health care is severely hampered (National Audit Service, 2017).

As such, access to and receipt of appropriate mental health treatment whilst detained within the Criminal Justice System (CJS) is something that is not currently guaranteed, and many serving prisoners experience significant problems in gaining access to adequate mental health and social care services (Department of Health 2009; Senior et al. 2012). The Department of Health has highlighted this as an area of concern and has pledged to ensure that people in contact with the CJS will have improved access to mental health care (Department of Health, 2011). However it is clear that it is not just mental health services in need of reform in order to achieve this, but also quality arrangements within the prison estate. Rates of self-harm and self-inflicted death have risen significantly over the last 5 years (specifically by 73% between 2012 and 2016, National Audit Service, 2017), suggesting that standards of care and well-being in the prison estate have declined. This is perhaps not surprising given the long-standing understaffing issues within the prison estate and the more recent reduction in staff numbers.

The funding for the National Offender Management service (NOMS)¹ fell by 13% between 2009-10 and 2016-17, causing a significant reduction in staff number in public prisons by 30% over the same period (National Audit Service, 2017). This reduction may have exacerbated the mental health issues faced by prisoners and contributed to the well documented effects the prison environment can have on an individual's mental state (for example; OHRN, 2010). This issue has recently been addressed by the House of Commons Committee of Public Accounts (HCCPA). This report highlights that current understaffing is causing restriction to the prison regime (such as prisoners spending prolonged periods of the day locked in their cells), thereby reducing the likelihood of both staff identifying prisoners requiring mental health referral and self-referral from prisoners (HCCPA, 2017). The Ministry of Justice has acknowledged the detrimental effect that this could have on prisoner mental health and has committed to improvements that include recruitment of over 2000 new officers and the provision of enhanced mental health training for all new staff with emphasis on suicide awareness. The HCCPA has mandated that the Ministry of Justice provide details of the number of additional staff who have been recruited, along with any existing staff who have resigned, and a report of officers who have taken part in mental health training by the end of July 2018 (HCCPA, 2017).

¹ Until 31 March 2017, NOMS was responsible for prisons. On 1 April 2017 NOMS was replaced by a new executive agency called Her Majesty's Prison and Probation Service (HMPPS). HMPPS retains NOMS' responsibility for the operational management of prisons, but the Ministry of Justice will take on NOMS' responsibility for prison policy and commissioning. This thesis refers to NOMS, as NOMS was the responsible body at the time of fieldwork and writing, but makes recommendations to HMPPS.

1.2 Prison mental health services

The introduction of multi-disciplinary prison mental health services in 2002 (known as "inreach" services) was an important step forward in treatment provision. Prior to 2002, prison mental health care had been provided by the Prison Health Service (run by the Home Office, now the Ministry of Justice) and had been deemed inadequate, and was criticised for being both ineffective (Department of Health & HM Prison Service, 2001) and not being tailored to clinical need (Birmingham, 2003). With the call for a higher standard of healthcare within prisons gaining much attention, in 1996 it was proposed that the National Health Service (NHS) should assume responsibility for the delivery of health care within prisons (Her Majesty's Inspectorate of Prisons, 1996), making prisons one of the few settings in which the NHS would operate outside of its typical domain (Centre for Mental Health, 2011). The National Service Framework (1999) was a starting point for the development and modernisation of mental health service provision within prisons, followed by the strategy "*Changing the Outlook*" (Department of Health & HM Prison Service, 2001), which outlined the necessary steps to be taken over the following 3-5 years. Initially, the Department of Health and the Home Office shared responsibility for prison healthcare, but this responsibility was transferred solely to the Department of Health from April 2006.

While not having a blueprint or particular model to follow, the overall aim of prison inreach services was to provide mental healthcare equivalent to that which prisoners would receive were they to have remained living in the community. As such, they were designed to replicate the Community Mental Health Team (CMHT) model, yet with prioritisation for those prisoners with severe and enduring mental health problems (Steel *et al.*, 2007). Whilst a wealth of positive change has been noted following the introduction of inreach teams (Appleby *et al.* 2010; Durcan, 2008), recent reviews still highlight room for further development (OHRN, 2009) and the need for these services to adopt a more psychosocially-orientated model of care, thereby recognising the complex and multiple needs of those detained in the CJS. Services are now also encouraged to work towards more recovery-oriented approaches, as is the national guidance and policy for the community equivalent services (Durcan *et al.* 2014).

However, the reality of providing equivalent care faces a number of challenges before these approaches can be implemented. Prison mental health care is grossly underfunded and that spending per prisoner varies between regions (Sainsbury Centre, 2008). Studies have shown that inreach teams have unsophisticated care models (OHRN, 2009; Steel *et al.*, 2007), and are poorly

resourced in relation to their workload (Brooker & Gojkovic, 2009), and that some team members lack the relevant training required to cater for prisoner mental health needs (Pearce, 2004; Read & Lyne, 2000). Likewise, the prison environment and ethos can also act as a barrier to delivering effective mental healthcare, given that the ideologies of the NHS and the prison system are significantly different, and the operational issues that currently exist, including poor information sharing between different agencies, and the deep-rooted customs and practices inherent in the prison system (Bradley, 2009). As such, it has been suggested that the partnership agreement between NOMS and NHS England does not take into account these complexities of the prison environment, and it is not clear what 'equivalent services' look like in practice or in what ways this phenomenon can be measured (National Audit Service, 2017).

Early evaluations of prison inreach services focused on operational considerations, such as; variations in service models, relationships between CJS professionals and inreach services, and barriers to implementing the Care Programme Approach (CPA, Department of Health, 1990) in custody (Telfer, 2000). More recent studies, however, have begun to focus on clinical considerations. The first large-scale study of inreach services' capacity to successfully identify and manage prisoners with diagnoses of SMI was conducted across 6 prisons (Senior *et al.*, 2012). This study observed that, of 551 prisoners with a diagnosis of SMI, just one-quarter were successfully identified by inreach teams, and that just 13% of those individuals were accepted onto an inreach caseload within a month of reception into custody (Senior *et al.*, 2012). As a result, it has been posited that, nationally, only a small proportion of prisoner mental health needs are likely being met (Forrester *et al.* 2013). Additionally, as policy has since broadened to include all prisoners with a mental disorder, it has also been suggested that inreach teams are even less likely to sufficiently target and treat those prisoners with more severe mental health needs that the government had originally deemed as being high priority. Instead services are described as resembling a primary mental health care provision, and a re-focus on SMI is considered necessary (Forrester *et al.*, 2013).

Inreach services are also uniquely positioned to contribute to preparing prisoners with SMI for release back into the community following sentence completion. The transition from prison to the community is a vulnerable period associated with increased risk of relapse, reoffending, suicide and other causes of death, particularly for those with a diagnosis of SMI (Farrell & Marsden, 2008). Therefore the ability of prison inreach services to ensure continuity of care between custodial settings and the community is a key clinical concern. Preparation for release from custody represents a challenge for prison mental health services (Dyer and Biddle 2013), and widespread disengagement from mental health services at the point of release from custody has

been identified (e.g. Lennox et al. 2012). Failure to connect with appropriate mental health services post release has been linked to high mortality risk among recently released prisoners (Binswanger *et al.*, 2007). Therefore it is important that preparation for release includes referral and engagement with CMHT's and post-release support. NHS England recognises that there is currently clear disconnect between information available to community healthcare providers in relation to the care patients have received during their time in prisons which may restrict access to community services for some patients upon their release. As such, this has been included as a key objective in the most recent prison mental health service specification guidance (Objective 3, NHS England, 2018). However, at present neither NOMS (now HMPPS) nor NHS England monitor whether continuity of care is provided post-release from inreach services (National Audit Service, 2017); therefore it is unclear how this will be reviewed.

1.3 Prisoners requiring mental health inpatient treatment

Prisoners who require mental health treatment and monitoring outside of that which the inreach team can provide may be admitted to a prison-based hospital wing and can be returned to ordinary prison location following treatment. However, just a fraction of prisons have this facility available, and a recent review of prison-based inpatient services observed that, of the 11 services included, just one had dedicated mental health beds which were distinct from physical healthcare beds (OHRN, 2015). In all other services patients requiring mental or physical health treatment were treated in the same healthcare facility which were operated as small residential style units, whilst they remained subject to prison rules and regimes. Such an approach to a wide range of clinical need was deemed to restrict the quality of care that could be provided and prioritisation of some prisoners' needs over those of others was deemed inevitable. As such, for patients with SMI, there is little opportunity within these facilities to partake in wellbeing activities or tailoring of them to individual need.

Prisoners with SMI should have the same access to inpatient beds and standards of care as persons living in the community. Therefore government policy now outlines that prisoners who require inpatient mental health assessment/treatment, and who meet the criteria for treatment in hospital under the Mental Health Act 1983 (MHA), should be diverted away from the CJS and towards secure mental health services (Department of Health & National Institute of Mental Health in England, 2005; Department of Health, 2009). This pathway is for both prisoners deemed to require compulsory treatment, along with patients for whom appropriate care cannot be given to in a prison environment. Secure psychiatric services now operate on three levels of security: high, medium and low, and some secure care services also have a specialist community team,

providing community based care for former secure care service users or liaison for mainstream community mental health teams working with them.

1.4 Secure mental health services

In England and Wales, up until the 1970s, the only designated forensic secure facilities for treatment outside of ordinary psychiatric hospitals for prisoners with mental health problems were in three high secure “special hospitals”. With their origins closer to prison services than mental health services, these hospitals were mainly custodial. Following a backlash of complaints, the poor conditions within these facilities became high on the political agenda, whilst at the same time there were a growing number of prisoners with serious mental disorder who were unable to access psychiatric hospital treatment. With a view to bridging the gap between high secure psychiatric hospitals and community mental health services, both the *Glancy* and *Butler Reports* (Department of Health and Social Security, 1974; Home Office & Department of Health and Social Services, 1975) highlighted the need for step-down services from high-secure hospitals. What followed was the establishment of regional secure units, which have expanded substantially within the last twenty years. Now known as medium secure services, this provision is expected to provide the link between higher and lower levels of secure inpatient care.

There remain three NHS high secure hospitals in England; Ashworth, Broadmoor and Rampton hospitals and one in Scotland, Carstairs. High secure beds are designed for patients detained under the MHA who ‘pose a grave and immediate danger to the public’. Prisons in England and Wales are categorised as A, B, C, or D settings, with Category A prisons housing inmates who pose the highest level of risk to the public. High secure services are provided in hospitals that have physical security designations no less than a Category B prison, but which (through operational and relational security measures) can provide a Category A environment in which to treat individuals who would, in a prison setting, be in such an environment. Medium secure beds are provided by both the NHS and the independent sector; the latter providing around 35% of medium secure capacity (Centre for Mental Health, 2011). They are designed for patients detained under the MHA who ‘pose a serious danger to the public’. Patients in medium secure services move from admission, through rehabilitation, and towards leave and discharge or transfer to lower secure services. These are tertiary services that tend to cover one or more counties and have between 30 and 120 beds, however at present there is no comprehensive database of medium secure services. Low secure services are more difficult to define as this term is used to include an array of different service models, including psychiatric intensive care units and ‘locked rehabilitation’ facilities. There is also no reliable register of low secure services yet it is estimated that there are 150 low secure units in England and Wales, providing step-down from

higher tiers of secure care, and people will frequently move down through to low security after a period of time spent in high or medium secure care. These services are commonly provided alongside general acute adult psychiatry services, although some low secure services are integrated with medium security.

Currently, there are approximately 6000 individuals in secure mental health services commissioned in England, of which 680 are in high security, 2800 are in medium security, and 2500 are in low security (Joint Commissioning Panel for Mental Health, 2013). At any given time it is estimated that forensic secure services work with approximately 8,000 people, at a cost of £1.2 billion for the NHS in England in 2009/10 (Mental Health Strategies, 2010). The number of people detained in forensic services has increased year on year for more than a decade, rising from 2,650 in 1997, to nearly 4,000 by July 2007. In addition, the number of people newly transferred into forensic services is increasing every year, despite delays in transfers from prisons to hospitals.

1.5 Diversion and legal frameworks

During the 1970s early recommendations were given that offenders with SMI should be dealt with via the receipt of psychiatric treatment as opposed to the standard prosecution process (Butler report; Home Office and DHSS, 1975). This view was reiterated in a well-cited Home Office circular some 15 years later, alongside detailed advice for all agencies likely to be involved with an offender (Home Office, 1990). At present, these diversionary practices involve multiple agencies exercising discretion at all stages of the criminal justice process, principally via; informal diversion by the police and formal implementation of section 136 (under the Mental Health Act); referral for psychiatric examination or treatment during a court hearing; disposal to mental health services at court; and, disposal at a later stage – such as transfer of sentenced prisoners to secure psychiatric services. It is via court or transfer disposal that prisoners with SMI enter secure services.

In England and Wales, the MHA sections are used to detain individuals against their will if they are: i) experiencing a mental disorder of a nature or degree that warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; or ii) they ought to be so detained in the interests of their own health or safety or with a view to the protection of other persons. Although MHA civil sections can be used to detain forensic patients, Part III of the MHA deals specifically with *Patients Concerned in Criminal Proceedings or Under Sentence*. The main sections of Part III of the Act, and how these concern prisoners, are summarised below and in Table 1.1.

Table 1.1 Mental Health Act 1983, Part III:
Sections for patients concerned in criminal proceedings or under sentence

Section	Description
Remand to Hospital	
s. 35	Remand to hospital for report on accused person's mental condition
s. 36	Remand of accused person to hospital for treatment
Hospital and Guardianship Orders	
s. 37	Powers of the courts to order hospital admission or guardianship
s. 38	Interim hospital order
Restriction Orders	
s. 41	Power of higher courts to restrict discharge from hospital (added to section 37 hospital order)
Hospital and Limitation Directions	
s. 45A	Power of higher courts to direct hospital admission ('hybrid' order)
Transfer to Hospital of Prisoners	
s. 47	Removal to hospital of persons serving sentences of imprisonment
s. 48	Removal to hospital of other prisoners
s. 49	Restriction on discharge of prisoners removed to hospital (added to sections 47 or 48)

1.5.1 *Transfers of prisoners found to be mentally disordered*

Prisoners cannot be afforded the application for compulsory treatment under current mental health legislation (with the exception of urgent treatment without consent under common law/the Mental Capacity Act 2005) as prisons are not recognised as being hospitals under the MHA. Therefore, in these cases, the Home Secretary can order the transfer of sentenced under Section 47 (s. 47) and remand prisoners (under Section 48 (s.48)) from prison to hospital if they are found to be experiencing a mental disorder as defined in the Act². This may or may not be accompanied by a Section 49 'restriction direction' (s. 49). This is the power of the Secretary of State to place restrictions on the discharge of prisoners removed to hospital. A direction under this section has the same effect as a restriction order made under s.41 (See 1.5.2, b).

Annually, approximately 950-1000 transfers to hospital from prison take place (Royal College of Psychiatrists, 2010) according to the guidance of the "*Good Practice Procedure Guide*" (Department of Health, 2007). However in recent years, transfers have increased in volume by 21% (2011-2014, Yeung, 2016), with the largest increase observed amongst sentenced prisoners transferred under section 47/49 for treatment. There is currently a lack of adequate information about the effectiveness of diversion for these individuals, particularly as regards long-term outcomes for those who are diverted.

1.5.2 *Court stage diversion*

The statutory requirement for the provision of mental condition reports is laid down in the Criminal Justice Act 1991, Section 4(3). Before passing a custodial sentence other than one fixed by law (for example murder) on an offender who is, or appears to be mentally disordered, a court should consider:

- a) Any information before it which relates to his mental condition [whether given in a medical report, or given in a pre-sentence report, or otherwise]; and
- b) The likely effect of such a sentence on that condition and on any treatment that may be available for it.

² The individual has a disorder of the nature or degree which warrants detention, they appear to be a risk to themselves and others, and appropriate treatment is readily available in hospital.

Powers of courts in relations to prisoners with mental disorder

Crown and magistrates' courts have the powers to direct hospital admission of prisoners with mental disorder. This includes the powers to remand a person to hospital, to order hospital admission during sentencing procedures, and to impose a hospital treatment order in place of/alongside a custodial sentence. These powers and the corresponding sections of the MHA are detailed below.

a) Courts have the powers to remand an accused person to hospital as opposed to prison whilst awaiting trial under:

- Section 35 (s. 35) for report on the accused's mental condition
- Section 36 (s. 36) for treatment

b) Courts have the powers to order hospital admission under:

- Section 37 (s.37 Hospital Order) in place of receiving a custodial sentence. An order for s.37 may or may not be accompanied by a Section 41 restriction order (s. 41 Restriction Order). This is the power of higher courts to restrict discharge from hospital. This is dependent upon the degree to which it appears to the court necessary to set special restrictions for the protection of the public from serious harm, based on the nature of the offence, the antecedents of the offender, and their risks of committing further offences. Therefore the powers for a Responsible Clinician to grant leave, organise transfer or to discharge restricted patients into the community are exercisable only with the consent of the Secretary of State.
- Section 38 (s. 38 Interim Hospital Order) for offenders who have been convicted of an offence, but medical evidence is required in relation to the nature of the offender's mental disorder to inform sentencing.
- Section 45A (s. 45A 'Hybrid' Order) for offenders who have received a custodial sentence, but require a period of psychiatric treatment in hospital prior to removal for detention in prison.

1.6 Medium secure services

Medium secure services are designed for patients detained under the MHA who “pose a serious danger to the public” (Centre for Mental Health, 2011) and focus on the assessment and treatment of mental health problems; managing the risk that patients pose to others; and reducing further offending (NHS Commissioning Board, 2013). These services are required to adhere to a range of security measures to ensure the safety of the patient, the staff and the general public, whilst also delivering mental health care and treatment. This is achieved through the provision of evidence-based interventions provided by expert practitioners, which often includes services such as specialist offence-related treatment programmes and aggression management programmes etc. (NHS Commissioning Board, 2013). The majority of medium secure detainees are young adult males, with only one eighth of the population being women (twice the proportion of the female prison population (Rutherford & Duggan, 2007). Patients typically have complex and chronic mental disorders, with co-morbid difficulties of substance misuse and/or personality disorder that are often linked to offending or serious harmful behaviour (NHS England, 2018). The types of offence committed by patients are mixed, with almost half being of a violent or a sexual nature.

Diversion of prisoners via court procedures or transfer from prison is just one function of medium secure services. Referrals for admission also originate from a number of locations, including; the secure hospital estate (high, low and other medium secure services), general psychiatric hospitals, and the community (including police stations and court engagement and liaison schemes, and recall of patients subject to s. 37/41 or a Community Treatment Order, CTO). Access to secure care is determined by an assessment conducted by the ‘Access Assessment Service’ (NHS England, 2018). Eligible patients are those with a mental disorder of the nature or degree to warrant detention under the MHA who present as a serious risk of harm to others and require specialist risk management procedures. If a prison transfer, the patient should be charged with or convicted of an offence outlined in Schedule 15 of the Criminal Justice Act 2003 or other serious offence (such as arson). Non-forensic patients may be admitted as long as there is evidence of serious risk to others in the context of mental disorder and they cannot be safely managed in a less or non-secure environment (NHS England, 2018).

Whilst these eligibility criteria exist it is difficult to characterise the medium security population. Variations in local population characteristics and individual MSU provision impact on who is accepted for admission and therefore generalisation from studies of single medium secure services are problematic (Coid et al. 2001). Individual unit criteria appear to vary from unit to unit and admission decisions are often judged on a case by case basis and are dependent on factors

such as the nature of an individual's disorder, the notoriety of their offence and lack of alternative arrangements (Coid & Kahtan, 2000). Differences between those admitted to and detained in NHS and private sector services have also been highlighted. For example, whilst 86% of NHS patients are diagnosed with a mental illness, 7% with a personality disorder, and 2% with a learning difficulty (Ministry of Justice, 2009), the trends in the independent sector are strikingly different; with 17% diagnosed with a learning disability, 31% with a personality disorder and 47% with a mental health diagnosis (Renshaw, 2010).

Few studies have captured data on the characteristics of those referrals that are accepted alongside those who are rejected. The first national study of this type was published in 2004 and focused on the observation of factors associated with being assessed as requiring a medium security admission and factors associated with being accepted for admission (Melzer et al. 2004). The review captured data from 418 assessments for admission across 34 medium secure services, and highlighted the ways in which medium secure units prioritised admissions. Thirty-nine percent of assessments were received from prison, 28% of which were accepted. Referrals from prison were two times more likely to be accepted than referrals from other NHS facilities. The observed characteristics of persons assessed as requiring a medium security placement, but not necessarily being admitted, included: diagnosis of schizophrenia, non-compliance with treatment prior to admission, a history of sexually inappropriate behaviour, having inflicted serious self-harm, having committed a 'grave' index offence, and having received a recent prison sentence or many previous prison sentences. However, almost a fifth of those considered to require a medium security placement were not admitted. Of those who were admitted, some were considered to require low or no security, and were therefore inappropriately placed in a disproportionate level of security. It was concluded that: (i) on the whole there are more individuals requiring admission to medium security than can be accommodated; (ii) that the insufficient range of secure service provision available subsequently leads to inappropriate use medium security beds, where those who are assessed as needing lower levels of security are admitted over those who are considered to require long-term medium security. Since the publication of this paper there has been an increase in low secure provision.

A concurrent qualitative study by the same research team investigated admission decision-making further and uncovered a range of contextual factors that guide and influence who is admitted to medium secure services (Grounds et al. 2004). With a view to ensuring maintenance of unit throughput, there was a collective view on which referrals were considered 'inappropriate' for admission. Clinicians described how 'easy cases' for prioritisation were those individuals considered treatable and whose SMI and offending were related, whereas 'difficult cases' were

referrals who were considered as unlikely to respond to treatment and had a personality disorder diagnosis. These individuals were anticipated to impact on the care of other patients and to contribute to staff burn-out, and therefore clinicians also described how they are required to consider the conditions in the unit and the professional culture at the time when considering a referral for admission. Likewise gate-keeping and waiting list pressures were described as guiding and restricting admission decisions, as were relationships with external colleagues and the policy context at the time of the study. Nevertheless, policy has broadened and adapted in the 14 years since the publication of this study, and factors relevant to clinicians in 2004 may not be particularly relevant currently.

Alongside a non-unified criterion for admission to medium secure services, individual units evolved regionally, resulting in there being no national model of medium secure mental health care (Centre for Mental Health, 2011). Nationally agreed standards for medium secure services, legislation and guidance frameworks do exist, which encompass guidance on areas such as security, dignity and core interventions (see Box 1). However, there is wide variation in resources to manage medium secure services and many different styles of service delivery exist (Shaw et al. 2013; Coid et al., 2001). For example, the distribution of both NHS and independent sector capacity is uneven throughout the country and the inclusion of a long-term bed provision is rare (Laing & Buisson, 2006). Some medium secure services also include a low secure step-down service and on-site independent living suites (Shaw, *et al.*, 2013).

Box 1. Medium secure services must deliver services within the guidance contained in:

- Royal College of Psychiatrists Quality Network Standards for Forensic Care CCQI
- Environmental Design Guide MEDIUM Secure Services (Department of Health, 2011)
- Mental Health Act 1983 and Code of Practice 2015
- Mental Capacity Act 2005 and Code of Practice 2007 and supplement to the Code on Deprivation of Liberty Safeguards 2007.
- Criminal Justice Act 2003
- The Good Practice Guide. The Transfer and Remission of Adult Prisoners under s47 and s48 of the Mental Health Act (Department of Health, 2011)

Disparity across resources and services available regionally and the range of circumstances under which patient can be admitted suggest that “medium security” does not necessarily reflect the care received by patients, but only the circumstances under which patients are treated (Maden *et al.*, 1999). This is further evidenced by the varying characteristics of persons detained, which raises uncertainty about whether these environments are always the most appropriate and the least restrictive option available in accordance with the MHA. For example, transfers from prisons can be for both high risk individuals with severe index offences who require the relational security of the unit as well as for low risk individuals with non-violent index offences for whom treatment is unavailable in the prison environment. Likewise long-stay patients subject to hospital treatment orders can share wards with those whose assessment admissions can last only weeks or even days before transfer back to courts (Maden, *et al.*, 1999).

1.7 Pathways through medium secure care

Pathways through medium secure services are more notional than actual, and movement along a care pathway is often slow and difficult to achieve (Centre for Mental Health, 2011). A patient’s progress is dependent upon a reduction in risk and a number of clinical outcomes outlined in their individual care plan (for example; clinical responsiveness, ceasing problem behaviour, gaining insight, etc.) and a discharge to conditions of lower security is considered a successful treatment milestone within a patient’s pathway (NHS England, 2018). This care plan should be formed collaboratively with the patient and will summarise the patient’s movements into, through and out of medium secure care (NHS Commissioning Board, 2013). The pathway through and out of medium secure services must be identified early in a patients’ admission, although transition and discharge should be reconsidered at all stages of the care pathway and may be subject to change depending on changing needs or circumstances (NHS England, 2018). Each patient will work through their care pathway at an individual pace with the aim of discharge to an appropriate destination. Ideally this destination should be decided prior to admission if possible (NHS Commissioning Board, 2013). The average length of stay for patients should be 18-24 months (Bradley, 2009), although there is an increasing trend for patients to now stay for longer than 2 years (Shah, Waldron, Boast, Coid & Ullrich, 2011). In reality, the majority of patients are detained in medium secure units for 5 years or less, with more than a quarter being detained for at least 10 years (Rutherford & Duggan, 2007).

Discharge from medium secure services and placement within different levels of the secure pathway is determined by the level of risk of harm to others presented by the patient concerned.

Progress and transition along the pathway must be determined by the reduction in assessed risk of harm to others, and a reduction in the need for care and supervision (NHS England, 2018). The indicators and criteria used for assessing progress and transition along the pathway are listed in Box 2.

Box 2.

Factors considered when assessing patient progress:

- Nature and degree of mental disorder and its relationship to risk
- Level of risk to others
- Level of care and supervision required
- Need for input from specialist services or staff
- Need for offence/risk behaviour related therapy
- Level of engagement with treatment/care plan
- Level of engagement in structured and meaningful activities
- Level of misuse of drug or alcohol

(NHS England, 2018).

The final discharge decision will be formally agreed at the patient's Care Programme Approach (CPA) review (except for when a patient is discharged via the powers of a Mental Health Review Tribunal against the responsible clinician's wishes), and a Section 117 meeting (s. 117, MHA) will be held prior to discharge (for those patients detained under Sections 3, 37, 45A, 47/49 and 48/49 of the Mental Health Act 1983). Before transitioning the patient, responsible clinicians should ensure that: a) the patient's health and social care needs have been assessed, b) the care plan incorporates the patient's individual needs, c) the risk of the patient to others has been assessed, and d) if the patient is an offender, the victim and their family have been considered (Richards & Mughal, 2010). Section 117 of the MHA provides the legal right to aftercare services, a right that is ongoing and remains in place regardless of circumstances, and should only stop if health and social services jointly agree (Richards & Mughal, 2010). The duty to provide aftercare begins when the patient leaves the hospital, and aftercare bodies should make preparations for the patients' care in advance of them leaving hospital.

Patients are usually discharged from medium secure services to one of 3 settings (see Figure 1.1). For many prisoner-patients, the aim of an admission to medium secure services is rehabilitation and reintegration into society, and therefore for these patients discharge may be directly into the community. Prior to discharge, some of these patients may also enter a low security pathway to further aid their transition. Whether this level of security is required is dependent on the patient’s potential risk and progress through their care plan (Centre for Mental Health, 2011), yet whether these step-down services are available is dependent on historical/geographical variation as to how services were configured locally. Transfers and discharges are managed by the unit’s clinical team and discharge care plans should focus on transition and engagement with the next service along the pathway. Where discharge is to community services, the appointed community care coordinator is involved in the development of transition back into the community based on risk assessment and proactive risk management strategies to ensure recovery and rehabilitation (NHS England, 2018). Transition back into the community is recognised as being a particularly difficult time, and therefore a recent development in provision has seen the introduction of Forensic Outreach and Liaison Services (FOLS). These services manage and facilitate the transition of high risk patients from medium secure services into the community (NHS England, 2018). Where discharge is to a prison environment, involvement of the prison mental health inreach team should be ensured and effective handover should include an end of treatment report and an updated multi-disciplinary formulation (NHS England, 2018), alongside liaison with criminal justice agencies in line with the requirements of the national guidance on remission (Department of Health, 2011).

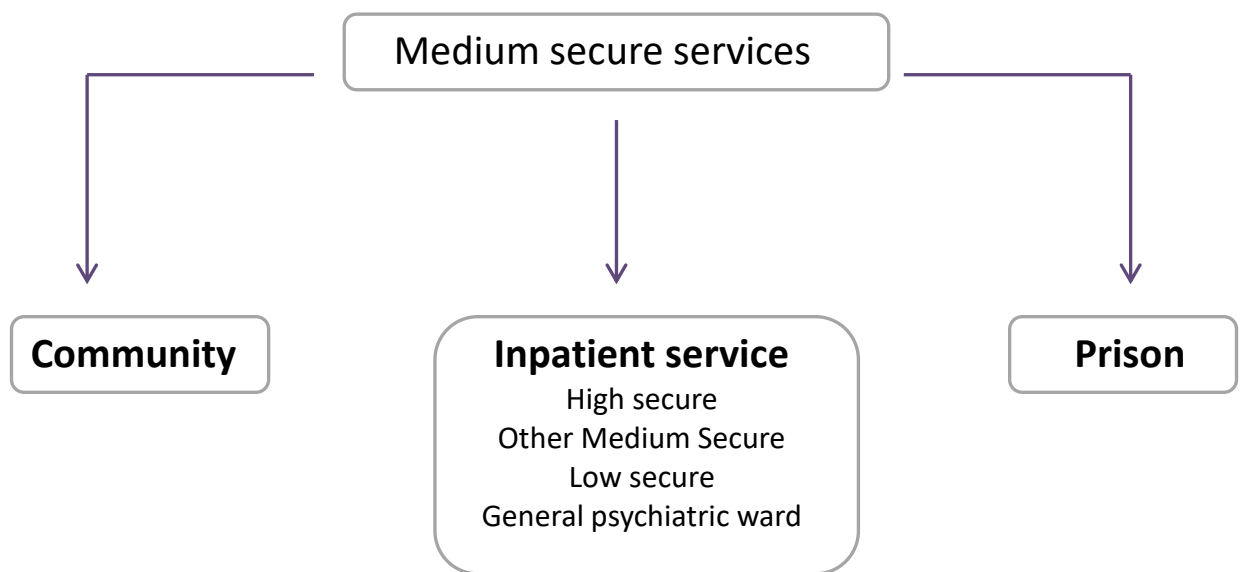


Figure 1.1: Medium secure discharge pathways

Whilst responsible clinicians are required to assess the suitability and timing of a patient's discharge, as described above, not all discharges from medium secure services are directed by or in agreement with the patient's clinical team. For pre-sentence/remand prisoner-patients who are admitted to medium secure services for assessment and/or treatment, their discharge can be directed by the courts as part of the sentencing procedure (relevant to those detained under s. 35, s.35, s.38 and s.48/49). These prisoner-patients can receive custodial sentences and can be remitted to prison from court, regardless of their clinical needs. Re-admission to medium secure services would require a referral from a prison-based clinician for transfer under s.47/49. Alternatively these patients may receive community sentences or be acquitted and therefore released into the community from court on the day of trial. Some patients may also receive Hospital Treatment Orders in lieu of/alongside their custodial sentences (as described in Section 1.5.2), which can restrict a patient's discharge care pathway post-treatment. For example, patients subject to s.37 may only be discharged via a community care pathway and patients subject to s. 45A may only be remitted to prison post-treatment.

Patients transferred during a custodial sentence (s.47) may also have their pathway restricted due to the circumstances of their sentence/tariff. Where it is not clinically justified for a sentenced prisoner with a particularly long sentence tariff to remain in medium secure services, patients are remitted to prison post-treatment (Doyle, et al., 2014); for example, a prisoner subject to a life sentence or an Indeterminate sentence for Public Protection (IPP). However sentenced prisoners who reach their earliest release date during their admission can apply to the Parole Board for release into the community if they have completed their treatment and are no longer considered a risk (Sedwic et al. 2016). In these cases successful risk reduction may not always guarantee discharge into the community. Key stakeholders, including the Ministry of Justice and medium secure service commissioners, are less likely to be supportive of an offender's discharge via a community care pathway if their index offence is particularly notorious. For this very small subset of patients, remittal to prison to work towards parole is usually applied (Centre for Mental Health, 2011). Patients who complete their custodial sentence during their medium security admission are still considered to require treatment remain detained in hospital under a National Hospital Order (s.37N). These patients may only be discharged via a community care pathway following treatment.

The extent to which these factors shape patient discharge and pathways through medium secure services nationally has not been a focus of previous research, and neither the Ministry of Justice nor NHS England routinely publish figures on legal pathway changes for patients detained in secure services. Equally, previous empirical studies have paid little attention to patients'

circumstances leading to discharge and their legal status at time of discharge. Studies of factors associated with length of admission have identified that patients subject to s. 37/41 have a significantly longer length of stay in medium secure services compared to prison transfers and civil patients (Brown & Fahy, 2009; Kennedy, Wilson & Cope, 1995; Shah *et al.*, 2012).

1.8 Medium secure care outcomes

Medium secure services are required to be outcome-focussed, although there is currently very little data from which the efficacy of outcomes of medium secure services can be judged (Davies, Clarke, Hollin & Duggan, 2007). The latest indicators of quality outcome are outlined in the medium secure service specification and include assessment of patient experience, structure and process of the service and clinical outcomes in accordance with the five domains of the National Outcomes Framework 2013/14 (NHS Confederation 2012). Indicators of clinical outcomes include: number of episodes of physical restraint; number of self-harm incidents; average length of time to first un/escorted leave; average length of stay; improved Health of the Nation Outcome Scales (HoNOS) scores on discharge, percentage of patients accepted onto a CMHT caseload, etc. (NHS England, 2018). Researchers cannot currently gain access to these data nationally.

Medium secure services are also required to participate in research/development activity which promotes the continual improvement of the service and outcomes for patients (NHS England, 2018). The body of research concerning medium secure services focuses predominantly on the capacity of services to manage the risk that patients pose to themselves and others and to reduce further offending, through the measurement of patient outcome post-discharge. The most commonly used research design in this field is a cohort study, whereby a sample of medium security patients is followed-up in the community post-discharge, either retrospectively or prospectively, over an elected period of time to determine outcome. Outcome data are obtained from a number of sources including; data from multidisciplinary notes, official databases (such as the Home Office Offenders Index, the Police National Computer and the NHS Central Register), telephone interviews/questionnaires, information from the multidisciplinary team, interviews with patients, etc. Collectively, studies highlight that patients discharged from secure services have lower offending rates than many comparative groups (e.g. released prisoners: Ministry of Justice, 2013; Home Office, 2003), but that services need to consider improving interventions aimed at reducing premature mortality, particularly suicide, among discharged patients; see Fazel, et al. (2016) for a systematic review and meta-analysis of all-cause mortality and suicide, readmission, reoffending and length of stay.

Whilst reoffending is a major concern for both services and the general public, investigations of criminal behaviour alone have been described as disregarding clinical issues in a clinical population (Jamieson & Taylor, 2004). However, the research area has moved beyond descriptive studies and onto more complex evaluations of risk management and outcomes over the past decade, through the investigation of factors that predict and are associated with outcome; see Sedwick et al. (2016) for a systematic review of factors associated with inpatient violence, length of stay and reoffending. Demographics most commonly found to be associated with reoffending post-discharge include; a primary diagnosis of personality disorder (78% of studies); history of previous offending (67%); a short secure admission (50%) and younger age at admission (50%). Further research to increase the knowledge of factors pertinent to effective discharge will equip clinicians in making informed decisions about timing of discharge and appropriate discharge destination, as will assessment of post-discharge factors that prevent relapse and offending, such as access to appropriate care and services. However whilst study of community transition and discharge from medium security has received much attention over the last 15 years, in contrast, significantly less attention has been given to the direct study of those patients discharged to settings other than the community, particularly those patients who are remitted to prison.

1.9 Remittal to prison

Remitted patients are those originally transferred to hospital from prison, except in exceptional circumstances where a civil patient is convicted of a crime during admission. Remittal is conducted in line with the requirements of the national guidance on remission (Department of Health, 2011), which outlines the shared responsibility between the medium secure service and receiving inreach provider in overseeing the remittal process. Patients are transferred to the local prison in the region of the medium secure service unless there are exceptional circumstances to prevent this, for example if they are a Category A prisoner (Department of Health, 2011). A number of pre-2010 studies documented admission and discharge of prisoner-patients in individual medium secure services and the levels of variation further reflect the differences in provision and practices nationally; prison transfers represented between 13% to 60.4% of admissions, and remittals 8% to 25.6% of discharges (Brown & Fahy, 2009; Edwards, Steed & Murray, 2002; Kennedy, Wilson & Cope, 1995; Maden, et al., 1999; Mohan et al., 1997; Rickets et al., 2001).

There are few national studies of discharge from medium security services. The first and largest was a national prospective cohort study of discharges from 34 medium secure services (Maden et

al., 2006). The study captured data from 1997/98 for all patients discharged from medium secure services over a 12 month period ($n = 959$), and included services from both NHS and independent sector providers (28 NHS, 6 independent). This study observed that 12.8% of all discharges were remittals to prison. However, approximately 12 years later (2010/11), the proportion of remittals from medium secure services was observed to have risen to 20.1% (Doyle et al. 2014). This study accessed all patients discharged from 32 NHS medium secure services over a 12 month period ($n = 794$) and aimed to identify the reason for this increase by establishing factors associated with remittal to prison. Community discharges ($n = 409$, 51%) and prison remittals ($n = 159$, 20%) were compared across demographic, clinical and criminological characteristics, along with mean scores on 4 standardised assessment tools at discharge.

The authors speculated that the rise in remittals may reflect the overall increase in volume of transfers from prisons, some of which may not have been appropriate for admission. The higher proportion of persons with primary and co-morbid diagnoses of personality disorder among remittals might support this notion; patients with a primary diagnosis of personality disorder were 6 times more likely to be remitted to prison (37% vs. 6%), and those with a co-morbid diagnosis of personality disorder were 2 times more likely (45% vs. 20%). In contrast, patients with a primary diagnosis of schizophrenia were 43% less likely to be remitted to prison than discharged into the community (38% vs. 66%) and those with a primary diagnosis of schizoaffective disorder were 71% less likely (4% vs. 13%). Nonetheless it remains concerning that there was still a high prevalence of SMI in the prison remittal group (66%). This is compounded by the fact that prison remittals were rated as experiencing significantly more psychotic symptoms at time of discharge; overall severity of symptoms of mental disorder was significantly higher among prison remittals with average symptomatology scores rated as mild-to-moderate, whereas community discharges were virtually asymptomatic (as measured by the Positive and Negative Symptom Scale (PANSS), Kay, Fiszbein, & Opler, 1987). Likewise prison remittals were rated as having significantly higher risk of future violence on the HCR: 20v3 (Webster et al., 1997; Douglas et al., 2008), with the largest difference observed across the clinical subscale, which assessed the level of recent problems with psychological adjustment prior to discharge (for example; lack of insight, violent ideation or intent, and instability). This suggests that risk of future violence, as rated by the HCR: 20v3, for those remitted to prison was predominantly attributed to deficits in mental state and functioning at time of discharge. Prison remittals also collectively scored lower for the presence of protective factors (as measured by the SAPROF, de Vogel, Ruiters, Bouman, de Vries & Robbe 2009), with the largest difference observed across the motivational subscale which assessed presence of motivation for and attitude towards several aspects of treatment (e.g. motivation to

use medication effectively and attitudes towards authority). Risk of reoffending was also assessed using the Medium Secure Recidivism Guide (MSRAG, Hickey, Yang & Coid, 2009). In general prison remittals were rated higher for future risk of offending with the largest difference observed for risk of future serious offending.

According to the current evidence-base, there is no clear explanation as to why these differences across presentation at time of discharge were observed. However, the lower average risk of future violence/reoffending observed for community discharges could be due to the proportion of non-prisoner-patients in this group; just 39% of community discharges were originally transferred to medium secure services from prison, compared to 90% of prison remittals. The remaining community discharges entered medium security from high security (6%), low security (2%) and other medium secure services (11%). Some patients were also admitted from the community (15%), non-forensic wards (7%) and other sources (6%). This disproportionate presence of non-offender patients in the community discharge group may have inflated the differences observed in risk profiles across community discharges and prison remittals. As such, it may be more useful for future research to focus on the characteristics and risk profiles of prisoner-patients (i.e. those admitted to medium secure services from prison) and how these individuals differ across discharge destination. To ensure that this comparison is meaningful, studies should include only patients who are eligible for both remittal to prison and community discharge pathways at admission. As such, in line with the issues raised in Section 1.7, factors observed to shape and restrict patient pathways and discharge destinations during admission should be documented (e.g. criminal court proceedings and changes to MHA status) as should circumstances leading to discharge (e.g. court directed discharge or instructed by the responsible clinician). It is likely that these factors will add valuable context to any investigation that seeks to study prison remittal and observed changes in clinical practice.

However, this does not take away from the fact that patients remitted to prison were deemed to be too symptomatic and unmotivated for treatment at discharge, which appears at odds with the indicators and criteria used to assess progress and transition along a medium secure pathway (as are listed in Box 2). Discharge should be determined by an individual's level of engagement with their treatment/care plan, a reduction in assessed risk of harm to others, and a reduction in the need for care and supervision (NHS England, 2018). As such, it is unclear why some prisoner-patients were remitted at this time in their treatment, as it appears unlikely that these patients would be considered appropriate for discharge back into community. It is therefore concerning that collectively prison remittals had a mean length of admission that was much shorter than the recommended 18-24 months (Bradley, 2009), and significantly shorter than community

discharges (317 days vs. 879 days). It might be that patients working towards community discharge are required to evidence their stability and progress over a prolonged period of time prior to discharge, particularly those whose discharge is dependent on the availability of post-discharge accommodation and CMHT support.

It is currently unclear what targeted services are available in the prison estate for those returning from an admission to medium secure services, particularly for those who present with significant psychiatric needs and high risk of future violence. For these patients, thorough discharge planning should be conducted and aftercare under section 117 MHA should be facilitated through the CPA process. However, prison mental health services are currently under-resourced, as described in Section 1.2, and it is concerning that the needs of remitted individuals might not be addressed in prison – a concern which appears to be shared by some forensic clinicians. In a consultation with 53 forensic psychiatrists, 39% of participants indicated that they had previously been reluctant to remit an individual back to prison (Royal Collage of Psychiatrists, 2011). Most commonly cited reasons were either due to concern that their patient's mental health needs would not be adequately met in prison (47%) or that their patient would likely relapse in prison (24%). In addition, there are currently few safeguards to ensure medication and treatment adherence within the prison environment and readmission to medium secure services may be met with significant delays if required. In stark contrast however, almost three quarters (73%) of community discharges reported by Doyle et al. (2014) were discharged subject to a section 37/41 restriction order (44%) or a Community Treatment Order (CTO, 29%). These restrictions act as a safeguard and give clinicians the power to recall patients who are considered to be at risk of relapse or who are not fulfilling the conditions of their order (e.g. non-adherence to prescribed medication, illicit drug use, violation of residency and curfew restrictions). The authors speculated that prison remittal may be viewed by clinicians as a safe discharge destination due to the external security of the prison environment, and therefore may be a more expedient pathway option for some high risk individuals.

The community discharges in this study were followed up to examine the validity, reliability and practical utility of the standardised assessments tools used (Shaw et al., 2013). Data were successfully accessed for 95% of community discharges at 6 month ($n = 387$) and 82% at 12 months ($n = 344$ post-discharge), which included detailed information about the nature and frequency of violence/reoffending. Loss to follow-up was predominantly due to readmission to inpatient mental health services ($n = 26$) or imprisonment ($n = 10$). Across the 12 month follow-up period, 22% of community discharges were documented as committing a violent act ($n = 87$). Those patients who had a longer admission to medium secure services and were subject to

community restrictions were significantly less likely to be violent within 12 months post-discharge. Individuals who were documented as being violent were considered to have a significantly higher risk of being violent at discharge; violent patients were rated higher on all total and subscale scores across the HCR:20 v3, MSRAG and PANSS (aside from Negative subscale), and significantly lower on total and subscale scores on the SAPROF at time of the discharge, compared to non-violent individuals. With the exception of the PANSS negative subscale, all measures utilised at time of discharge in this study successfully predicted violence post-discharge from medium secure services (Doyle, et al., 2013). The strongest predictors of violence were the HCR: 20v3 (AUC = 0.70) and SAPROF (AUC = 0.69) total scores.

Through extraction of risk profile data from both studies it can be observed that the risk profile of prison remittals is strikingly similar to that of the violent community cohort (see Table 1.2). In fact, average scores on all measures of the HCR: 20 v3, MSRAG and PANSS were larger for prison remittals, whereas average scores for the SAPROF total, internal and motivational measures were smaller. Average score for external factors was, however, larger for prison remittals, which likely reflects the increased security of the prison environment. This suggests that, collectively, prison remittals presented as higher risk of future violence at time of discharge than did those community discharges who went on to be violent. Whilst these individuals may well be considered to be in a safe and appropriate environment for risk management purposes, their risk of future violence raises issues of public protection regarding the eventual release of these patients back into the community.

Information regarding remaining sentence lengths for remitted patients was not provided in this study, and therefore it is unclear how soon after remittal these individuals were eligible for release into the community. However, it remains concerning that some of these individuals may have been released soon after remittal. The release experience for prisoners with mental health problems is considered to be far from satisfactory (Centre for Mental Health, 2014). Unlike community discharges from inpatient services, prisoners are not generally released into the community on the basis of clinical judgement (Gagliardi et al., 2004) (for example; subject to improved mental health, lowered risk, or the availability of a less restrictive and supportive environment), but instead according to the legal conditions and time limits of the relevant sentence. As such, prisoners with mental health problems may be released with little to no mental health aftercare planning or actual receipt of social services in the community. As previously described, follow-up of ex-prisoners with SMI is known to be relatively poor (Lennox et al., 2012) and there remains a clear disconnect between information available to community healthcare providers in relation to the care patients have received during their custodial sentence.

This may restrict access to community services for some patients upon release as it is unlikely that previous mental health assessments will inform decisions around eligibility for CMHT services (Byng, Quinn, Sheaff, et al., 2012; NHS England, 2018). Therefore, it is concerning that these individuals may not have access to care upon release, or may disengage from mental health services.

Table 1.2. Mean scores on assessment tools at time of discharge for violent community discharges and prison remittals

Measure	Violent cohort (n = 87)	Prison remittals (n = 159)
HCR:20 V3		
Hictorial	14.31	14.36
Clinical	6.24	7.08
Risk	5.20	5.79
Total	25.75	27.23
SAPROF		
Internal	6.23	5.33
Motivational	9.23	7.87
External	6.62	7.41
Total	22.08	20.61
MSRAG		
Acquizitive	6.85	7.74
Serious	6.35	7.18
Total	13.20	14.92
PANSS		
Positive	13.89	14.89
Negative	13.61	15.29
General	29.91	32.26
Aggression	7.15	8.74
Total	64.55	71.18
Length of stay	585 days	317 days

Data extracted from Shaw et al., 2013 and Doyle et al., 2014

1.10 Conclusions and study rationale

There is evidence of overlap in some of the characteristics of prison remittals (Doyle et al., 2014) and indicators of violent outcome (Shaw et al., 2013). The high prevalence of SMI and current symptomatology identified among prison remittals, and the accumulating evidence of under-resourced inreach services makes it fair to assert that those remitted to prison are particularly vulnerable to relapse if not in receipt of appropriate targeted treatment. The needs of these individuals post-remittal are currently unclear. Considering the reported increase in prison remittal nationally, and the impending release of these prisoners into the community, the paucity of research in this area is concerning. As such, this represents an important area for further, up-to-date inquiry into the discharge of prisoner-patients from medium secure services

To meet the needs of prisoner-patients it is essential that research attempts to understand the significance of the characteristics and pathways of those remitted to prison and their mental health needs. This will ensure that NHS's duty of care to prisoners with mental health problems is upheld and will enable steps to be taken to provide targeted support for this population (as already exists in the community), a move which may consequently help to reduce recidivism. In this context, my research project aimed to better understand the process of transfer between medium secure services and prison, including why some prisoner-patients are remitted and others are not, and to examine in considerable depth and detail the legal and contextual pathway factors that influence who leaves medium secure services, what factors determine discharge destination and what happens to prison remittals post-discharge. The intention was to provide a clear understanding of the impact that remittal to prison has on access to mental health services and will provide essential data to improve the continuity of care for patients discharged from medium secure services back to prison. It is also the intention to utilise these research findings for advisory practice, in the form of contributing to good practice guidance for the effective and ethical remittal of prisoner-patients from medium secure services.

1.11 Study Aims

Study 1 aimed to;

- Describe and explore the legal pathways of prisoner-patients admitted to medium secure services and their reasons for discharge.
- Establish the characteristics of prisoner-patients who are discharged from medium secure services, either into the community or back to prison.
- Compare community discharges versus prison remittals to gain novel insights into which characteristics are associated with discharge destination type.

Study 2 aimed to;

- Gain insight into clinicians' experiences of receiving, managing and discharging prisoner-patients within medium secure services.
- Gain understanding of the processes that guide prisoner-patient pathways through medium secure services.
- Explore how clinicians' account for the differences in characteristics for those discharged into the community versus those remitted back to prison

Study 3 aimed to;

- Describe and explore the follow-up care pathways for prison remittals from medium secure services
- Describe follow-up access to care post-remittal and early outcomes upon remittal

1.12 Chapter summary

This chapter has introduced a range of relevant service developments and background literature to the study of prisoner-patients detained in medium secure services who are remitted to prison following treatment. An overview of prison-based and secure mental health services was provided, along with description of pathways through medium secure care relevant to the prisoner-patient population. Description of the mixed methodological approach used to conduct this research is provided in Chapter 2, followed by a detailed description of the methodology utilised in Study 1.

Chapter 2 Methodological overview and Methodology 1: National prospective cohort study

This chapter provides an overview and justification for the methods used in the studies that are reported in this thesis. A brief description of the mixed methodological approach is provided, followed by an in-depth outline of Study 1. This includes a description of study governance procedures and ethical considerations which took place at the study design phase. The study research sites are also described alongside the materials and procedure used to collect and analyses the quantitative data.

2.1 Research paradigm

A research paradigm refers to a belief system which guides both how research design decisions are made and how research is carried out methodologically (Guba, 1990; Kuhn, 1962). The two most common belief systems are Positivism and Constructivism, and each has an established methodology and set of research conventions and practices that have evolved from rigid ontology and epistemology (see Table 2.1 for a summary). Positivist research is conducted from the perspective that there is a single reality that can be measured and therefore utilises quantitative methodology (Crotty, 1998). Constructivists argue that there is no single reality and, as such, realities should be interpreted as opposed to measured. They believe that researchers construct rather than discover meaning, and they adopt qualitative methodologies of inquiry (Burr, 2003). With its routes in empiricism, quantitative methodology focuses on the collection, analysis and interpretation of predominantly numerical data with the intention of measuring, observing or testing reality. Qualitative methodology, on the other hand, is the collection, analysis and interpretation of predominantly narrative data. These approaches dominated social research throughout the 20th century and ‘the battle’ between the two has been referred to throughout the literature as the ‘paradigm wars’ (Bryman, 2006).

As a relatively new research paradigm, pragmatism overrides the assumptions of these two older philosophies and provides a new direction for understanding the nature of a social phenomenon (Morgan, 2014). Pragmatism suggests that reality is constantly negotiated, debated and interpreted and is therefore not rigid in its epistemology. In a pragmatist paradigm the theoretical perspectives of positivism and constructivism are of equal importance, yet it is the belief that the mode of investigation used to address a phenomenon should be that which most appropriately addresses the research question (Creswell, 2003; Pritchard, 2012). As such in a pragmatist paradigm, either quantitative or qualitative methodology may be adopted, as can a combination of both methodologies in a mixed methodological design (Creswell, 2015).

Table 2.1. Characteristics of positivist, constructivist and pragmatist research paradigms

	Positivism	Constructivism	Pragmatism
Ontology <i>The nature of reality</i>	There is a single reality or truth	There is no single reality or truth	Reality is constantly renegotiated
Epistemology <i>The nature of knowing</i>	Reality can be measured	Reality should be interpreted	The most appropriate means to examining a phenomenon should be used
Theoretical perspective	The world exists apart from our understanding of it	The world is created by our conception of it	These two assertions are equally as important
	Empiricism - focus on reliability and validity of tools to obtain it	Interpretivism – focus on the underlying meaning of phenomenon	Rejects the choice associated with positivism and constructivism - ‘What works’ a
Methodology	Quantitative	Qualitative	Quantitative and qualitative
Methods	Measurement	Observation, interviews	Mixed methods
Sources	Numerical	Narrative	Numerical and narrative

Table adapted from various sources, including Crotty (1998). a Silverman 2005, p6

The characteristics and pathways of prisoner-patients discharged from medium secure services are understudied, as are the organisational processes and clinical decisions which influence these pathways. As such, a pragmatist approach to research design was adopted for the studies outlined in this thesis. The methodology deemed most appropriate to address the research questions outlined in section 1.11 was adopted, resulting in a mixed methodology approach to the research. This approach suited the more exploratory nature of the research questions posed and allowed for an in-depth perspective that a narrow quantitative or qualitative approach alone would have not (Seale, 1999).

2.2 Mixed methodology

A mixed methods approach can be used as a means of examining the phenomenon in question from multiple perspectives, and can also act as a strategy for assessing and enhancing the validity of the data collected (Creswell, 2015). It includes utilising both quantitative and qualitative methodologies for data collection, either concurrently or sequentially. Each approach to a mixed-methods design has a distinct set of practices covering the following aspects: the implementation of quantitative and qualitative methodology, the priority each approach takes, the stage at which the data is integrated and whether the research is conducted from a theoretical perspective or not (see Table 2.2 for description of mixed methodological designs according to these 4 criteria). In a concurrent mixed methodology design, the quantitative and qualitative elements of the research are conducted at the same time but remain distinct throughout, with integration usually taking place at the interpretational stage of the research. In contrast, in a sequential design approach, data collection happens in two or more phases, with one methodology being used first, and the other used to build on the earlier findings generated via the preceding phase.

Table 2.2 Mixed methodological designs by four criteria

Design	Implementation	Priority	Stage of integration	Theoretical perspective
<i>Sequential explanatory</i>	Quantitative followed by qualitative	Usually quantitative; can be qualitative or equal	Interpretation phase	May be present
<i>Sequential exploratory</i>	Qualitative followed by quantitative	Usually qualitative; can be quantitative or equal	Interpretation phase	May be present
<i>Sequential transformative</i>	Either way around	Quantitative, qualitative or equal	Interpretation phase	Definitely present (i.e. conceptual framework, advocacy, empowerment)
<i>Concurrent triangulation</i>	Concurrent collection of qualitative and quantitative data	Preferably equal; can be qualitative or quantitative	Interpretation phase or analysis phase	May be present
<i>Concurrent nested</i>	Concurrent collection of qualitative and quantitative data	Quantitative, qualitative	Analysis phase	May be present
<i>Concurrent transformative</i>	Concurrent collection of qualitative and quantitative data	Quantitative, qualitative or equal	Unusually analysis phase; can be during interpretation phase	Definitely present (i.e. conceptual framework, advocacy, empowerment)

Adapted from Creswell et al. (2003), Advanced mixed methods research designs, Chapter 8, p.244, in Tashakkori and Teddie (2003). Handbook of mixed methods in social and behavioural research.

Given the nature of the research questions outlined in section 1.11, a concurrent triangulation design was deemed most appropriate for the current investigation. This design is the most frequently used approach to mixed methodology, likely due to the efficient and practical nature of the data collection process (Creswell et al., 2004). The design ideally treats the quantitative and qualitative data collected as equal, although there is flexibility in the design if one dataset is deemed to be of more importance than the other (Creswell, 2015). Table 2.3 details the objectives of each study and the methodological approaches utilised for this investigation.

Table 2.3. Study objectives and design

	Study 1	Study 2	Study 3
Study	Factors associated with discharge destination	Clinicians' experiences of managing and discharging prisoner-patients	Follow-up of prison remittals
Objectives	1) Describe the characteristics of prisoner-patients who are discharged from medium secure services 2) Establish differences in characteristic across community discharges and prison remittals	1) Explore clinicians' experiences of treatment, management and discharge of prisoner-patients from medium secure services 2) Explore how clinicians account for the apparent differences between community discharges and prison remittals	1) Describe access to services and outcome for prison remittals from medium secure services 2) Establish the feasibility of conducting follow-up of prison remittals
Sample	157 prisoner-patients	24 forensic clinicians	96 prison remittals
Design	Observational: national prospective cohort study	Qualitative: interviews and focus group study	Observational: national feasibility follow-up study
Analysis	- Descriptive analysis - Rate ratio comparisons of characteristics between discharge destinations	Thematic analysis	Descriptive analysis

2.3 Concurrent triangulation design

The concurrent triangulation design in this study prioritised quantitative methodology in that a national prospective cohort study was used in Study 1 to establish the characteristics of prisoner-patients who were discharged from medium secure services, and to compare these characteristics across discharge designation (community discharges vs. prison remittals). Qualitative methodology was then utilised to address the research questions that the quantitative study could not. Individual semi-structured interviews and a focus group were used to establish clinicians' perspectives on prisoner-patient care pathways and to gain insight into contextual processes that impact on discharge destination, alongside clinicians' perceptions of differences between patients of each destination. The quantitative (Study 1) and qualitative data (Study 2) are integrated in the Discussion (Chapter 10). A third feasibility follow-up study of prison remittals was also conducted which utilised quantitative methodology to gain insight into the services accessed and outcome of prisoner-patients remitted from medium secure services. These data are also integrated with the data from Studies 1 and 2 in the discussion chapter. Whilst Pragmatism has informed the overall design of the current work, there is no overarching theoretical perspective which guided the interpretation of research findings. However, the informal personal stances that have influenced the qualitative work are discussed in the reflectivity section in Methodology 2 (Chapter 6).

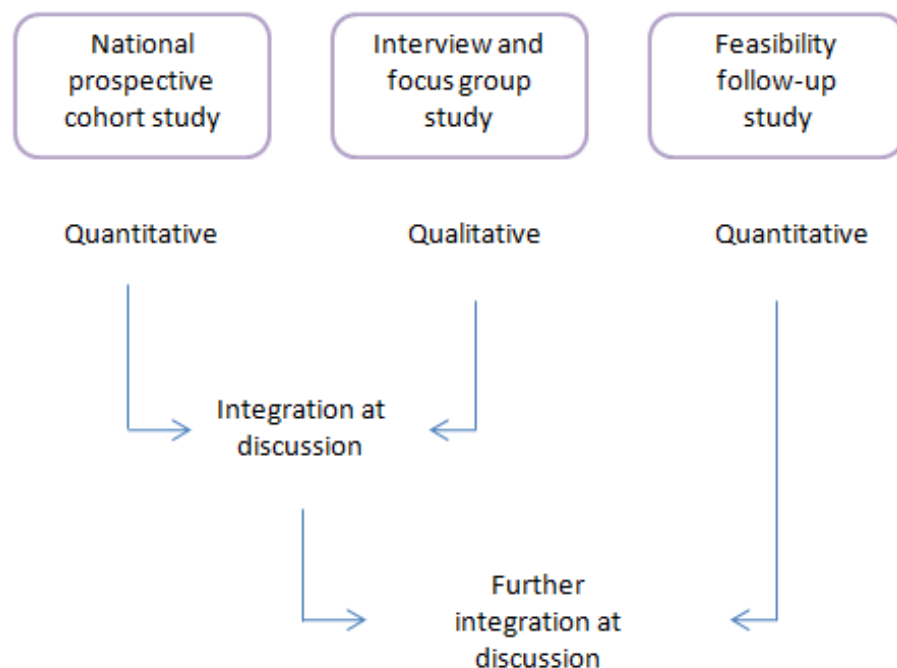


Figure 2.1: Concurrent triangulation design

The following sections of this chapter provide a description of Study 1.

2.4 Methodology 1 – national prospective cohort study

2.4.1 Study objectives

The objectives of Study 1 were to:

- Describe and explore the legal pathways of prisoner-patients admitted to medium secure services and their reasons for discharge
- Establish the characteristics of prisoner-patients who are discharged from medium secure services, either into the community or back to prison
- Compare findings across community discharges and prison remittals to gain insight into which characteristics are associated with each specific discharge destination

Quantitative methodology was chosen as the most appropriate way to meet these objectives as it allowed for objective measurement of prisoner-patient legal pathways and characteristics.

2.5 Design considerations

2.5.1 National prospective cohort study

The study adopted a descriptive prospective national cohort design of prisoner-patients discharged from medium secure services over a 6 month period, either back to prison or into the community. A cohort design provides a robust framework for determining prevalence and assessing whether associations exist between multiple patient characteristics and a specified outcome. Whilst this design is costly and time-consuming, it was considered necessary for accurate examination of differences between community discharges and prison remittals at discharge from medium secure services. All prisoner-patients discharged from medium secure services over a six month inclusion period were assessed. Assessment took place at date of discharge from medium secure services (baseline).

During the design phase of the investigation, a retrospective cohort design was considered. This design is concerned with events that have already happened (in this case, prisoner-patient discharge) and typically constructed from databases of healthcare records that have already been collected (Sedwick, 2014). Whilst this design is cost-effective and allows for a relatively quick data collection period, it is more open to bias than a prospective design, due to issues such as missing data on exposures, covariates and outcomes (Hassan, 2005). This design relies on accessing existing records, and thus not all pertinent characteristics and factors present at time of discharge were likely to have already been identified and subsequently recorded (Sedwick, 2014). For example; it would have been difficult to determine the mental state of the patient at discharge and to accurately document circumstances and care received at discharge when using a retrospective design (as observed by Friendship et al., 1999).

The prospective design adopted allowed for the discharge of prisoner-patients from medium secure services to be pre-empted. Presence of all eligible prisoner-patients detained in all 33 medium secure services was established prior to the baseline data collection period, and services were therefore aware that case-note access and collateral informant interviews might be required for these individuals. As such, the design allowed access to clinical notes immediately after discharge, ensuring that all relevant clinical and criminological information was up-to-date and valid at time of assessment and any gaps in information could be easily sourced from administrators or clinical staff. This resulted in higher quality of data, with greater validity, compared with a retrospective design (Sedwick, 2013). This also ensured optimum recall from collateral informant during telephone interviews that took place as soon as the staff member was available following each discharge. A retrospective design would have required staff members to

recall events a year after a prisoner-patient had been discharged, and therefore likelihood of staff accurately reporting patient presentation at time of discharge may have been reduced (Sedwick, 2012). Additionally, retrospective identification of a full population cohort of prison-remittals would have been difficult due to inter-prison transfer post-remittal. The prospective design allowed for the tracking of remitted prisoner-patients throughout the one year follow-up post-discharge. Necessary prison, healthcare and NHS approvals could be obtained in advance and instances of post-remittal transfer could be identified, in most cases, in advance of each follow-up date. As such the prospective design allowed for the capture of all remittals of prisoner-patients over a six month baseline period, which would not have been an achievable goal with a retrospective design.

Whilst a national study is a large undertaking, it was deemed necessary to conduct this study with a full population of NHS prisoner-patients, as opposed a regional or unit level sample. Admission and referral criteria for the sites used across previous discharge studies have differed, as have the range of treatments provided within each secure facility and the ratio of prisoner-patients detained (Coid et al., 2007), making generalisations from these studies problematic. Additionally, in order to capture a sizable cohort, previous unit and regional level cohort studies have used lengthy sampling time frames of patient discharges (usually retrospectively)– with most studies requiring discharge period of almost 10 years (e.g. Shah, Waldron, Boast, Coid & Ullrich, 2011; Wilkes, 2012), and some as long as 16 years (Ricketts, Carnell, Davies, Kaul, & Duggan (2001). Such sampling time frames make the interpretation of study findings difficult as across the discharge phase, government policy and service provision within the studied medium secure unit may have changed, as may have the admission and referral criteria of the service. As such a study which attempted to include multiple services over a shorter time frame was deemed optimal.

A previous national study examined a cohort of 303 prisoner-patients discharged from 32 medium secure services over a one year discharge period (Doyle et al., [2014]; i.e. 161 community discharges and 142 prison remittals). Therefore, at the outset of my study, I estimated that a discharge period of six months would include 151-2 prisoner-patients. Capture of prisoner-patients over a 12 month baseline period would have been preferable as this would have increased the number of prisoner-patients under study and may had allowed for a more sophisticated analysis of sub-groups. However, this would not have been feasible to conduct within the timeframe of a doctoral programme. The relatively small number of prisoner-patients in the six month baseline period may to some extent have limited the interpretation of the findings and subsequent recommendations made in this thesis, therefore application of the study findings to future prisoner-patients should be considered with this in mind. Nevertheless, this

timeframe still allowed for the capture of a complete population of NHS prisoner-patient discharged from medium secure services, and descriptive analysis and comparison of variables across community discharges and prison remittals was feasible.

2.5.2 *Medical records based research*

Medical records reviews are routinely carried out for the purpose of service and research audits and are often published as peer-reviewed academic output. For these routine investigations, both consent from patients involved and NHS ethical approvals are not required for use of patient information, if the data extraction does not influence patients' care or treatment and therefore no risks or benefits to patients ensue as a result of the audit taking place (Johnston, Crombie, Alder, Davies & Millard, 2000).

Previous large-scale service audits of patients detained and released from medium secure services have taken place (e.g. Duke, Furtado, Guo & Vollm, 2018, Coid et al., 2001). For these studies the patient information is collated by the medical records department of each service and is received by the research team as an anonymised database. This is a relatively quick and efficient approach to conducting observational research, yet it can be problematic nonetheless. The types of data collected are limited to that which is routinely recorded and the research team have to rely on the data being accurately collated by the services, resulting in little opportunity to challenge missing data or gain insight regarding conflicting recorded information. In some cases researchers have to infer the presence or absence of specified variables from the clinical information and data available, introducing additional researcher bias (as in Shah et al., 2011).

Likewise for studies which access patient standardised assessment measures, for example violence risk assessment tools, it is standard practice for clinician-rated assessment scores to be extracted, as opposed to receiving the assessment in full. These scores alone provide very little context or information regarding a patient's presentation at the time of assessment. Whilst these assessments presumably are conducted attentively by clinicians who have considerable insight into their patients' condition, it is well established that quality and accuracy of assessments of this type varies between clinicians within the psychiatry profession (Singh et al., 2015). Additionally these assessments are routinely administered at 6 month intervals and there is therefore no control over when these assessments are conducted for the purpose of the audit. As such the researchers do not receive an accurate representation of their cohort at the same point in time, resulting in a lack of reliable description of the population of interest at baseline.

Taking all of this into account, it was deemed both necessary and good practice to gain the national research ethical approvals required to conduct a research study involving patient medical records, to conduct a thorough investigation into the characteristics of prisoner-patients discharged from medium secure services, and to aid reliable scoring of standardised assessments.

2.5.3 *Medical records vs. research interviews with patients*

A study of this type is not limited to only accessing routinely collected data and therefore consideration of how to access accurate and up-to-date patient information took place. Previous cohort studies have used structured research interviews with medium secure patients to gather clinical information (e.g. Snowden, Gray, Taylor & Fitzgerald, 2009). This mode of data collection is valid as it allows for both the patient's narrative and perspective, yet it can also be an impractical approach to conducting observational research. The type of consent required and level of involvement in research required of patients is known to impact on consent/selection bias, particularly in relation to research requiring structured interviews (El Emam, et al., 2013).

Medium secure services are highly structured clinical environments and therefore access to patients for the purpose of research interview is limited to convenient times for both the patient and clinical staff, and can be disrupted by ward based incidents or dictated by when the patient is feeling mentally well enough to participate in the research. Likewise as this research concerns patients who were discharged from medium secure services, it may have been difficult to conduct a research interview with patients prior to discharge, especially if the patient was unaware of their impending remittal to prison. For this investigation interview assessments would have had to have been conducted at a time of heightened vulnerability for patients, as discharge from medium secure services is a key transition point in a patient's care pathway. Taking part in a research interview at this time may have been triggering for the patient due to the negative impact assessments for research can pose (Allmark, et al., 2009). Interviews for the purpose of rating assessment tools often cover sensitive topics such as traumatic or adverse life events and therefore have potential to induce or exacerbate emotional distress (Jorm, Kelly & Morgan, 2007). Forensic psychiatric patients also have a vested interest in appearing 'low risk' at assessment. Studies which conduct assessments directly with patients in forensic settings have previously struggled to gain true accounts from patients in regards to their risk and mental health factors, as patients are often concerned about issues that might influence their privileges or the likelihood of their release (Snowden, Gray, Taylor & Fitzgerald, 2002). Additionally, documented instances of

previous events, for example violence, are often more accurate than patient self-reports (Doyle, Carter, Shaw, Dolan, 2012).

Therefore it was considered in this case that conducting research interviews with patients would be both impractical given the scope of the study, and had the potential to bias research findings pertaining to the assessment tools used. As secure patients tend to have lengthy histories and contact with services, historical demographic, clinical, and criminological information could be easily gathered through a thorough review of the patient's medical record, as is good practice when assessing historical/static factors contained in violence risk assessments tools (Royal College of Psychiatrists, 2016) (see section 2.10.4 for a description of the medical documents accessed for data extraction, and reflections on using these documents for research purposes).

This file information could therefore be used to conduct the violence risk assessments used in this study. The MSRAG, SAPROF, and PCLR: SV are not routinely collected in medium secure services, although it was anticipated that, in many instances, patient file information would include a clinician-rated HCR: 20. This assessment is used as part of standard clinical practice in forensic settings. Consideration was given as to whether to use these clinician rated assessments for the purpose of this study, as these assessments were conducted by a clinician who may have known the patient well. However, the decision was made for the HCR:20 v3 to be researcher-rated, using the same method as with the other assessments included in this study, due to the following reasons:

- For the purpose of this study, assessments were conducted at baseline (date of discharge) taking into account patient presentation in the six months prior to discharge. It could not be guaranteed that all available clinician-rated HCR:20s were conducted at the same point in each patient pathway.
- This study utilised version 3 of the HCR: 20. It could not be guaranteed that all medium secure services included in this study were already routinely using the HCR: 20 v3. The HCR:20 v2 continues to be used in forensic services where clinicians have not yet received training for the current iteration of the assessment.
- There is evidence to suggest that use and accuracy of the assessment differs across professional groups (Doyle & Leonard, 2014). The clinician rated HCR: 20s available may have been completed by professionals across varying professions (for example; psychiatry, psychology and nursing).

These inconsistencies would have introduced subjectivity and a degree of bias to the study's findings, thereby limiting the comparisons that could have been made as regards patient

presentation at baseline. Although not without bias, researcher rated HCR: 20 assessments were considered to provide a degree of standardisation which clinician rated HCR: 20's could not.

Dynamic items

The degree of detail required to rate the dynamic risk factors in the chosen assessment tools was unlikely to be readily available using solely hospital records. For example, the information required to assess the individual's recent and anticipated future problems with psychological adjustment would be incomplete.

Therefore I decided that collateral interviews would also be conducted with a member of each patient's care team to add context to the data routinely collected in a patient's medical notes regarding their presentation prior to discharge (dynamic items on the SAPROF and HCR:20 V3) and facets such as personality traits (items on the PCLR:SV). These were professional staff currently working with the patients with good knowledge of their past history, recent mental state and functioning (e.g. their Responsible Clinician, Named Nurse, Care Coordinator etc.). Where gaps existed in case notes, collateral informants provided an interpersonal perspective on the patient's personality and factors prior to discharge, and further anecdotal information where required. Whilst collateral interviews are also prone to bias, the final assessment judgements were conducted using both sets of information gathered. Where discrepancies occurred, further information was gathered from care teams and, where agreement could not be managed (e.g. in the case of 'team-split' as regards a patient), a composite score for items was generated in conjunction with the clinical supervisors. This method has previously been successful when completing measures such as the Brief Psychiatric Rating Scale (BPRS), which has been reliably rated using information from collateral informants, patient observation, and information noted in case records (Monahan, Steadman, Silver & the MacArthur Group, 2001).

2.5.4 Issues with obtaining patient consent

To accurately describe the characteristics of prisoner-patients discharged from medium secure services this study was designed to capture a national population of prisoner-patients. As such it was important to gain a full cohort of these persons discharged over a 6 month period. Therefore thoughtful decision making was required on the need to obtain mandatory consent from patients to access their medical records and conduct interviews with collateral informants.

It is well established that having to ensure informed consent in prospective observational studies involving access to medical records introduces consent/selection bias. Consent rates across

observational studies, in particular those of forensic patient populations, vary substantially. In many cases efficiency of recruitment is poor and consent rates are low (Paris 2003; Davies, Clarke & Duggan, 2007), with at least 30% of approached participants refusing to consent (Doyle & Dolan, 2006; Monahan et al., 2001).

The nature and severity of ‘the condition’ under study is known to impact on a patient’s capacity and willingness to consent (El Emmam, et al., 2013). In the current study it was anticipated that the prisoner-patient cohort would inevitably contain a large number of individuals with antisocial tendencies. Those participants who would have refused to consent were likely to be the group who were most at risk of being non-compliant and antisocial. Therefore if data for these patients were excluded, description of prisoner-patients would not have been representative and would likely underestimate the risk factors present in this population. Therefore, as the study’s objective was to make prevalence estimates, differences across consenters and non-consenters could have jeopardised the validity of the study findings and threatened the generalisations that can be made³. As such, to achieve a meaningful and representative sample, an application under Section 251 of the NHS Act (2006) to conduct this investigation without obtaining patient consent was deemed necessary.

Table 2.4 Overall strengths and weaknesses of chosen approach

Strengths	Weaknesses
<ul style="list-style-type: none"> · Allows for capture of a full cohort 	<ul style="list-style-type: none"> · Loss of patient narrative and perspective
<ul style="list-style-type: none"> · Avoids bias related to differential participation 	<ul style="list-style-type: none"> · Information is not always present or reliable
<ul style="list-style-type: none"> · Enhanced researcher objectivity 	<ul style="list-style-type: none"> · Introduces bias from collateral informant accounts
<ul style="list-style-type: none"> · Avoids negative impact of research assessment 	<ul style="list-style-type: none"> · Moral implications of conducting research without patient consent

³ Differences between consenters and non-consenters relate to multiple socio-demographic variables (including age, sex, race/ ethnicity, mental health status, educational attainment level, socioeconomic status, physical health status, lifestyle factors, and functioning) (see El Emam et al, 2009; Kho, et al., 2009 for reviews).

In summary it was decided that this would be a national prospective cohort study of all prisoner patients discharged from medium secure services, back to prison or into the community. All eligible patients were included subject to section 251 of the NHS Act (2006). Data were collected using full medical records review and supplemented by structured interviews with collateral informants.

2.6 Patient sample

The patients involved in this study were a population of all prisoner-patients discharged from NHS medium secure services over a 6 month period, either back to prison or into the community. This took place between 1st May 2014 and 31st October 2014.

2.6.1 Inclusion Criteria

For the purpose of this study, prisoner-patients are defined as those patients admitted/transferred to medium secure services directly from a prison establishment. This includes emergency transfers of both remand (under Section 48/49 of the Mental Health Act 1983) and sentenced prisoners (under section 47/48 of the Mental Health Act 1983). Those patients subject to court orders (e.g. 37/41, 38, and 45A) but admitted to the unit directly from a prison establishment where they were detained prior to sentencing were also eligible for inclusion in the study, as they too represent a significant proportion of the prisoner-patient and medium security populations.

There are three discharge pathways for prisoner-patients out of medium secure services: (i) transfer to another inpatient service, (ii) discharge into the community; (iii) remittal to prison. Only those patients discharged into the community or remitted to prison were eligible for inclusion in this study. Patients transferred to another hospital environment were excluded as they were deemed to still require inpatient psychiatric care.

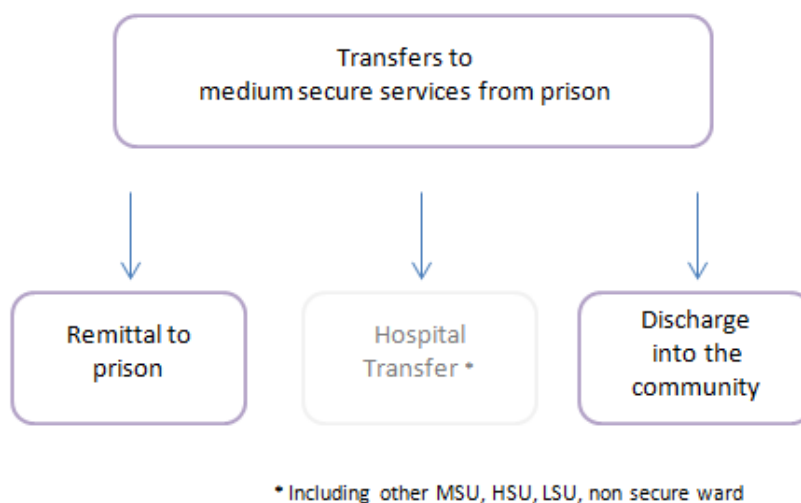


Figure 2.2: Pathways for prisoner-patients

2.7 Research sites

All 33 NHS Medium Secure Services across England and Wales dedicated to persons with a mental disorder diagnoses were included in the study. NHS units dedicated to people with learning disabilities alone were excluded.

The independent sector provides around 35% of medium secure capacity (Centre for Mental Health, 2011), although the characteristics of persons admitted to and detained in NHS versus independent sector services are markedly different (see section 1.6). All medium secure services follow the national service specification, which defines the scope of services and pathways through and out of secure care. They also share a range of core objectives focused on the provision of services, which are recovery-orientated and outcome-focused, and function in accordance with the statutory national standards (please refer to Box 1.1). However, I established previously in my literature review that there is much variability across NHS medium secure services; this variability is magnified when NHS and independent sector medium secure services are compared (Coid et al., 2007; Renshaw, 2010). Independent sector medium secure services tend to encompass provision for individuals who require care and treatment in a more specialised service; for example, patients who are audiologically deaf, those with neurodevelopment disorders (including learning disabilities and Autism Spectrum Disorders) and patients with Personality Disorder. I therefore decided not to approach medium secure services run by independent, non-NHS providers with a view to maintaining a degree of consistency across study sites in terms of service remit and procedures.

As such, the individuals included in this study are a population of NHS prisoner-patients discharged from all NHS medium secure services over a six month period. The analyses in the following chapters therefore cannot be generalised beyond prisoner-patients detained and discharged from NHS medium secure to independent sector services, for instance.

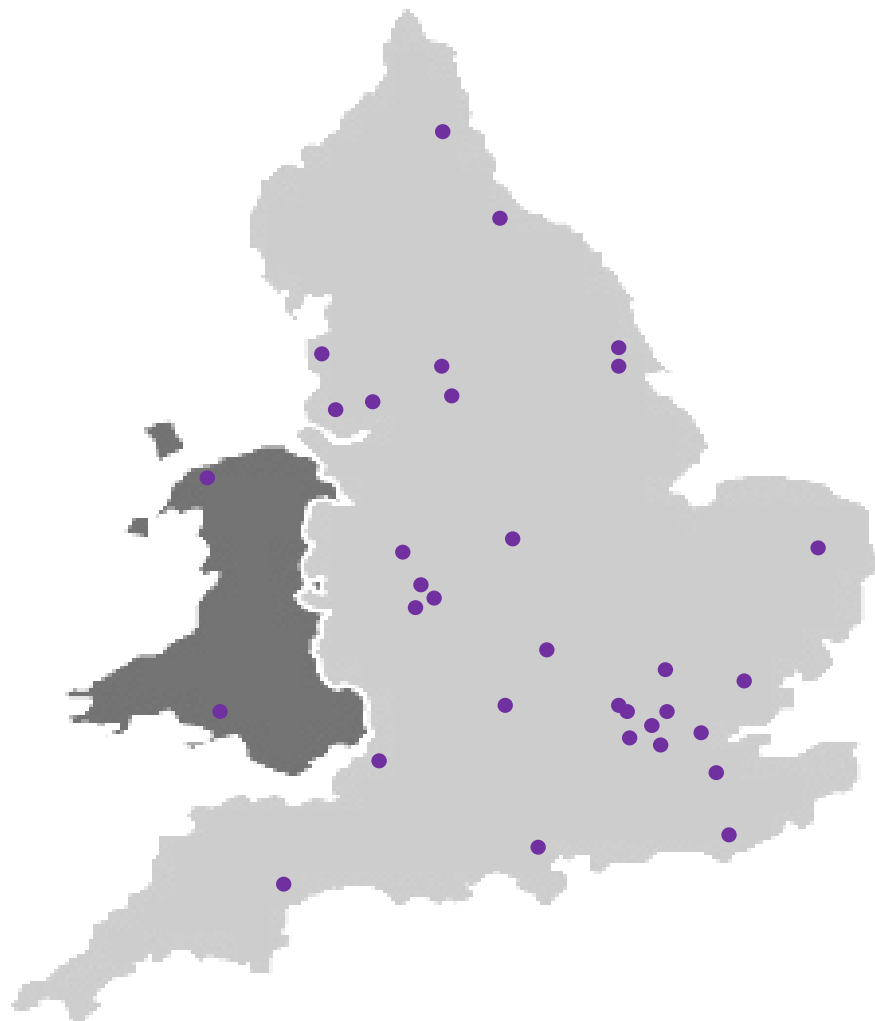


Figure 2.3: Research sites – 33 medium secure units in England & Wales

Table 2.5. Research sites – 33 medium secure units in England & Wales, NHS Trust information

NHS Trust	Medium secure unit	Location
Abertawe Bro Morgannwg University NHS Trust	Caswell Clinic	Bridgend (Wales)
Avon and Wiltshire Mental Health Partnership NHS Trust	Fromeside Clinic	Bristol
Barnet, Enfield & Haringey Mental Health NHS Trust	Camlet Lodge	North London
Besti Cadwaladr University Health Board	Ty Llywelyn	Llanfairfechan (Wales)
Birmingham and Solihull Mental Health NHS Foundation Trust	Ardenleigh	Birmingham
	Reaside Clinic	Birmingham
	The Tamerind Centre	Birmingham
Devon Partnership NHS Trust	Butler Clinic	Exeter
East London Foundation NHS Trust	John Howard Centre	East London
Greater Manchester West Mental Health NHS Foundation Trust	The Edenfield Centre	Greater Manchester
Humber Mental Health Teaching NHS Trust	The Humber Centre	Hull
	Green Trees	Hull
Kent and Medway NHS and Social Care Partnership Trust	Trevor Gibbens Unit	Maidstone
Lancashire Care NHS Trust	Guild Lodge	Preston
Mersey Care NHS Trust	Scott Clinic	St Helens
Norfolk and Suffolk Foundation Trust	Norvic Clinic	Norwich
Northumberland Tyne & Wear NHS Trust	Bamburgh Clinic	Newcastle
Nottinghamshire Healthcare Trust	Arnold Lodge	Leicester
	Wathwood Hospital	Rotherham
Oxford Health NHS Foundation Trust	Oxford Clinic	Oxford
	Marlborough Clinic	Milton Keynes
Oxleas NHS Foundation Trust	Bracton Centre	Dartford
South Essex Partnership University NHS Foundation Trust	Brockfield House	Wickford
South London and Maudsley NHS Foundation Trust	Bridge House	South London
	River House	South London
South Staffordshire and Shropshire Healthcare NHS Trust	Hatherton Centre	Stafford
South West London and St George's Mental Health NHS Trust	Shaftesbury Clinic	South London
South West Yorkshire Mental Health NHS Trust	Newton Lodge	Wakefield
Southern Health NHS Foundation Trust	Ravenswood House	Portsmouth
Sussex Partnership NHS Foundation Trust	The Hellingly Centre	Halisham
Tees Esk and Wear Valleys NHS Trust	Roseberry Park	Middlesbrough
West London Mental Health NHS Trust	Orchard	West London
	Three Bridges	West London

2.8 Ethical approvals and considerations

2.8.1 Sponsor

The University of Manchester acted as the sponsor for the research and undertook an initial review of the study. The Faculty of Medical and Human Science Research Ethics Team provided sponsor support following review on 21st January 2014. Final approval was received from Lynne McCrae, Research Practice Coordinator, on 29th January 2014.

2.8.2 Research Ethics Committee

Multi-site research ethics approval was sought from The National Research Ethics Service – North West – Preston Committee (09/H1016/126) to include all eligible prisoner-patients discharged from a medium secure pathway in England and Wales, and was granted on 31st January 2014.

2.8.3 Confidential Advisory Group (CAG)

An application, under Section 251 of the NHS Act (2006), was submitted to the Confidential Advisory Group (CAG) to process NHS patient identifiable information without consent. This approval allows the data controller at individual NHS sites to provide specified information for the purpose of the study, without being in breach of the common law duty of confidentiality, although other legislative provisions are still applicable.

The role of the CAG is to review the application, under Regulation 5 of the Health Service (Control of Patient information) Regulations (2002), and to advise the Health Research Authority, to inform their recommendation to the Secretary of State, on whether the application should be approved, and if so, any relevant conditions.

On 7th January 2014, following the advice from the CAG, the Health Research Authority agreed to recommend *provisional* support to the Secretary of State, in line with the conditions and clarifications highlighted by the CAG. Conditions of support included:

1. Confirmation of suitable security arrangements via the Information Governance Toolkit submission.
2. Confirmation of a favourable opinion from the Research Ethics Committee.
3. Assurance that fair processing of information is made available in line with the requirements of the Data Protection Act (1998).

The Information Governance Toolkit was completed via the online application and evidence was supplied to the Information Governance Working Group in the form of:

1. The Centre for Mental Health & Safety's Information Security and Management Policy
2. The project's System Level Security Policy
3. An Improvement Plan and Evidence Report on how the project's information governance procedures will be developed over the first year of the project.

The project received a satisfactory information governance score of 72% (Confirmed 25th March 2014) and the CAG were provided with both assurance of the project's compliance with the Data Protection Act (1998) and confirmation of a favourable opinion from the Research Ethics Committee (confirmed 31st January 2014). The information Governance Toolkit was completed annually throughout the investigation. Following the advice from the CAG, the Health Research Authority agreed to recommend full support for approval of the application, and the Secretary of State for Health provided final approval for the project to process NHS patient identifiable information without consent, subject to compliance with the standard and specific conditions of the approval. Confirmation of approval was received on 4th April 2014.

2.8.4 Site-specific research and development approvals

Individual site approval was obtained from the Clinical or Medical Director of each of the 33 medium secure services. Directors were contacted directly and provided with study information. Site-specific governance approval from individual NHS Trust Research and Development departments (R&D) was sought from 29 individual NHS organisations. The investigator's Research Passport was processed and granted by the lead trust (Lancashire Care NHS Foundation Trust) and individual Letters of Access or Honorary Research Contracts were obtained from the other 28 NHS Trusts. Many individual trust approvals were contingent upon the researcher completing the trust-specific Information Governance Training, in line with their site-specific regulations, and completing IT training prior to accessing patient notes.

2.8.5 *Individual staff consent*

All participating staff were provided with a Staff Information Sheet that outlined the purpose of the study, their involvement, the ethical approvals obtained and their ability to withdraw from the project at any opportunity. During the initial telephone contact, staff received a full explanation of the study rationale, relevant approvals and nature of staff involvement. Members of staff were given 48 hours to decide if they wished to take part in the study and written consent was sought, prior to staff participation in the study. Study details were reiterated prior to the interview taking place and verbal consent was also confirmed. If a staff member objected to participating, ward managers were asked to nominate another appropriate member of staff for approach.

2.8.6 *Patient identifiable information*

The study adhered to a stringent set of policies and procedures to ensure the security of patient identifiable information. All patient identifiable information was stored and processed in line with the Information and Security Management Policy of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, the project's System Level Security Policy and the ISO27002:2013 (the 2013 version of the international Standard for best-practice information security management systems, ISMS).

Data items such as patient's name, NHS number, date of birth, etc. were required to enable tracking and identification of patients during assessment. These data was stored on the department's internal network and not on an external server; therefore this information could not be accessed from outside of the project office, nor was it vulnerable to external cyber-attack to university systems.

2.9 Materials

2.9.1 Data collection proforma

A data collection proforma was developed to capture the data extracted from participants' medical records. This proforma allowed for efficient capture of a range of variables identified by the literature as important for understanding and describing the characteristics of patients discharged from medium security, and was structured using the following 4 distinct subsections:

1) Demographics and length of stay

General demographics were collected (including gender, age at admission and discharge) as was patient length of stay (in days) for their current detention in medium secure services. Length of stay was initially dichotomised as 'more than 2 years' vs. 'less than 2 years' and then across 5 subcategories with increments of 6 months (see Table 4.3, Chapter 4) to identify other key differences in length of stay across discharge destination. Pathway data in regards to each patient's legal status throughout their detention in medium secure services was also recorded. For the purpose of this study, '*legal status*' is defined as the patient's criminal justice system status (sentenced / remand/ pre-sentence) and their corresponding detention status under the Mental Health Act 1983 (the section the patient was subject to). See section 4.1 for a detailed breakdown of time points for legal status recording.

2) Clinical characteristics

This section was used to record key clinical characteristics of the patients. Patients' primary diagnoses were ICD10 coded (World Health Organisation, 2018) and categorised into 8 distinct groups (see Table 4.5, Chapter 4) and any recorded co-morbid diagnoses were also documented. Historical clinical variables were also recorded, including childhood diagnosis of conduct disorder, mental health service treatment, self-harming behaviour and clinically relevant adverse incidents (e.g. sexual assault, victim of or witness to domestic violence, etc.)

Specific treatments received by each individual during their detention were not extracted and coded as stand-alone variables for the purpose of comparison across the two patient groups (for example; receipt of therapy, medication, etc.). However this information was reviewed and used to support the rating of items in the standardised assessment. These assessments included factors such as degree of insight, symptoms of major mental illness, attitudes towards treatment, and treatment response (see section 2.9.2).

3) Criminological characteristics

This section was used to record patients' key criminological characteristics. The index offence - the most recent offence for which the participant was convicted or for which he/she was awaiting trial prior to admission to medium secure services from prison - was categorised into one of the following 4 groups: violent, acquisitive, sexual and 'other'.

To categorise violent index offences the same definitional criteria as for the categories used in the British Crime Survey were applied (Office for National Statistics, 2017), with 'violence' including offences of actual or attempted wounding, assault, injury and violence without injury (such as harassment and abuse). In my study, violence also included instances of homicide, which are not included in the British Crime Survey (due to this being a self-report survey). Sexual offences take many different forms and are not limited to physical acts of non-consensual intercourse and sexual acts, but include a wide range of sexual behaviours (for example; rape, assault by penetration, attempts to obtain a sexual act, sexual harassment; coercion, trafficking or sexual exploitation, female genital mutilation, indecent exposure, or unwanted touching [Henry, 2012]). Sexual offences were therefore categorised separately from violent offences to reflect this important distinction.

The index offence was also graded according to the Severity of Index Offence Scale (Young, Justice & Erdberg, 1999). This scale was designed specifically to measure the severity of offences committed by detained psychiatric patients. Categories of Index offences range from 'non-violent' to 'loss of life with extreme violence'. Patients' criminal histories were also recorded including any previous custodial sentencing.

4) Violence risk assessment tools prior to discharge

This section assessed patients' clinical presentations immediately prior to discharge using standardised clinical assessment tools that measured presence of risk and protective factors for each patient. These measures also captured clinically relevant historical risk factors found to be indicative of future violence risk among forensic patients. The measures used and the justification for inclusion of each is provided below. Detailed explanation of how these measures were used is provided in Results sections 4.6 to 4.10.

2.9.2 Assessments

Historical, Clinical & Risk: 20 items, version 3

(HCR-20v3: Webster et al., 1997; Douglas et al., 2008)

The HCR: 20 is a structured violence risk assessment instrument. There are 20 items that align risk markers into past, present, and future and incorporate Historical (10 items), Clinical (5 items) and Risk Management (5 items) factors which have been found to be predictive of future violence. The Historical items are static variables whereas the Clinical and Risk items represent current and future dynamic risk.

Items are rated on a three-point scale; 0 = not present, 1 = partially present, and 2 = clearly present. Total scores range from 0 to 40.

The HCR: 20 is the most frequently-used structured professional judgement guideline for violence risk assessment at both a national (Doyle & Leonard, 2016) and international level (Singh et al., 2014). The tool has been widely tested in forensic mental health settings within the UK with promising evidence to support its use (Doyle & Dolan, 2006; Gray, Taylor, & Snowden, 2008) and is also a mandatory assessment tool to be used for every secure psychiatric patient in the UK.

The Structured Assessment of Protective Factors for Violence Risk

(SAPROF: De Vogel et al., 2009)

The SAPROF is a guideline developed to measure protective factors for violence risk. It is designed to be used in conjunction with a reliable and valid risk assessment tool according to the Structured Professional Judgement method, such as the HCR: 20 and related tools. There are 17 items covering Internal (5 items), Motivational (7 items) and External (5 items) factors that have been found to protect against violence.

Each item is rated on a 3-point scale; 0 = absent, 1 = present to some extent or 2 = Clearly present. Scores range between 0 and 34.

The SAPROF aims to provide a more complete view of the individuals' risk of violence and to balance/compensate for highlighted risk factors. The SAPROF has recently been found to increase the validity of violent recidivism prediction versus using the HCR: 20 alone (De Vries Robbe, De Vogel, De Spa, 2011).

Psychopathy Checklist Screening Version

(PCL-SV; Hart, Cox, & Hare, 1995)

This is a 12-item inventory of perceived personality traits and recorded behaviours. There are two subsections which cover Interpersonal personality traits (6 items) and Socially Deviant personality traits (6 items).

Each of the items has a 3-point rating (0, 1 or 2). Scores range between 0 and 24

The PCL: SV is the third most commonly used risk assessment tool at an international level (behind the Psychopathy Checklist Revised and the HCR: 20; Singh et al., 2014) and has been used extensively in research of this type (e.g. Monahan et al., 2001; Doyle and Dolan, 2006).

Medium Secure Recidivism Assessment Guide

(MSRAG; Hickey, Yang & Coid, 2009)

This is a 12-item actuarial violence risk assessment tool designed in two parts to predict acquisitive recidivism and serious offending recidivism from patients discharged into the community up to 2 years post-discharge. It was designed for use by clinicians at the pre-discharge stage of rehabilitation.

Each of the items has a simple 3-point rating (-1, 0, +1) or binary rating (-1, +1). Scores range from -12 to 12.

Positive and Negative Syndrome Scale

(PANSS; Kay, Fiszbein & Opler, 1987)

This is a 30-item rating instrument that evaluates the presence/absence and severity of positive, negative and general psychopathology of schizophrenia. All thirty items are rated on a seven-point scale (1 = absence, 7 = extreme).

In the initial stages of this investigation I intended to use PANSS to assess patient presence of symptoms associated with severe mental illness in the months prior discharge (as in Coid et al.,2015). However, it became clear in the early stages of data collection that this was not an appropriate measure to use across the whole of the cohort. Just under half of the patients involved in the study had a primary diagnosis of schizophrenia, however for just over a third of patients this tool was not clinically relevant (37%). For these patients data could not be accurately extracted from clinical documents due to issues such clinician detection of ‘pseudo’ symptoms in those with a primary diagnosis of personality disorder. Early feedback received from collateral informant interviews corroborated this, with informants also expressing difficulty in being able to accurately rate the PANSS items. As such, I decided to cease using the PANSS as a data collection tool in this investigation, and PANSS scores are not discussed further or presented in this thesis. At this stage of data collection it was not feasible to add another measure of symptomology as this would have required a submission of a substantial amendment to the Research Ethics Committee, which may have caused delays, as would re-accessing the medical notes and collateral informants for the assessments that has already been completed.

Note on impact of assessment removal

The absence of this clinical rating of symptomology at baseline assessment limits to some degree the conclusions about presentation and clinical needs at time of discharge. However, whilst the nature of an individual’s active systems was not categorised in this way, the Clinical Subscale on the HCR:20 v3 captured degree of psychosocial adjustment in the period preceding discharge. This subscale collected presence/partial presence of the following items: patient’s lack of insight into their mental disorder, violence risk or need for treatment (C item 1); violent ideation or intent (C item2); symptoms of mental disorder (C item 3); instability (recent problems with maintaining stable adjustment with respect to affective, behavioural or cognitive functioning, C item 4); and issues with compliance or responsiveness to/with intervention, management or supervision strategies (C item 5). As such, this acted as a meaningful measure ensuring that risk factors that were highly relevant to intervention and management were captured in the assessments

(Andrews, 2012). Likewise the Motivational Subscale on the SAPROF captured motivation for and attitude towards several aspects of treatment in the time prior to discharge, including items such as whether the individual deemed treatment to be necessary, whether they understood the need for their prescribed medication and had the motivation to take it, and whether they had the motivation to change their behaviour.

As this was the first time each patient was rated for the purpose of this research, the evaluation timeframe for C subscale and SAPROF dynamic items was the previous six months (in line with manual guidance (De Vogel et al., 2009; Douglas et al., 2008)). If the patient had been detained for less than six months prior to discharge, then the evaluation covered as much of the previous six months as possible. In addition to rating whether the C items were present at any time in the evaluation window, the manual instructs assessors to also consider whether the C item was present at time of evaluation (Douglas et al., 2008). For example, if during the six-month evaluation window a patient had active symptoms of psychosis in the first month, but had not shown them since, that patient received a rating that was pertinent to them, which indicated that the risk factor was present at some point during the evaluation period. Using this approach allowed capture of the trajectory of each risk factor over the evaluation timeframe (i.e. increasing, decreasing, fluctuating, or stable) and documentation of the nature of each risk factor for a given patient.

2.9.3 *Training and reliability*

Accredited training was provided in the application of each assessment measure via the Manchester Forensic Academy, and certificates for each were obtained prior to data collection. Whilst this was an independent PhD study, it was important to ensure the tools were being reliably used for the purpose of this investigation. Therefore data were extracted from 10 patient test cases and used to rate the HCR:20V3, SAPROF, and MSRAG assessments. Results were compared to those of 4 other forensic psychiatry researchers within the University of Manchester's Centre of Mental Health and Safety, producing an overall inter-rater reliability score for each measure and subscale (see Table 2.6). Any areas of discrepancy were addressed prior to the commencement of data collection and clinical colleagues provided ongoing advice if there was any uncertainty around how to score an item for a particular patient. Due to no other member of the accessible research network having used the PCLR: SV for a clinical records based investigation previously, inter-rater reliability could not be assessed for this measure. As such, special attention was given to the appropriate use of this tool with clinical supervisors.

Table 2.6. Inter-rater reliability for 5 researchers

Measure	Reliability score
HCR-20: v3	
Historical	.930
Clinical	.991
Risk management	.994
Total	.989
SAPROF	
Internal	.978
Motivational	.996
External	.889
Total	.988
MSRAG	
Acquisitive	.996
Serious offending	.942
Total	.975

2.9.4 Data extraction

The data collection proforma was used to record clinical data extracted from patient medical records. The medical records of each participant were accessed via the NHS healthcare provider. The formatting of medical records varied across the medium secure units. Most medical records were held in electronic form using systems such as RiO, PARIS or Paragon. Some units used both electronic notes and paper notes held in files, and some services kept paper records only.

Data extraction using paper clinical records took a substantial amount of time due to not all of the required documents being readily accessible or as a result of apparently disorganised record keeping. In some cases this caused delays in extraction whilst documents were sought or recalled from historical archives. However data extraction using electronic was less time consuming and could be conducted efficiently using key search terms for specified information and required documents.

Types of documents accessed for the purpose of data extraction included:

- Daily nursing and clinical staff records of patient observations
- Admission assessments
- Psychiatric and psychological assessments and reports
- Psychiatric reports prepared for courts
- Mental Health Act documentation (including remission warrants)
- Mental Health Review Tribunal documentation
- Standardised assessment tools⁴
- Police National Computer records
- Section 117 meeting documentation
- Discharge summaries

When using medical records as a study data collection source there is no guarantee that all required information will be available and the quality of reporting also cannot be guaranteed. However, due to the prospective nature of the study any missing information or discrepancies were cross-checked with administrators and clinicians who cared for the patient or had access to additional records not held on the patient's medical file.

Whilst data extraction from medical records in this case was reliable for risk factors and other historical information, the dynamic items of the HCR: 20 v3, and SAPROF could not be completed using medical records alone. These items require an in-depth evaluation of the patient's presentation preceding discharge from medium secure services, and therefore it was deemed necessary to also collect data from collateral informants who had worked closely with the patient prior to discharge. This was also the case for the PCL: SV. Whilst this is a measure of lifetime prevalence of the assessed personality traits, reliance on medical records alone to assess these traits inevitably meant that some information was difficult to obtain. As such, collateral information was also obtained to score this measure.

⁴ For most patients clinically-rated copies of the HCR:20 (predominantly version 2) were available for review. These were accessed when vital historical information could not be traced within medical records or as a tool to cross-check information. However, the dynamic Clinical and Risk items from this tool were not accessed or used to complete the researcher-rated HCR:20 v3 dynamic items to ensure that the process was standardised and was not influenced by clinicians' judgements.

2.9.5 *Collateral informant interview schedule*

Collateral informant interview schedules were devised to include the Clinical and Risk items of the HCR20v3, and each item of the SAPROF and the PCL-SV (see Appendix H). A range of response options were available and the informant provided a rating for each item based on their knowledge of the patient 6 months prior to discharge. Staff members were asked questions regarding the patient's presentation during the 6 months prior to discharge and the measures were scored based on the details they provided. This yields a more detailed overview of the patient's presentation compared to if staff were asked to assign a value to each item themselves. For example; rather than requesting staff to score whether Empathy is 'not present' (0), 'partially present' (1) or 'clearly present' on the SAPROF, staff members were asked questions such as; "did the patient seem to empathise with others/potential victim?", "was the patient able to consider how their behaviour impacts on others?", "did the patient seem to care about others?", etc. and the item was scored dependent on the responses provided. Interview schedules were designed to last no more than 30 minutes to limit demand on staff time.

Where possible, the informant was the patient's Named Nurse to ensure that the most accurate and up to date information could be attained. When these professionals could not be accessed, informants were Care Coordinators or Responsible Clinicians. For the most part data obtained from informants was judged to be of good quality, in that informants expressed confidence when answering the questions posed and required little clarification or prompting. As such in these cases dynamic risk assessment items could be rated using collateral accounts in conjunction with information obtained from medical records. Where clinicians felt unable to provide the required information, further clarification was sought from subsequent informants. If there was not sufficient evidence to rate a dynamic risk item using collaborative information obtained from records and informants, items were omitted as described in section 4.6.1.

2.10 Procedure

The study was conducted concurrently at each of the 33 medium secure units. This was challenging practically but necessary to ensure a full population cohort was studied.

2.10.1 *Approvals and link person*

Individual unit approval was sought from clinical directors and research leads at each of the 33 medium secure units. Gaining approval involved providing each clinical director with a breakdown

of the study and an outline of the assistance required to establish the study at their site. Clinical directors were asked to nominate a link person to act as a point of contact throughout the baseline period of the study. Link people were required to have access to patient admission, referral and discharge information and capacity to keep in regular contact for the purpose of discharge notification. Link people were asked to provide contact details for each ward manager within the medium secure service. Ward managers were briefed about the project and informed that their ward may be contacted over the 6 month baseline period to request for a member of clinical staff to act as collateral information with regards to a discharged prisoner-patient. Link people varied in terms of profession and grade. Most link people belonged to the administrative or research department within the medium secure service but some clinicians also agreed to take on the role (see Appendix I).

2.10.2 Discharge notification procedure

A discharge notification procedure was developed with each link person. In the majority of sites, this included updates via nhs.net email of planned and actual discharges of prisoner-patients on a fortnightly basis, to ensure that baseline assessment was completed within two weeks of discharge from medium secure services. When providing notifications, link people provided the patient's name, discharge date, discharge destination, and name of the patient's 'named nurse' / care coordinator prior to discharge. Where named nurse information was unavailable, respective ward managers were contacted to nominate an appropriate member of staff to take part in the interview. The notification period commenced on 1st May 2014 and lasted for 6 months, up until 31st October 2014.

2.10.3 Data collection

Multiple site visits were conducted at each of the 33 medium secure units for the purpose of data collection. Completion of data collection proformas was informed by a full clinical case-note review and a structured interview with a clinical collateral informant.

Case-note reviews were conducted in person at each Trust site and reviews took approximately three hours each to complete. During the first stages of the case-note reviews, documents such as admission assessments, discharge planning documents, mental health tribunal reports, etc. were sought and used for initial data collection. Where there were gaps in information, further document sources were reviewed. For dynamic risk factors and relevant symptoms of mental

illness, day-to-day nursing observations during the 6 months prior to discharge were reviewed. Where there was insufficient information to score an item, items were omitted and final measures were adjusted in line with instructions in each assessment manual (see section 4.6.1 for an overview of omitted items).

Collateral informant interviews took place over the telephone, ideally within two weeks of the patient's discharge date, and were conducted at a time most convenient for the member of staff. Staff members were asked questions in regards to the patient's presentation during the 6 months prior to their discharge and the measures were scored based on the details they provided. Relevant information provided during the interview was noted down on the data collection document and informants were given the opportunity at the end of the interview to add any further information they deemed relevant. Following the interviews, collateral informant responses were reviewed and scores were assigned to each item according to the manual guidance for each assessment.

Responses from collateral interviews and case-note reviews were then combined to populate a final data collection proforma for each patient and subsequently entered into electronic databases held on SPSS version 22 (IBM Corp, 2013). See section 2.11 for description of statistical analysis used.

At this stage of the research patients' names, dates of birth and remittal prisons were also recorded to aid follow-up of prison remittals. Known pseudonyms (or aliases) for names and dates of birth were also documented at this stage, as use of pseudonyms in populations of this type has been documented as causing attrition issues and cause follow-up delays when trying to track patients (Vollm, Jamieson, and Taylor, 2006; Vollm, Jamieson, Gordon, and Taylor, 2002) Initial contact with remittal prison sites was made using this information to pre-empt the patients one year follow-up (see Chapter 9 for full methodology of the follow-up feasibility study).

2.10.4 *Missing data*

Across the individual background variables collected there was no missing data, however in some cases information necessary to adequately score items on the assessment measures was not present. In these instances assessment items were omitted and scale and subscale total adjusted in line with assessment manual guidance. See section 4.9 for a full description of items omitted.

2.11 Data analysis

Data were analysed using Statistical Package for the Social Sciences (SPSS) for Windows version 22 (IBM Corp, 2013). Data screening to check accuracy of data entry was conducted by viewing descriptive frequencies and cross-checking the data entered for 20% of cases ($n = 31$) selected at random. Descriptive data and frequencies were used to describe the characteristics of the sample (legal status, socio-demographic clinical and criminological) and participant scores on the validated violence risk assessment tools. To identify any significant differences between community discharges and prison remittals the Mann-Whitney U Test⁵ was used for continuous variables and the Chi-squared Statistic used for dichotomous variables, across participant characteristics and risk assessment tool scores. Effect sizes are reported for Mann Whitney tests and relative risk for Chi-squared analyses.

2.12 Chapter summary

This chapter has provided an overview of the mixed methodological approach adopted throughout this thesis, alongside an in-depth description of the national prospective cohort design used in Study 1. Findings for Study 1 are presented in the following chapter (Chapter 3). Methodology for Studies 2 and 3 are described in Chapters 4 and 6, respectively.

⁵ Continuous variables were tested for normality using the Shapiro-Wilk test of normality across community discharges and prison remissions. Deviations from normality were observed for all study variables including violence risk assessment tool totals and subtotals (see Table A2 and A3 in Appendix Q) and non-parametric Mann-Whitney U tests were therefore conducted to assess median difference between community discharges and prison remissions across continuous variables.

Chapter 3

Results 1 a Prisoner-patient pathways through medium security

This Chapter provides a national overview of prisoner-patient criminal, legal and care pathways through medium secure care; from transfer into medium secure services from the prison estate, to discharge into the community / remission to prison. The information gathered below was extracted from patient clinical case files. Mental Health Act Administrators were contacted for supplementary information where a patient's legal status was unclear. Discharge circumstances were extracted from patient discharge summaries, warrants, and Mental Health Act documentation. Where reason for discharge was unclear, Responsible Clinicians were also contacted for clarification.

Data are summarised in Tables 3.2 to 3.6; with description in text. The tables present findings for all prisoner-patient discharges from medium secure services over the 6 month baseline period. Findings are explored and presented under 4 distinct headings;

- Prisoner-patient discharges
- Legal status – admission and baseline
- Legal status – community discharges
- Discharge circumstances

3.1 Prisoner patient discharges

A total of 243 prisoner-patients were discharged from medium secure services between May 2014 and October 2014 (see Table 3.1). Of these, 153 were eligible for inclusion. Fifty-seven (37%) were discharged into the community and 96 (63%) were remitted to prison.

Table 3.1 Prisoner-patients discharged from 33 medium secure services between May 2014 and October 2014

Discharge destination	N (%)
<i>Included destinations</i>	
Prison	96 (39)
Community	57 (23)
<i>Excluded destinations</i>	
Low secure unit	46 (19)
Medium secure unit	15 (6)
High secure unit	7 (3)
Non-secure mental health unit	11 (4)
Deported	5 (2)
Other	6 (2)

Figure 3.1 presents eligible discharges across the 33 medium secure services.

Community discharges and prison remittals from 33 medium secure services across a 6 month period.

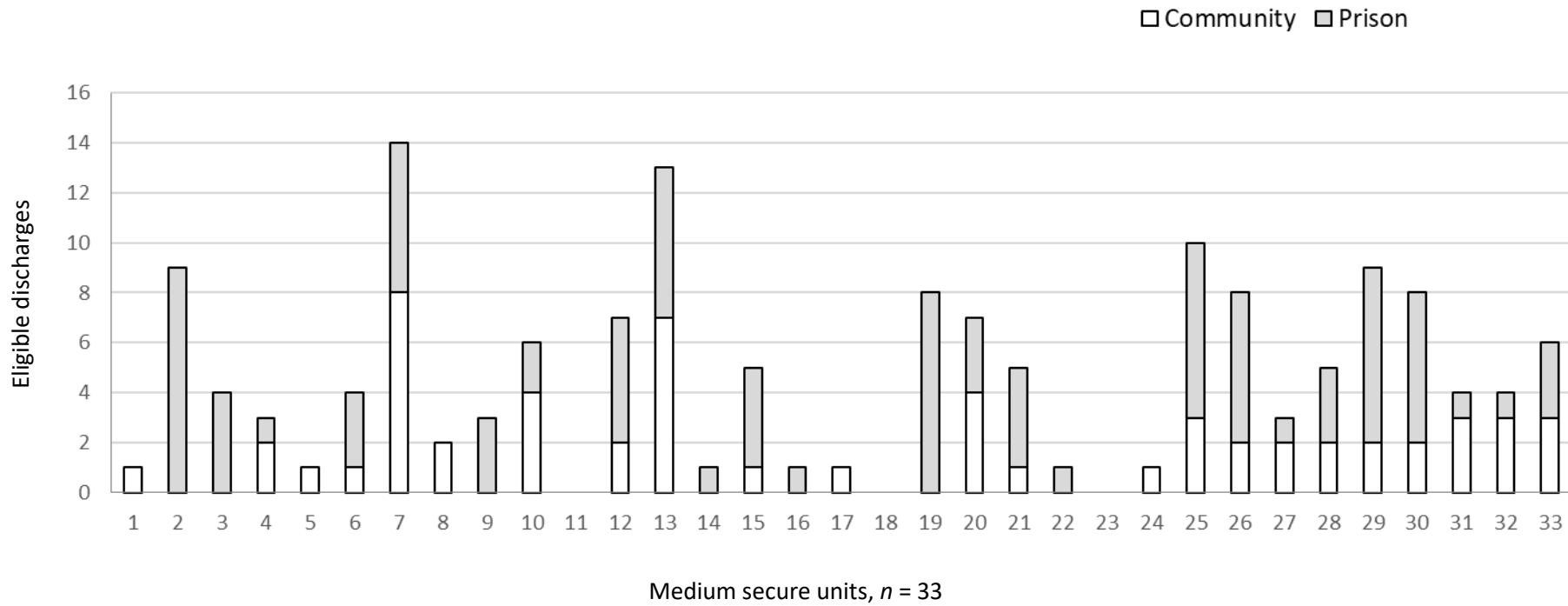


Figure 3.1: Eligible prisoner-patient discharges from 33 medium secure services

3.2 Legal status

The clinical and legal pathways through medium secure services for prisoner-patients were complex. Therefore in order to establish and document key criminal and clinical decisions, prisoner-patient legal status and any changes throughout their admission and discharge were extracted. For the purpose of this study, '*legal status*' is defined as the participants Criminal Justice System (CJS) status (sentenced / remand/ pre-sentence) and their corresponding detention status under the Mental Health Act 1983 (MHA) (the section the patient was subject to).

Legal status was recorded for the four following time points during the participant's detention in medium secure services;

- Legal status at time of admission ($n = 153$)
- Legal status at baseline (immediately prior to discharge, $n = 153$).
- Legal status change during the participant's detention in medium secure services between admission and baseline status (e.g. changes to CJS and MHA status, $n = 47$).
- Legal status after discharge into the community ($n = 57$)

3.3 Legal status – admission and baseline

3.3.1 Sentenced

The majority of patients were sentenced at time of admission ($n = 89$, 58.2%) and were either;

- Serving a custodial sentence (s. 47/49, $n = 81$) or were;
- Subject to a Hospital Treatment Order directed by the courts at sentencing ($n = 8$).

Sixty-nine of those serving a custodial sentence (s. 47/49) remained so up until baseline;

- Three were discharged into the community at sentence expiration
- 66 were remitted to prison to complete their sentence.

Twelve of the patients serving a custodial sentence completed their sentence during detention in medium security;

- Ten remained detained on a Notional Hospital Treatment Order (s. 37N); 9 were discharged into the community and one was remitted to prison subject to an Immigration Removal Order.
- One patient had a pre-existing Hospital Restriction Order for Treatment with restrictions (s. 37/41) reinstated at baseline following sentence expiration and the other became subject to the same order following appeal of an Imprisonment for Public Protection (IPP) sentence. Both were conditionally discharged into the community.

The 8 participants subject to a Hospital Treatment Order directed by the courts at sentencing were all discharged into the community following treatment.

- One patient detained under s. 37 at admission was detained under a civil section 3 for Treatment prior to discharge.

3.3.2 *Remand / pre-sentence*

Sixty-four (41.8%) patients were admitted whilst on remand waiting for trial (s. 49/49, $n = 47$; s. 35, $n = 5$; s. 36, $n = 2$) or subject to an Interim Hospital Order awaiting sentencing (s. 38, $n = 10$).

Of these, 27 received sentences during their detention (between admission and baseline);

- Four received Hybrid Hospital Orders (s. 45A) and were remitted to prison to complete their sentence following treatment, and
- Twenty-one received a Hospital Treatment Order directed by the courts at sentencing and were discharged into the community following treatment (s. 37/41, $n = 11$; s.37, $n = 10$). One patient subject to s. 37 was an informal patient prior to discharge.
- The remaining 2 patients became subject to an Interim Hospital Order prior to sentencing (s. 38); one received a custodial sentence and was remitted and the other a community sentence and was discharged.

Four patients subject to an Interim Hospital Order (s.38) at admission received custodial sentences at baseline and were remitted to prison on that date, one was re-remanded to prison and one bailed into the community.

Twenty-five participants remained as remand status throughout their detention (s. 35, $n = 4$; s. 36, $n = 1$; s. 48/49, $n = 20$ (one s.48/49 changed to s. 35 prior to baseline)); 19 were remitted to prison and 6 discharged into the community.

Six participants detained under s. 48/49 at admission became subject to a civil section under section 3 for Treatment during detention, and were discharged into the community, one of these had informal status patient prior to discharge.

Table 3.2 presents participant legal status at both admission to medium secure services and at baseline for both community discharges and prison remissions.

Table 3.2. Legal status at admission and at baseline assessment

Section at admission	Discharge destination		Overall (n, %)
	Community	Prison	
Sentenced			
s. 37	6	-	6 (3.9)
s. 37/41	2	-	2 (1.3)
s. 47/49	14	67	81 (52.9)
Remand / pre-sentence			
s. 35	1	4	5 (3.3)
s. 36	1	1	2 (1.3)
s. 38	3	7	10 (6.5)
s. 48/49	30	17	47 (30.7)
Section at baseline			
Sentenced			
s. 37n	9	1	10 (6.5)
s. 37	14	-	14 (9.2)
s. 37/41	15	-	15 (9.8)
s. 45a	-	4	4 (2.6)
s. 47/49	3	66	69 (45.1)
Remand / pre-sentence			
s. 35	-	5	5 (3.3)
s. 36	-	1	1 (0.7)
s. 38	2	6	8 (5.2)
s. 48/49	6	13	19 (12.4)
Civil			
s. 3	6	-	6 (3.9)
Informal	2	-	2 (1.3)

See Table 3.3 for a cross tabulation of legal status at admission and baseline for both community discharges and prison remissions.

Table 3.3 Legal status at admission and baseline from medium secure services for prison remissions and community discharges *

Discharge destination	Legal status at baseline	Legal status at admission							Total
		Sentenced			Remand / pre-sentence				
		s. 37	s. 37/41	s. 47/49	s. 35	s. 36	s. 38	s. 48/49	
Prison remissions	Sentenced								
	s. 37n	-	-	1	-	-	-	-	1
	s. 45a	-	-	-	-	-	2	2	4
	s. 47/49	-	-	66	-	-	-	-	66
	Remand/ pre-sentence								
	s. 35	-	-	-	4	-	-	1	5
	s. 36	-	-	-	-	1	-	-	1
	s. 38	-	-	-	-	-	5	1	6
s. 48/49	-	-	-	-	-	-	13	13	
Community discharges	Sentenced								
	s. 37n	-	-	9	-	-	-	-	9
	s. 37	5	-	-	-	1	1	7	14
	s. 37/41	-	2	2	1	-	1	9	15
	s. 47/49	-	-	3	-	-	-	-	3

Remand / pre-sentence								
s. 38	-	-	-	-	-	1	1	2
s. 48/49	-	-	-	-	-	-	6	6
Civil								
s. 3	1	-	-	-	-	-	5	6
Informal	-	-	-	-	-	-	2	2
Total	6	2	81	5	2	10	47	153

**For 4 participants multiple legal status changes during detention in medium secure services were observed, these are not included in this table but are represented in Fig 2 and Fig 3.*

3.4 Legal status – community discharge

Over half of the community discharges ($n = 30$, 52.6%) were discharged liable to hospital recall or with a Mental Health Treatment requirement:

- Fifteen community discharges (26.3%) were discharged subject to a section. 41 restriction and 12 (21.5%) were discharged subject to a Community Treatment Order (CTO). As such these 25 community discharges (43.9%) were liable to hospital recall.
- Three community discharges (5.3%) were subject to a Mental Health Treatment Requirement (MHTR) as part of a court imposed Community Order.

Twenty-seven patients (47.4%) were discharged into the community without requirement to receive or continue with mental health treatment.

Twenty-one community discharges (36.8%) were discharged into accommodation which was staffed with mental health Support Workers, 10 (17.5%) were discharged to bail hostels and 16 (28.1%) to a family home or home shared with their partner. Seven (12.3%) were discharged to single occupancy accommodation and 3 (5.3%) had no fixed abode at discharge into the community.

Table 3.4 presents the post-discharge legal status and living circumstances for the 57 patients discharged into the community, according to legal status at baseline.

Table 3.4. Legal status at baseline (criminal and MHA) and circumstances post-discharge into the community (n = 57)

Section at baseline	Legal Status at community discharge			Living circumstances upon discharge				
	s. 41 Restriction	CTO	MHTR	Supported accom	Bail hostel	Family/partner	Single occ	NFA
Sentenced								
s. 37	-	7	-	3	1	7	3	-
s. 37n	-	2	-	6	1	1	-	1
s. 37/41	15	-	-	7	6	1	1	-
s. 45a	-	-	-	-	-	-	-	-
s. 47/49	-	-	-	1	1	1	-	-
Remand/ pre-sentence								
s. 35	-	-	-	-	-	-	-	-
s. 36	-	-	-	-	-	-	-	-
s. 38	-	-	1	-	-	2	-	-
s. 48/49	-	-	2	-	-	3	1	2
Civil								
s. 3	-	3	-	2	1	1	2	-
Informal	-	-	-	2	-	-	-	-

CTO = Community Treatment Order, MHTR = Mental Health Treatment Requirement, supported accom = supported accommodation,

Single occ = Single occupancy accommodation; NFA = No fixed abode

3.5 Discharge circumstances

For the purpose of this study ‘discharge circumstance’ refers to whether participants were discharged under the powers of their Responsible Clinician, due to other powers within the Mental Health Act 1983, or due to criminal court proceedings. Whether the latter two circumstances were in accordance with clinical recommendations is also presented.

3.5.1 Community discharge circumstances

Twenty-three of the sentenced participants at baseline were discharged into the community under the powers of their Responsible Clinician after completing treatment, whereas 18 were discharged into the community under powers within the Mental Health Act 1983, with the support of their Responsible Clinician; four by the Parole Board, 13 by Mental Health Review Tribunals, two by Hospital Managers Hearings and one by their Nearest Relative.

Eight remand participants at baseline were discharged into the community due to criminal court proceedings. Seven of these were recalled to court; five were sentenced and one was bailed into the community to await trial. One remand participant had criminal charges dropped whilst detained in medium sure services and was discharged into the community. All eight were in accordance with clinical recommendations.

Five of the civil participants at baseline were discharged into the community under the powers of their Responsible Clinician after completing treatment, whereas three were discharged into the community due to other statute within the Mental Health Act 1983, with the support of their Responsible Clinician; two by Mental Health Review Tribunals one by their Nearest Relative.

Table 3.5 presents discharge circumstances for community discharges according to legal status at baseline.

Table 3.5. Discharge circumstances by section at baseline for community discharges (n = 57)

Section at baseline	RC	Other MHA				Court proceedings		
	Treatment complete	Parole Board	MHRT	HMH	NR	Recall – sentenced	Recall – bailed	Charges dropped
Sentenced								
s. 37	11	-	2	1	-	-	-	-
s. 37n	4	1	2	1	1	-	-	-
s. 37/41	7	1	7	-	-	-	-	-
s. 47/49	1*	2	-	-	-	-	-	-
Remand / pre-sentence								
s. 38	-	-	-	-	-	1**	1	-
s. 48/49	-	-	-	-	-	4***	1	1
Civil								
s. 3	3	-	2	-	1	-	-	-
Informal	2	-	-	-	-	-	-	-

RC = Responsible clinician discharge; MHA = Mental Health Act; MHRT = Mental Health Review Tribunal discharge; HMH = Hospital Manchester Hearing discharge; NR = Nearest Relative discharge

* Patient presented as delusional in prison but symptoms resolved upon admission to MSU

** Community sentence

*** 2 community sentence, 1 suspended sentence and 1 time served whilst on remand

3.5.2 *Prison remittal circumstances*

Seventy of the sentenced participants at baseline were remitted to prison under the powers of their Responsible Clinician. For 38 sentenced participants this was after completing treatment; 27 were remitted to complete their sentence (one of these patients was considered appropriate for discharge into the community yet the Responsible Clinicians request was refused by the Secretary of State), six due to request of the patient), three to await deportation and three to await transfer to a Psychologically Informed Therapeutic Environment. Seven sentenced participants were remitted due to the clinical team not detecting evidence of severe mental illness or symptomatology which would warrant detention in medium secure services. The remaining 25 sentenced participants were remitted to prison due to not engaging with treatment/therapy ($n = 15$) or due to presenting as too 'high risk' to continue to be detained in the medium secure service ($n = 10$). One sentenced participant was remitted to prison under the powers of an Immigration Removal Order in opposition to clinical opinion.

Twelve of the remand patients at baseline were remitted to prison under the powers of their Responsible Clinician. For six remand participants this was after completing treatment; four were remitted to await trial and two to await deportation. Two of the remand participants were remitted to prison due to not engaging with treatment/therapy and two due to the clinical team not detecting evidence of severe mental illness or symptomatology which would warrant detention in medium secure services. The remaining 15 remand participants were remitted to prison due to criminal court proceedings (13 with the support of their Responsible Clinician); 11 were remitted due to receiving custodial sentences at court and four were re-remanded by the courts to await trial (for two of these patients this was in opposition to clinical opinion).

Table 3.6 presents discharge circumstances for prison remissions according to legal status at baseline.

Table 3.6. Discharge circumstances by section at baseline for prison remissions (*n* = 96)

Section at baseline	Responsible clinician							Court proceedings		
	Treatment complete				Engagement / risk issues		Other	Recall		
	Complete sentence/ await trial	Patient request	Await deportation	Await PIPE	Not engaging	High Risk	No SMI	Sentenced custodial	Re-remanded	IM Order
Sentenced										
s. 37n	-	-	-	-	-	-	-	-	-	1
s. 45A	4*	-	-	-	-	-	-	-	-	-
s. 47/49	22**	6	3	3	15***	10	7	-	-	-
Remand / pre-sentence										
s.35	-	-	-	-	-	-	-	3	2****	-
s. 36	-	-	-	-	-	-	-	-	1	-
s. 38	-	-	-	-	-	-	-	5	1*****	-
s. 48/49	4	-	2	-	2	-	2	3	-	-

PIPE = Psychologically Informed Therapeutic Environment; SMI = severe Mental Illness; IM = Immigration Removal

- * One 45A was considered fit for community discharge by their Responsible Clinician (has a previous 37/41) but Secretary of State refused and they were therefore remitted
- ** Eight of these returned to complete the work needed to apply for parole and seven were documented as close to their Earliest Release Date
- *** One patient was remitted as the service were not able to provide the right setting to meet their needs and one patient was documented as close to their Earliest Release date
- **** For one patient the court decision was in opposition to clinical opinion
- ***** This court decision was in opposition to clinical opinion

3.5.3 Summary diagrams

The three figures below present the discharge pathways for prisoner-patients who were discharged into the community or remitted to prison. The figures are split by criminal legal status, with prisoner-patients who were sentenced prisoners at time of admission included in Figure 3.2. Figures 3.3 and 3.4 include prisoner-patients who were on remand/pre-sentence at time of admission. Figures are organised into patients who were detained under hospital orders at time of admission and patients who were transferred for treatment under Sections 47/49 and 48/49. Section changes during admission, discharge circumstances and legal status at discharge for those discharged into the community are also included. Table 3.7 provides details for acronyms used within the figures.

Table 3.7 Reference table for discharge reason acronyms

MHR Tribunal	Discharged by Mental Health Review Tribunal
MH Hearing	Discharged by Hospital Managers Hearing
R Clinician	Discharged by the Responsible Clinician
Parole Board	Discharged by Parole Board
N Relative	Discharged by Nearest Relative
IR Order	Discharged due to being subject to an Immigration removal Order
ER Date	Discharged as it is the prisoners earliest release date
Treated	Discharged due to completing treatment
Not engaging	Discharged as not engaging with therapy/treatment
Risk	Discharged as patient is too high risk to be managed in medium security
No SMI	Discharged as no diagnosis or current symptomatology to warrant stay
Sent Custodial	Discharged due to receiving a custodial sentence
Sent community	Discharged due to receiving a community sentence
CT Order	Discharged subject to a Community Treatment Order
s. 41	Discharged subject to a s.41 restricted
MHT Requirement	Community sentence includes A Mental Health Treatment Requirement

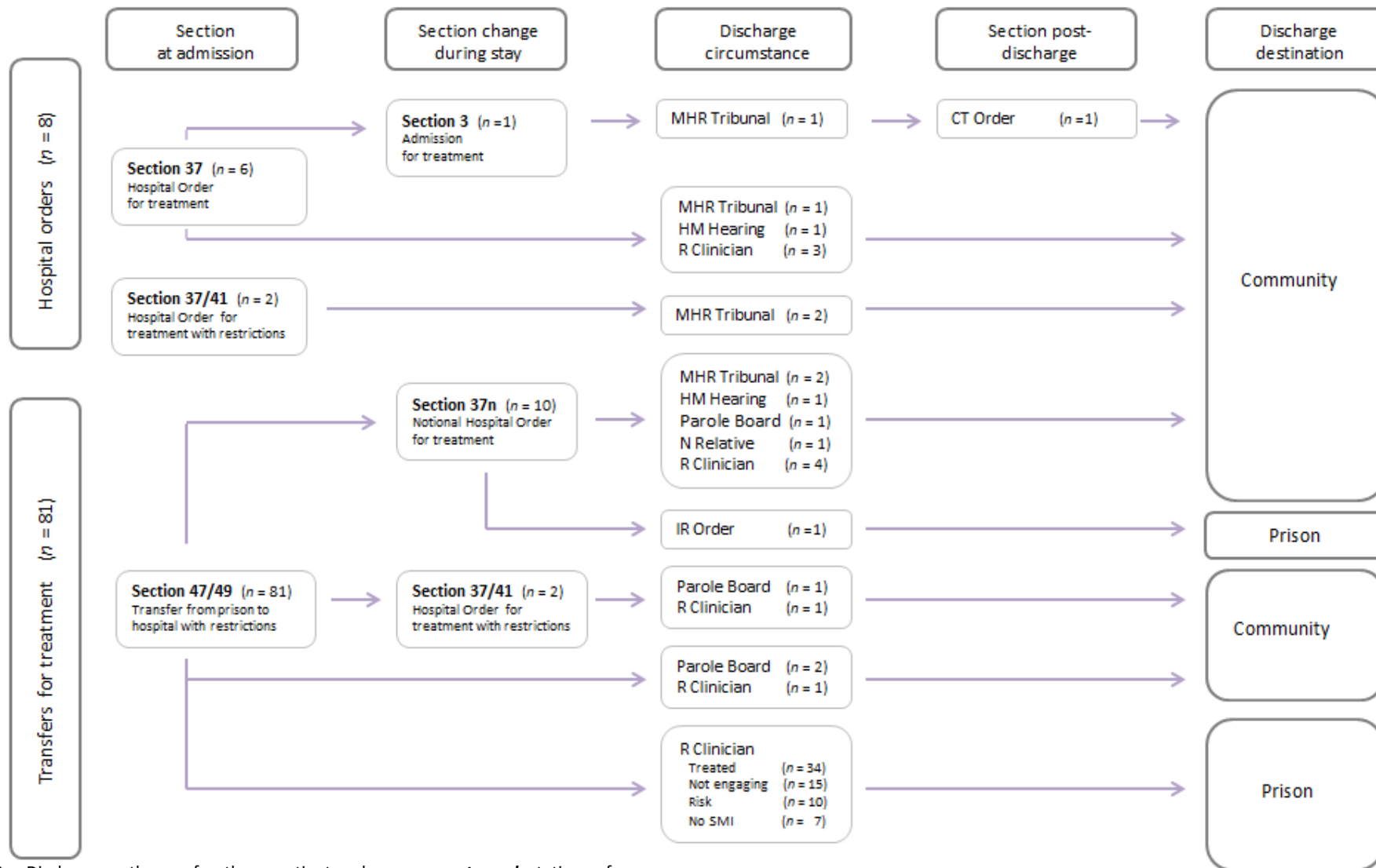


Figure 3.2: Discharge pathways for those patients who were *sentenced* at time of admission to medium secure services from prison services, including sentenced hospital orders and transfers for treatment.

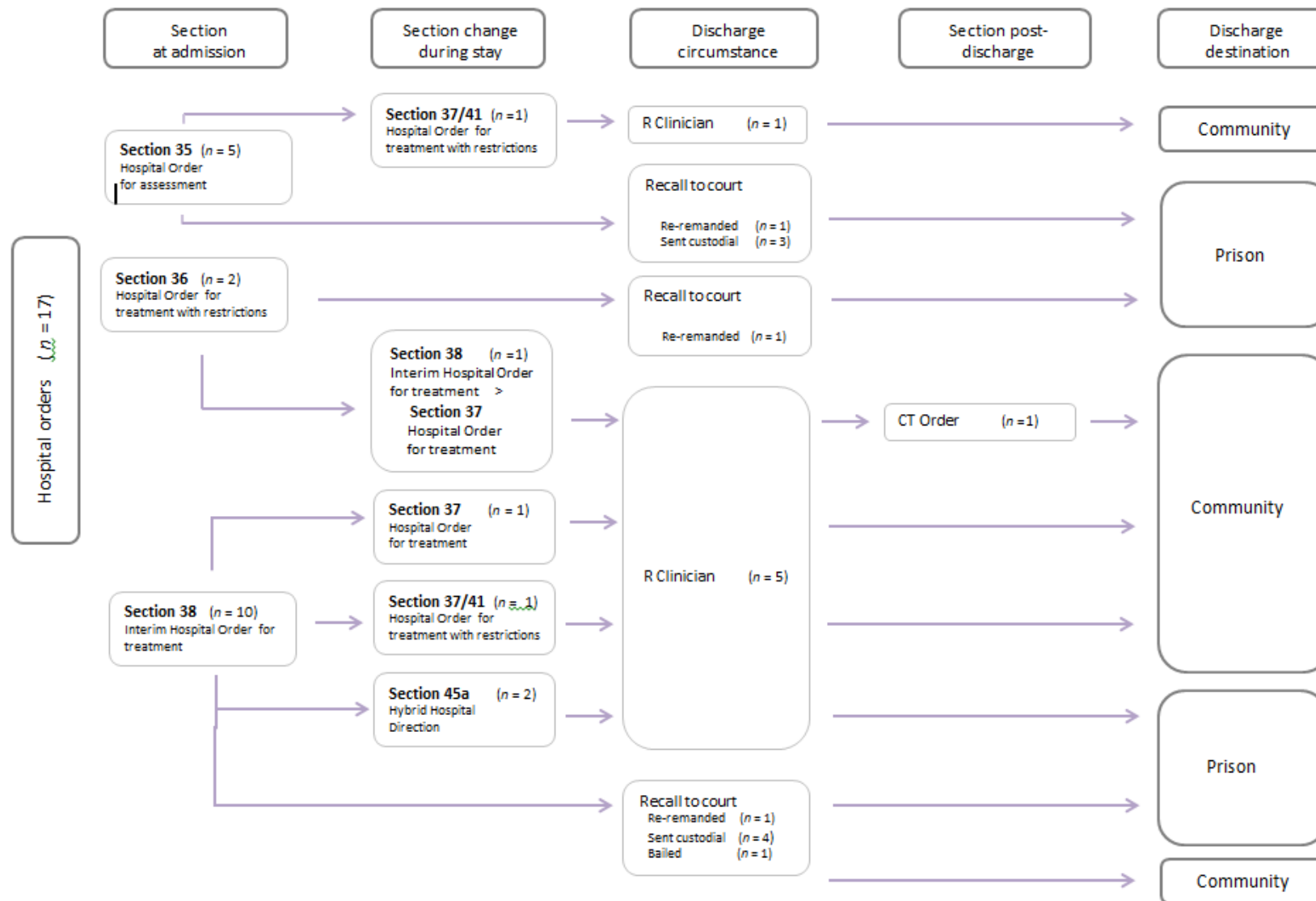


Figure 3.3: Discharge pathways for those patients who were on *remand* at time of admission to medium secure services from prison services – hospital orders

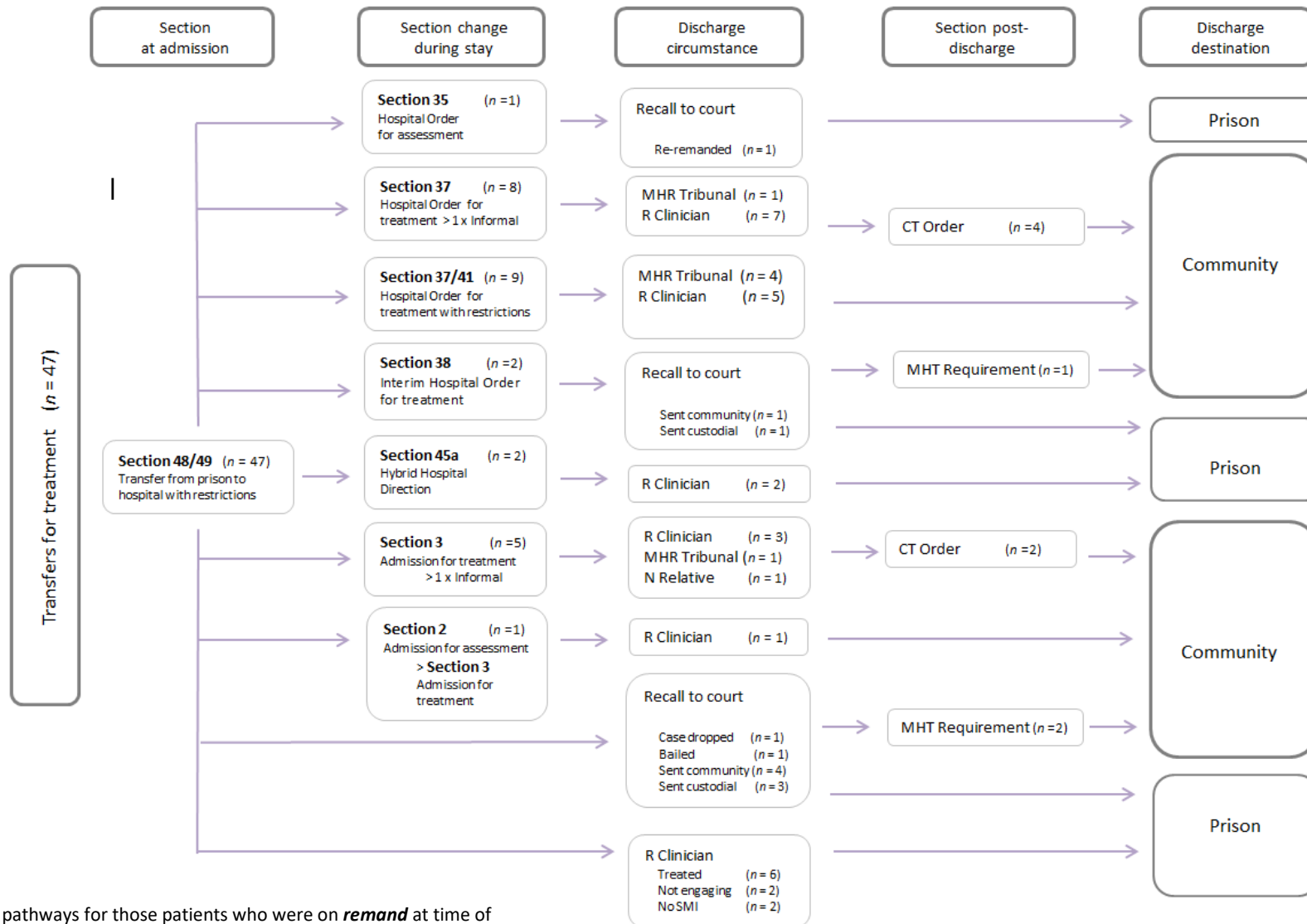


Figure 3.4: Discharge pathways for those patients who were on *remand* at time of admission to medium secure services from prison services - transfers for treatment.

3.6 Chapter summary

This chapter has provided insight into the legal and clinical pathways through medium secure services, for prisoner-patients who are remitted to prison or discharged into the community. There were 256 prisoner-patients discharged over the 6 month baseline period, 153 of whom were eligible for inclusion in Study 1, Part a.

3.6.1 *Community discharges*

Over half of community discharges were remand prisoners at admission to medium secure services (n = 35, 61%), and criminal court proceedings directed the discharge pathway for 20 of these patients (all received section 37 hospital treatment orders at court disposal, 11 with restrictions). The remaining remand prisoners received non-custodial sentences, were bailed into the community or had the charges against them dropped at court recall during their admission. Therefore remittal to prison following treatment was not a discharge pathway option for any of these patients on date of discharge. This was also the case for nine of the community discharges who were sentenced at time of admission. These patients had remained detained in the medium secure service beyond their sentence expiration and became notional hospital orders (two were reverted to a Section 37/41 restriction order). There were just three community discharge patients who were eligible for both community discharge or prison remittal at time of discharge. These were sentenced prisoners at admission and remained in medium secure services up until their earliest release date when they were discharged; two via the Parole Board and one by their Responsible Clinician. The final eight community discharges were those admitted to medium secure services under Hospital Treatment Orders and therefore their discharge via a community pathway was pre-determined at time of admission.

3.5.2 *Prison remittals*

Twenty-nine of the prison remittals were remand prisoners/pre-sentenced at admission to medium secure services. For 19 of these, a community discharge pathway was not an option due to criminal court decisions during their admission⁶, whereas the remaining 10 were remitted solely at the discretion of their responsible clinician⁷.

⁶ Criminal court decisions 4 x 45A Hybrid Hospital Orders (1 of these was in opposition to clinical opinion), 11 x custodial sentences, 4 x re-remanded prior to sentencing (2 of these were in opposition to clinical opinion)

⁷ Responsible clinician discharge: 6 x completed treatment (2 x deportation), 2 x not engaging, 2 x no SMI).

The majority of prison remittals were sentenced prisoners at admission ($n = 67$, 74%), three of whom could only be remitted to prison as they were awaiting deportation, and one other was removed via an Immigration Removal Order against the responsible clinicians wishes. However the remaining sentenced patients were remitted solely at the discretion of their Responsible clinician. Thirty-four patients were remitted to complete their sentence following treatment. For some of these patients, a community discharge pathway would not have been an option at time of discharge as a result of their s.49 restriction order, especially if they had a particularly lengthy sentence tariff left to complete. Remaining in medium secure services beyond this point for these patients might have taken up valuable beds that could otherwise be used for other prisoners requiring transfer. However 16 of these remitted patients were documented as working towards parole or close to their earliest release date at time of discharge. It is unclear why these patients were remitted so close to expiration of their sentences, when others were released from the medium secure unit directly into the community on their earliest release date, or remained detained on hospital treatment order post sentence expiration. It might be that remittal to prison is considered a quicker route into the community for these patients, as patients are often required to prove stability over a longer period of time before community discharge whereas prison remittal does not (Doyle et al., 2014). However, whilst a speedier discharge may be preferable from the patient's perspective, it is concerning that those remitted may not receive the equivalent aftercare arrangements following prison release, that they would when discharged from medium secure services.

Seven sentenced prisoners were remitted due to the service not detecting evidence of severe mental illness or symptomatology that would warrant detention in medium secure services. However, the final 25 sentenced patients were remitted due to not engaging with treatment on the unit ($n = 15$) or for being too high risk to remain within the service ($n = 10$). It is unclear why these patients, along with the two non-engaging remand remittals, were remitted on these grounds, given that discharge into the community from medium secure services of non-engaging high risk patients would be highly unlikely. This indicates that different factors may be taken into account depending on a prisoner-patients discharge destination. It might be that in these instances prison is considered to be a safe place (Doyle, et al., 2014), although it is currently unclear how these patients will be managed post-remittal and what targeted resources are available.

3.6.3 *Conclusions*

The objective of Study 1, Part a) was to describe and explore the legal pathways of prisoner-patients admitted to medium secure services and their reasons for discharge. However, as a subsidiary aim, this descriptive data also allowed for identification of which discharges are appropriate for comparative analysis of characteristics across community discharges and prison remittals (Study 1, Part b). The purpose of the comparative analysis is to gain insight into which characteristics are associated with each discharge destination (community vs. prison), and therefore may have the potential to influence clinical pathway/discharge decisions. For the analysis to be meaningful, only those prisoner-patients whose pathway was under the instruction of, or in agreement with the Responsible Clinicians recommendations were included. Likewise, the analysis also included only those prisoner-patients whose discharge pathway was not pre-determined at time of admission.

Whilst a number of patient discharge pathways from medium secure services were directed by criminal court decisions during their admission to some degree, all of these decisions were made with the support of the patient's Responsible Clinician, who will have provided medical reports in regards to the patient's suitability for hospital treatment orders, release into the community from court, or hybrid hospital orders. Likewise, regardless of any pathway restrictions, all decisions around suitability and timing of discharge were made by the patient's Responsible Clinician. As such, these prisoner patients were included in the comparative analysis.

See section 4.1 for details of included and excluded prisoner patients on this basis.

Chapter 4

Results 1 b Factors associated with discharge destination:

all prison-patients irrespective of their diagnosis

This chapter provides an overview of the characteristics of a population of prisoner- patients who were discharged from medium secure services.

Comparison of findings across community discharges and prison remittals was made to gain insight into which characteristics are associated with discharge destination and therefore may have the potential to influence clinical team decisions, with regards to the discharge of prisoner-patients.

The study generated a large number of detailed clinical data that are summarised in Tables 4.3 to 4.23; with key findings described in text. The tables present findings for *all included* patients alongside findings according to discharge destination. Significant differences across discharge destination are discussed and summary diagrams of significant findings are presented in Figures 4.1 to 4.4.

Investigation of factors associated with discharge destination focused on socio-demographics, psychopathology, criminal history and risk factors.

Findings are explored and presented under 4 distinct headings;

- Demographics and length of stay
- Clinical characteristics
- Criminological characteristics , and
- Violence risk assessment tools prior to discharge

4.1 Inclusion and excluded prisoner-patient discharges

Findings are presented for those patients whose discharge from medium secure services was managed under the instruction of their Responsible Clinician, or whose Responsible Clinician was in agreement with their discharge subject to powers under the Mental Health Act 1983 / criminal court proceedings. Additionally, patients were required to be eligible for both community discharge and prison remittal at time of admission to medium secure services from prison. Therefore, those patients whose discharge destination was determined pre-admission from prison (i.e. subject to a hospital disposal from court) were not included for analysis. Twelve patients did not meet this criteria and were excluded (*community discharges* = 8, *prison remissions* = 4), leaving a total of 141 patients for inclusion in this analysis.

4.1.1 Community discharges exclusion

All discharges from medium security into the community were under the instruction of the Responsible Clinician or took place with the Responsible Clinicians agreement, including for those patients who were discharged following court recall or subject to other powers under the Mental Health Act 1983. Eight of these patients were admitted to medium security from prison after receiving a Hospital Treatment Order directed by the courts at sentencing. These patients were therefore excluded from the following as their discharge destination was determined pre-admission. Table 4.1 presents discharge circumstances for community discharges, highlighting the 8 patients excluded from the analysis and the 49 patients who were included.

4.1.2 Prison remittals exclusion

Ninety-two of the prison remissions were under the instruction of the Responsible Clinician or took place with the Responsible Clinician's agreement, including for 13 of those patients who were remitted following court recall. As this analysis aimed to examine which patient characteristics have the potential to influence clinical team decisions around discharge, four patients whose discharge was in disagreement with their Responsible Clinician's recommendations were excluded from the following analysis:

- Two of those patients who were re-remanded to prison following court recall were in opposition to the Responsible Clinician’s recommendations
- One patient was considered appropriate for discharge into the community by their Responsible Clinician yet this request was refused by the Secretary of State, resulting in remission back to prison.
- One patient was remitted to prison subject to an Immigration Removal Order in opposition to the Responsible Clinician’s recommendations.

Table 4.2 presents discharge circumstances for prison remissions and highlights the 4 patients excluded from the analysis who were remitted against the recommendations of the Responsible Clinician and the 92 patients included in for analysis.

Table 4.1 Inclusion / exclusion criteria for community discharges (*n* = 57)

	With RC agreement	Hospital order sentence at admission
Responsible clinician	25	3
MHA process		
MHRT	9	4
HMH	1	1
NR	2	-
Parole Board	4	-
Court recall		
Sentenced	5	-
Bailed	2	-
Charges dropped	1	-

RC = Responsible Clinician;
MHA = Mental Health Act
MHRT = Mental Health Review Tribunal discharge;
HMH = Hospital Manchester Hearing discharge;
NR = Nearest Relative discharge

Table 4.2. Inclusion / exclusion criteria for prison remissions (*n* = 96)

	With RC agreement	With RC disagreement
Responsible clinician	79	1 *
Court recall		
Sentenced	11	-
Re-remanded	2	2
IR Order	-	1

RC = Responsible Clinician ; IR Order = Immigration Removal Order

* 45A patient ready for discharge into the community but secretary of state declined

4.2 Demographics and length of stay

4.2.1 General demographics

The majority of the patients were male ($n = 132$, 94%), females represented only 6% ($n = 9$) of the sample and were less likely to be remitted to prison, than discharged into the community (2% vs. 14%, $p = .009$). Over half of the patients were of White ethnicity ($n = 87$, 62%), 18% ($n = 25$) were Black or Black British and 10% ($n = 14$) were Asian or Asian British. Patients with mixed ethnicity were least represented in the sample ($n = 7$, 5%). Median age at admission was 32 years (IRQ = 17) and baseline was 33 years (IRQ = 17). There were no significant differences for age or ethnicity observed across discharge destination (see Table 4.4).

4.2.2 Legal status

Over half of the sample were sentenced prisoners at baseline, ($n = 80$, 57%), as expected, these patients were 2.5 times more likely to be remitted to prison (72% vs. 29%, $p < .001$). Just under 20% of patients were subject to an 'Indeterminate Sentence for Public Protection' ($n = 26$, 18%). Patients detained under this prison sentence were almost 4 times more likely to be remitted to prison than discharged into the community (24% vs. 3%, $p = .008$)

4.2.3 Length of stay

At 224 days (IRQ = 426), median length of stay across the sample was below the recommended stay of 18 months - 2 years (Bradley 2009). This was the case for both discharge destinations, yet length of stay for prison remittals was significantly shorter (Mdn = 173.5 days, IQR = 367) than for community discharges (Mdn = 404.0 days, IQR = 830) $u = 1423.0$, $p < .001$.

The range of length of stay was similar across discharge destination (see Table 4.4), therefore data were organised into categories of 'more than two years' and 'less than two years' and across five categories with increments of 6 months (see Table 4.3) to identify other key differences in length of stay across discharge destination. The majority of patients stayed in medium secure services less than 2 years ($n = 116$, 82%); however those patients who stayed for '24 months plus' were 66% less likely to be remitted to prison (10% vs. 33%, $P = .001$).

Just under half of patients stayed in medium secure services for 6 months or less ($n = 61$, 43%), these patients were 2 times more likely to be remitted to prison than discharged into the community (53% vs. 25%, $p = .001$). There was no association between categories 6 - 12 months, 12 - 18 months and 18 - 24 months across discharge destination (See Table 4.3).

Table 4.3 Rate ratio comparisons of prison and community discharges - demographics and length of stay (*n* = 141)

	<i>n</i> (%)			χ^2	<i>p</i>	Rate Ratio (95% CI)
	Total	Community discharge	Prison remission			
Gender						
Males	132 (94)	42 (86)	90 (98)	7.48	.009	1.14 (1.01 - 1.29)
Female	9 (6)	7 (14)	2 (2)			
Ethnicity						
White	87 (62)	28 (57)	59 (64)	0.66	.416	1.12 (0.84 - 1.49)
Mixed	7 (5)	2 (4)	5 (5)	0.13*	1.00	1.33 (0.27 - 6.61)
Asian or Asian British	14 (10)	4 (8)	10 (11)	0.27*	.771	1.33 (0.44 - 1.03)
Black or Black British	25 (18)	12 (25)	13 (14)	2.35	.125	0.57 (0.29 - 1.17)
Other	8 (6)	3 (6)	5 (5)	0.03	.867	0.89 (0.22 - 3.56)
Length of stay (2 categories)						
0 – 24 months	116 (82)	33 (67)	83 (90)	11.46	.001	1.34 (1.09 - 1.65)
24 months plus	25 (18)	16 (33)	9 (10)			

Length of stay (5 categories)						
0 – 6 months	61 (43)	12 (25)	49 (53)	10.78	.001	2.18 (0.13 - 0.45)
6 – 12 months	32 (23)	13 (21)	19 (21)	0.63	.427	0.78 (0.42 - 1.44)
12 – 18 months	15 (11)	5 (10)	10 (11)	0.02	.903	1.07 (0.37 - 2.94)
18 – 24 months	8 (6)	3 (6)	5 (5)	0.03*	1.00	0.32 (0.08 - 1.28)
24 months plus	25 (18)	16 (33)	9 (10)	11.46	.001	0.23 (0.14 – 0.63)
Legal status						
Sentenced vs.	80 (57)	14 (29)	66 (72)	24.27	<.001	2.51 (1.58 – 3.98)
remand	61 (43)	35 (71)	26 (28)			
IPP	25 (18)	3 (6)	22 (24)	6.94	.008	3.91 (1.23 - 12.40)

IPP = Indeterminate sentence for Public Protection.

Table 4.4. Mann Whitney U comparisons of prison and community discharges - demographics and length of stay (*n* = 141)

	Median (IRQ) min – max			<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
	Total	Community discharge	Prison remission				
Length of stay	224 (426) 17 to 1912	404 (830) 21 to 1912	173 (367) 17 to 1822	1423.00	-3.559	<.001	.30
Age at admission	32 (17) 19 to 64	29 (22) 19 to 62	33 (15) 19 to 58	2171.50	-.357	.721	.03
Age at baseline	33 (17) 19 to 65	30 (21) 22 to 65	34 (15) 20 to 60	2220.00	-.147	.883	.01

4.3 Clinical Characteristics

4.3.1 Psychiatric diagnosis

Patients' primary diagnoses were coded as 8 distinct categories (See Table 4.5). The most represented diagnosis within the sample was schizophrenia ($n = 41$, 29%), followed by personality disorder ($n = 39$, 28%) and 'psychosis other' ($n = 19$, 14% (including; transient psychotic episode, drug induced psychosis, and first episode psychosis)). Schizoaffective disorder, bipolar affective disorder and 'other diagnosis' (including; obsessive compulsive disorder, anxiety and acquired brain injury) represented 6% ($n = 9$) of the sample each. Patients with a diagnosis of depression represented 6% ($n = 8$) of the sample and 5% ($n = 7$) had no psychiatric diagnosis at baseline (due to lack of evidence of illness during patient admission and assessment).

Patients who were remitted to prison were 4.6 times more likely to have a primary diagnosis of personality disorder than those discharged into the community (38% vs. 8%, $p < .001$). In contrast, patients with a primary diagnosis of schizophrenia were 48% less likely to be remitted to prison (23% vs. 41%, $p = .025$) and those with a primary diagnosis of 'psychosis other' were 69% less likely to be remitted to prison (8% vs. 25%, $p = .005$). There was no association between the other 4 primary diagnosis categories and discharge destination (see Table 4.5).

Patient primary diagnoses were also coded into 3 distinct diagnostic categories; severe mental illness (SMI), personality disorder and 'Other' to establish whether presence of an SMI diagnosis or an 'other', less severe diagnosis were associated with discharge destination. Patients with a diagnosis of SMI were 41% less likely to be remitted to prison (40% vs. 84%, $p < .001$) whereas patients with a diagnosis other than SMI or PD were 2.7 times more likely to be remitted to prison (22% vs. 8%, $p < .001$). More than a third of the sample had a historical diagnosis of conduct disorder in adolescence, ($n = 52$, 38%). Whilst this was true for a higher proportion of prison remittals, there was no statistical association between conduct disorder and discharge destination (See Table 4.5).

4.3.2 Co-morbid diagnosis

Just over a quarter of the sample had a documented co-morbid diagnosis ($n = 38$, 27%); community discharges had a higher proportion of patients with a co-morbid diagnosis yet there was no association with discharge destination. Whilst the most common co-morbid diagnosis was Personality Disorder ($n = 14$, 10%), there was no association with the presence of a co-morbid

Personality Disorder and discharge destination. This indicates that a diagnosis of personality disorder may only be associated with remittal to prison when it is a patient's primary diagnosis.

4.3.3 *Historical access to psychiatric services*

Patients' previous treatments within psychiatric services were extracted from case files to enable the psychiatric histories of prisoner-patients to be described. Age at first contact with psychiatric services ranged from age seven to 48 years. Median age at first psychiatric contact was 22 years (IQR = 12); this did not differ significantly across discharge destination (See Table 4.7).

Of particular note is the high number of patients with previous inpatient psychiatric admissions (both forensic and non-forensic). Whilst this did not differ across discharge destination, 57% ($n = 80$) had had an inpatient psychiatric admission prior to their current admission to medium secure services.

For 13 patients (9%), their current medium security admission was their second or subsequent admission to medium secure services during their current prison detention. All of these patients were remitted to prison (14% vs. 0%, $p = .004$). Likewise, the 27 (19%) patients who had a previous admission to medium secure services at some point prior to their current admission (including prior to their current prison detention) were over two times more likely to be remitted to prison than discharged into the community (24% vs. 10%, $p = .049$). A historical admission to high secure services was also present for 6 patients (4%), all of whom were remitted to prison; however, there was no statistical association present (See Table 4.5).

4.3.4 *Self-harming behaviour*

History of self-harming behaviour was documented for 62% of the sample ($n = 87$); this was 1.5 times more likely for prison remittals than for community discharges (70% vs. 47%, $p = .008$). For 52 (37%) patients, self-harming behaviour was documented to be taking place in prison prior to transfer to medium secure services. These patients were three times more likely to be remitted to prison (48% vs. 16%, $p < .001$).

4.3.5 *Historical adverse events*

Exposure to adverse childhood events was widely documented within psychiatric assessments. These histories were extracted to provide an insight into the backgrounds of prisoner-patients. Forty-five (32%) patients had a history of being in the social care system as a child, 40 (28%) had witnessed domestic violence in the home as a child, 48 (34%) had been subject to physical and 35 (25%) subject to sexual assault during childhood. The proportion of patients across these four historical variables was higher for prison remissions, yet there was no association between these variables and discharge destination (See Table 4.6).

4.3.6 *Other historical variables*

Twenty percent of the prisoner-patients had been in specialist education during childhood ($n = 28$) and just under half had left school prior to the age of 16 ($n = 66$, 47%) and with no formal qualifications ($n = 70$, 50%). These factors were present for a higher proportion of prison remissions than community discharges yet they had no association with discharge destination. Over a third of patients had no history of formal employment ($n = 48$, 34%) and a history of homelessness at a time in their lives ($n = 48$, 34%). These factors had no association with discharge destination (see Table 4.6).

Table 4.5. Rate ratio comparisons of prison and community discharges across clinical characteristics (*n* = 141)

	<i>n</i> (%)			χ^2	P	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Primary diagnosis						
Schizophrenia	41 (29)	20 (41)	21 (23)	5.02	.025	0.52 (0.34 - 0.93)
Personality disorder	39 (28)	4 (8)	35 (38)	14.27	<.001	4.66 (1.76 - 12.35)
Schizo-affective disorder	9 (6)	5 (10)	4 (4)	1.74	.276 *	0.43 (0.12 - 1.51)
Bipolar affective disorder	9 (6)	4 (8)	5 (5)	.39	.719 *	0.67 (0.19 - 2.37)
Psychosis Other a	19 (14)	12 (25)	7 (8)	7.81	.005	0.31 (0.13 - 0.74)
Other b	9 (6)	4 (8)	5 (5)	.39	.719 *	0.67 (0.19 - 2.37)
No primary diagnosis	7 (5)	-	7 (8)	3.92	.096 *	-
Depression	8 (6)	-	8 (9)	4.52	.051 *	-
Primary diagnosis						
SMI c	78 (55)	41 (84)	37 (40)	12.39	<.001	0.59 (0.45 - 0.78)
Personality disorder	39 (28)	4 (8)	35 (38)	14.27	<.001	4.66 (1.76 - 12.35)
Other d	24 (17)	4 (8)	20 (22)	4.17	.041	2.66 (0.96 - 7.35)
Co-morbid diagnosis	38 (27)	15 (31)	23 (25)	.51	.474	0.82 (0.47 - 1.42)

Co-morbid PD	14 (10)	7 (14)	7 (8)	1.59	.242 *	0.53 (0.20 - 1.43)
Hx Conduct disorder	52 (37)	15 (31)	37 (40)	1.27	.260	1.31 (0.81 - 2.14)
2 nd or sub < MSU	13 (9)	-	13 (14)	7.63	.004 *	-
Previous HO from courts	8 (6)	3 (6)	5 (5)	.03	1.00 *	0.89 (0.22 - 3.56)
Previous MSU admission	27 (19)	5 (10)	22 (24)	3.88	.049	2.34 (0.95 - 5.80)
Previous HSU admission	6 (4)	-	6 (7)	3.34	.092 *	-
Previous detention (inc NF)	80 (57)	33 (67)	47 (51)	3.44	.063	0.76 (0.57 - 1.00)
Hx self-harm	87 (62)	23 (47)	64 (70)	6.93	.008	1.48 (1.07 - 2.06)
Self-harm prior to admission	52 (37)	8 (16)	44 (48)	13.12	<.001	2.93 (1.50 - 5.72)

PD = personality disorder

Hx = history

HO = hospital order

2nd or sub < MSU = second or subsequent admissions to medium secure services during current sentence

MSU = medium secure unit

HSU = high secure unit

Inc NF = including non-forensic

a Including ; 'Transient Psychotic Episode', 'Drug Induced Psychosis', and 'First Episode Psychosis'.

b Including; 'Obsessive Compulsive Disorder', Anxiety' and 'Acquired Brain Injury'

c Including categories; 'Schizophrenia', 'Schizo-affective disorder', 'Bipolar Affective disorder' and 'Psychosis other'

d Including categories 'Other', 'No primary diagnosis' and 'Depression'

* Fishers exact test used as 25% of expected count <5, and/or observed counts < 1

Table 4.6. Rate ratio comparisons of prison and community discharges across historical variables (*n* = 141)

	<i>n</i> (%)			χ^2	P	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Historical adverse events						
Hx care system	45 (32)	12 (25)	33 (36)	1.71	.191	1.47 (0.84 - 2.57)
Witness Dom violence	40 (28)	16 (33)	24 (33)	.68	.410	0.80 (0.47 - 1.36)
Hx physical assault	48 (34)	16 (33)	32 (35)	.07	.799	1.07 (0.65 - 1.74)
Hx sexual assault	35 (25)	10 (20)	25 (27)	.78	.376	1.33 (0.70 - 2.54)
Other historical variables						
Specialist education	28 (20)	8 (16)	20 (22)	.551	.458	1.33 (0.63 - 2.80)
No qualifications	70 (50)	20 (41)	50 (54)	2.03	.154	1.33 (0.91 - 1.96)
Left school < 16	66 (47)	19 (39)	47 (51)	1.95	.163	1.32 (0.88 - 1.98)
No Hx of employment	48 (34)	12 (25)	36 (39)	3.05	.081	1.60 (0.92 - 2.78)
Hx homelessness	48 (34)	18 (37)	30 (33)	.34	.563	0.89 (0.56 - 1.42)

Hx = history

Table 4.7. Mann Whitney U comparisons of prison and community discharges across clinical characteristics ($n = 141$)

	Median (IQR) min – max			U	z	p	r
	Total	Community discharge	Prison remission				
Previous psych hospitalization	1 (2) 1 to 21	1 (3) 0 to 21	1 (2) 0 to 15	1884.500	-1.685	.092	.14
Age at first psych contact	22 (12) 7 to 48	23 (11) 9 to 43	21 (13) 7 to 48	1868.50	-.322	.747	.03

4.4 Criminological characteristics

4.4.1 *Index offence*

Patient index offences were coded into 4 distinct categories (see Table 4.8). This was the most recent offence for which the patient was convicted or for which the patient was awaiting trial prior to admission to medium secure services from prison. The majority of patients had committed a 'Violent' offence ($n = 106$, 75%) and 11% ($n = 15$) had committed a 'Sexual' offence. Fewer patients had committed a 'Property' offence ($n = 12$, 9%) or 'Other' offence ($n = 6$, 5%). There was no association between type of index offence across these 4 categories and discharge destination (see Table 4.8).

To examine this further, patient index offences were also coded by severity according to the Severity of Index Offence Scale (Young, Justice & Erdberg, 1999), designed specifically to measure the severity of index offence in detained psychiatric patients. Index offences ranged from 'Non-violent' to 'Loss of life'. Median severity of index offence was greater for prison remissions (Mdn = 5, IQR = 0) than community discharges (Mdn = 5, IQR = 1), $U = 1790.0$, $p = .012$ (See Table 4.9). The most common index offence severity was 'Attacks on person' ($n = 79$, 56%); this was true for both community discharges and prison remittals. The most severe index offence categorised as 'Loss of life' was present for 14% ($n = 21$) of patients; these patients were over 10 times more likely to be remitted to prison (21% vs. 1%, $p = .002$). There was no statistical association between the other offence severity categories and discharge destination (see Table 4.8).

4.4.2 *Criminal history*

Over half of the patients had previous prison sentences ($n = 75$, 53%) and the majority had previous convictions ($n = 117$, 83%). Whilst a higher proportion of prison remissions had both previous sentences and convictions there was no statistical association with discharge destination (see Table 4.8). Likewise, there was also no difference between median numbers of previous convictions across discharge destination (See Table 4.9). However, patients who were remitted to prison had more previous sentences (Mdn = 2, IQR = 3) than those discharged into the community (Mdn = 1, IQR = 2), $U = 1689.0$, $p = .021$. The median age at first conviction was 17 years; this did not differ across discharge destination (See Table 4.9). Over half of the patients had a criminal conviction prior to the age of 18 ($n = 74$, 51%), and 41 (29%) had served a prison sentence prior to the age of 18, yet there was no statistical association between convictions and sentences prior to the age of 18 and discharge destination (see Table 4.8).

Table 4.8. Rate ratio comparisons of prison and community discharges across criminological characteristics (*n* = 141)

	<i>n</i> (%)			χ^2	<i>p</i>	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Index offence						
Violent offence	106 (75)	36 (74)	70 (76)	.12	.732	1.04 (0.85 - 1.27)
Property offence	12 (9)	5 (10)	7 (8)	.28	.750 *	0.75 (0.25 - 2.23)
Sexual offence	15 (11)	5 (10)	10 (11)	.02	.903	1.07 (0.39 - 2.94)
Other offence	6 (6)	3 (6)	5 (5)	.03	1.00 *	0.32 (0.08 - 1.28)
Severity of index offence						
None Violent	5 (4)	2 (4)	3 (3)	.06	1.00*	0.80 (0.14 - 4.62)
Ambiguous violence	2 (1)	-	2 (2)	1.08	.543 *	-
Property crime	12 (9)	5 (10)	7 (8)	.28	.752 *	0.75 (0.25 - 2.23)
Threats to person	23 (16)	12 (25)	11 (12)	.37	.055	0.58 (0.28 - 1.25)
Attacks on person	79 (56)	29 (59)	50 (54)	.30	.582	0.92 (0.68 - 1.24)
Loss of life	20 (14)	1 (2)	19 (21)	9.10	.002 *	10.12 (1.40 - 73.35)
Prev sexual offences	32 (22)	10 (20)	22 (24)	.22	.636	1.17 (0.60 - 2.27)
Previous sentences	75 (53)	21 (43)	54 (59)	3.08	.080	1.37 (0.95 - 1.98)
Previous convictions	117 (83)	40 (82)	77 (84)	.21	.650	1.03 (0.87 - 1.20)
Convictions < 18	74 (53)	25 (51)	49 (53)	.15	.699	1.04 (0.75 - 1.46)
Prison < 18	41 (29)	15 (31)	26 (29)	.11	.742	0.92 (0.54 - 1.57)

* Fishers exact test used as 25% of expected count <5, and/or observed counts < 1

Table 4.9. Mann Whitney U comparisons of prison and community discharges across criminological characteristics (n = 141)

	Median (IRQ) min – max			<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
	Total	Community discharge	Prison remission				
Severity of index offence	5 (1) 1 to 6	5 (1) 1 to 6	5 (0) 1 to 6	1790.00	-2.511	.012	.21
<i>n</i> previous sentences	1 (3) 1 to 25	1 (2) 1 to 15	2 (3) 1 to 25	1689.50	-2.313	.021	-.19
<i>n</i> of previous convictions	8 (15) 1 to 128	6 (12) 1 to 128	9 (15) 1 to 60	2145.00	-.370	.711	.03
Age at first conviction	17 (10) 7 to 61	19 (13) 11 to 61	17 (9) 7 to 52	2005.20	-3.80	.704	.32

4.5 Summary of investigated variables

Figure 4.1 presents the clinical and criminological characteristics which significantly differ across prisoner-patient community discharges and prison remittals. The figure highlights that community discharges can be characterised as more likely to be a remand prisoner at discharge, have a primary diagnosis of Schizophrenia or 'Psychosis other' and to have had a length of stay longer than 24 months. Community discharges also had a longer median length of stay, fewer previous sentences and had a less severe index offence, compared to prison remittals.

Prison remittals, however, were more likely to be sentenced prisoners, to be detained under an IPP prison sentence and to have committed an Index Offence categorised as 'Loss of life'. Length of stay for prison remittals was shorter, with them being more likely to have a length of stay of 0-6 months. Diagnostically, prison remittals were more likely to have a primary diagnosis of Personality Disorder or to have had no psychiatric disorder identified during admissions. Of particular interest were the psychiatric histories of prison remittals. They were both more likely to have had a historical admission to medium secure services and for their current admission to be their second or subsequent admission to medium secure services during the prison sentence they were currently serving. Prison remittals were also more likely to have a documented history of self-harming behaviour, and most alarmingly, to have a documented incidence of self-harming in prison prior to admission to medium secure services.

It is clear from these examined characteristics that community discharges and prison remittals may represent different populations of prisoner-patients who are admitted to and discharged from medium secure services. The particularly short length of stay for over half of the prison remittals is concerning, especially considering the apparently vulnerability of this group in regards to self-harming behaviour, some of which took place in the environment to which they were remitted. These variables, however, do not describe either the participants' psychological adjustment prior to discharge or their anticipated risk of relapse or future violence. To examine this, four validated violence risk assessment tools were administered; findings from these are presented from section 4.6 onwards.

4.5.1 Summary of characteristics associated with discharge destination

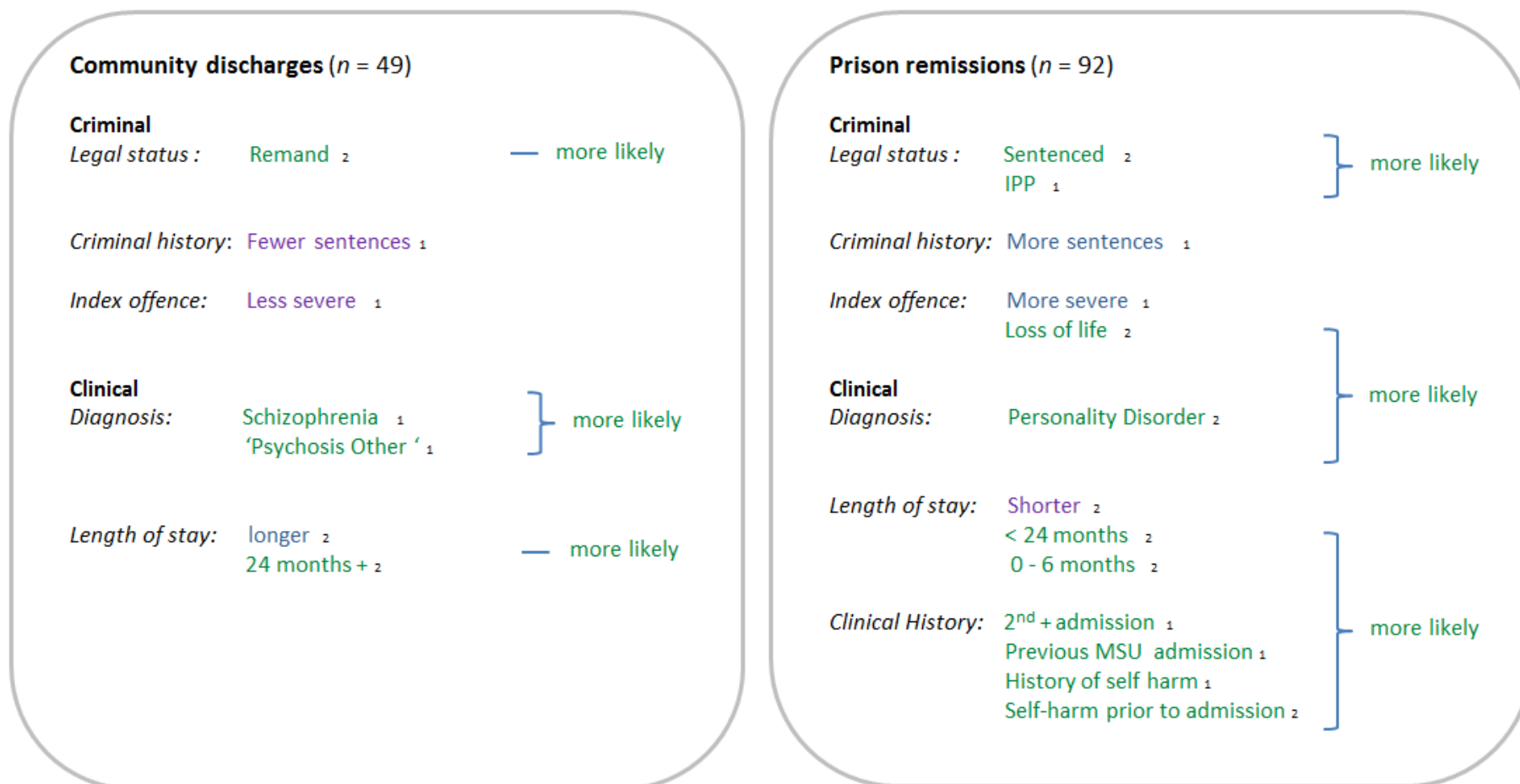


Figure 4.1:
 Variable associations across discharge destination

4.6 Validated violence risk assessment tools

Participants were compared across discharge destination for their total and subscale scores on the validated violence risk assessment tools. Presence of individual tool items was also compared across discharge destination to establish which risk factors represent key differences between community discharges and prison remissions, as were final risk, protection, psychopathy and recidivism judgements.

4.6.1 Omitted items

Where there was no information available to accurately rate an item within the violence risk assessment tools, that item was omitted. Across all three measures, individual item ratings were not replaced, however the subscale and total scores were pro-rated based on the mean score from the rated items (see Douglas, Ogloff, Nicholls & Grant [1999] for pro-rating guidance for assessments of this type).

A total of 1% (70 / 6909) of all the items were pro-rated over the following 3 measures.

Historical clinical-risk Management 20, version 3 (HCR: 20v3)

All omitted HCR: 20v3 items were from the Historical Subscale. The most frequently omitted items were 'Relationships' (H item 3, $n = 4$) and 'Violent Attitudes' (H item 9, $n = 4$), followed by 'Traumatic Experiences' (H item 8, $n = 2$), 'Employment History' (H item, 4 $n = 2$) and 'Treatment or Supervision Response' (H item 10, $n = 1$). Items were omitted according to the guidance within the manual due to lack of evidence within patient case files and collateral interviews to assess their presence.

Structured assessment of protective factors for violence risk (SAPROF)

Thirty-four items were omitted across the whole sample. These included; 'Secure Attachment in Childhood' (I item 2, $n = 4$), 'Effective Coping Strategies (I item 5, $n = 3$), 'Positive Attitudes towards Authority' (E item 10, $n = 2$), 'Positive Life Goals' (E item 11, $n = 8$), and 'External Control' (E item 17, $n = 1$). 'Using Medication Effectively' (M item 12) was omitted for 17 patients, according to the guidance within the manual, as they were not recommended psychotropic medication by their Responsible Clinician at time of discharge. No patient had more than two items omitted across the 14 items included in the analysis.

Due to the amount of missing data, three SAPROF items were removed for all participants (I item 1 and 3; M item 8). As such, for the Internal Subscale participants could receive a total score of 6 (usually 10) and a total of 12 (usually 14) for the Motivational Subscale. Therefore participants could receive a total score of 28 (usually 34) across all SAPROF items. 'Intelligence' (I item 1) was removed due to a lack of formal assessment required to rate this item (the SAFROF manual instructs that this item should be omitted if the assessor does not have access to a patient's IQ assessment). 'Financial management' (M item 8) was rarely commented on in patient case files. This may reflect the limited relevance of this item in secure settings, where access to money is restricted and monitored. 'Empathy' (I item 3) was also removed as in many cases collateral informants did not feel able to comment due to not conducting offence-related work with the participant in the period prior to discharge, alongside information not being available in participants' case files.

Psychopathy checklist revised, screening version (PCLR: SV)

Ten (7%) participants were removed from the analysis as they had more than two items omitted across the PCLR: SV measure, as per the guidance provided in the manual. The following analysis was therefore conducted on the remaining 131 participants.

A further 23 items were omitted. These included; 'Deceitful' (I item 3, $n = 5$), 'Lacks Remorse' (I item 4, $n = 4$), 'Lacks Empathy' (I item 5, $n = 6$), and 'Doesn't Accept Responsibility' (I item 6, $n = 1$) on the Interpersonal Subscale and 'Lacks Goals' (SD item 9, $n = 3$) and 'Irresponsible' (SD item 9, $n = 3$) on the Social Deviance Subscale

4.6.2 *Item presence*

The presence of each individual item across all three of the validated violence risk assessment tools was coded using a 3-level response format that reflects the certainty of the researcher's opinion:

Item presence	
Not present	Information indicates the factors is not present or does not apply / no evidence of presence (score of 0).
Partially present	Information indicates that the item is possibly or partially present, or information has been obtained indicating that the item is present but the evidence is weak, contradictory or inconclusive (score of 1).
Definitely present	Information indicates that the item is present (score of 2).

The following comparative analysis across individual items is twofold; items are compared across discharge destination for;

- 1) 'Definite' presence (score of 2)

Followed by a comparative analysis of

- 2) 'Partial/definite' presence (score of 1 or 2) (i.e. all participants who scored either definite (score of 2) or partial presence (score of 1) for an item, combined).

The 'partial/definite' presence analysis was conducted due to the low representation of 'definite' presence (a score of 2) across some of the individual assessment items. Largely this was due to contradictory or inconclusive evidence across case file review and collateral interview, resulting in an assignment of a score of 1 (partial/definite presence) in many cases, as per the manual guidance for each assessment tool. As such, it was felt that any indication of an assessment item being present to some degree was important to investigate and compare across discharge destination. This not only gave a more accurate representation of the presentation of the participants in this study prior to discharge from medium secure services, but also increased the power of some comparisons and allowed for the calculation of rate ratios across some items that were not possible in the 'definite' presence only analysis.

4.7 Historical clinical-risk Management 20, version 3 (HCR: 20v3)

4.7.1 Assessment total and subscale ratings

Median HCR:20v3 total and subscale ratings were compared across discharge destination to identify any differences in the two discharge groups in regards to historical, recent clinical and future indicators of violence risk.

A Mann-Whitney test revealed that HCR: 20v3 total assessment scores were greater for prison remittals (Mdn = 27, IQR = 11.7) than for community discharges (Mdn = 21, IQR = 11.5), $u = 1398.50$, $p < .001$, indicating that prison remittals posed an overall higher risk of future violence than did community discharges. Likewise, across the HCR: 20v3 Clinical and Risk Subscales, scores were greater for prison remittals (C-Mdn = 5, IQR = 4; R-Mdn = 6, IQR = 3.7) than for community discharges (C-Mdn = 2, IQR = 4; R-Mdn = 4, IQR = 4), Clinical Factors: $u = 1131.0$, $p < .001$; Risk Factors: $u = 1483.0$, $p = .001$. This indicates that prison remittals were more likely to have had *recent* problems with psychosocial adjustment in the period preceding discharge and were also more likely to be rated as having anticipated *future* problems with psychosocial adjustment, based on their goals and plans for the future. However, there was no difference between Historical Subscale scores across discharge destination (see Table 4.10), indicating that the participants had similar histories in regards to previous psychosocial adjustment.

Table 4.10. Mann Whitney U comparisons of HCR20 scores across discharge destination ($n = 141$)

	Median (IQR) min – max			<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
	Total	Community discharge	Prison remission				
<i>Historical Factors</i>	15 (6) 4 to 20	14.44 (5) 4 to 20	15 (6.4) 6 to 20	1864.50	-1.691	.091	-.14
<i>Clinical Factors</i>	4 (5) 0 to 10	2 (4) 0 to 10	5 (4) 0 to 9	1131.00	-4.893	<.001	-.41
<i>Risk Factors</i>	6 (4) 1 to 10	4 (4) 1 to 10	6 (3.7) 2 to 10	1483.00	-3.365	.001	-.31
<i>Total</i>	24 (12) 7 to 38	21 (11.5) 7 to 35	27 (11.7) 10 to 38	1398.50	-3.706	<.001	-.31

4.7.2 Final structured risk judgement

The structured professional judgement model of the HCR: 20 v3 uses a simple narrative approach to estimating future risk. This requires evaluators to make a final risk judgement which incorporates the patient's future risk of violence and highlights the patient's need for case prioritisation and subsequent intervention. A final risk judgement is presented as *low*, *moderate* or *high*, and is scored according to the criteria in box 2.

Risk for future violence	
Low	Participant is not considered to need special intervention or supervision strategies designed to manage violence risk and there is no need to monitor the person closely for changes in risk.
Moderate	Participant requires some special management strategies, including at the very least, an increased frequency of monitoring.
High	There is an urgent need to develop a risk management plan for the participant, which typically would involve (at a minimum) advising staff, increasing supervision levels, placing the person on a high priority list for available treatment resources and scheduling regular re-assessment. Some high risk cases will require emergency response (e.g. hospitalisation suspension of conditional release)

For the purpose of this study participants were coded as low, moderate and high risk based on both the presence and relevance of identified risk factors, alongside consideration of the degree of effort and intervention it would require to prevent them committing violence, on a case by case basis (see Douglas, et al., 2014, for a review).

Just under half of the participants were rated as moderate risk (44%), which was also the case across both community discharges (45%) and prison remittals (43%). However, those participants rated as low risk and not in need of special intervention were 47% less likely to be remitted to prison (25% vs. 47%, $p = .008$), whereas those participants who were rated as high risk and requiring urgent development of a risk management plan, were almost 4 times more likely to be remitted to prison (32% vs. 8%, $p = .001$)

Table 4.11. Rate Ratio comparisons of HCR 20: V3 final risk judgement (*n* = 141)

Risk	<i>n</i> (%)		χ^2	<i>p</i>	Rate ratio (95% CI)	
	Total	Community discharge				Prison remission
Low	46 (33)	23 (47)	23 (25)	7.00	.008	0.53 (0.34 - 0.85)
Moderate	62 (44)	22 (45)	40 (43)	.03	.872	0.97 (0.66 - 1.43)
High	33 (23)	4 (8)	29 (32)	9.73	.001	3.86 (1.44 - 10.35)

To allow for further investigation into which key factors may influence higher median ratings across total, clinical and risk scales and result in a high final risk judgement, the 20 individual HCR: 20v3 items were compared for presence across discharge destination in the following analysis.

4.7.3 *Definite presence*

(Participants rated with a score '2' vs. those rated with a score of '0' or '1', across all items)

Historical

Whilst there was no association with median historical subscale scores across discharge destination, differences across some of the individual historical items were observed. Definite presence of historical problems with 'Major mental illness' (H item 5) was 29% less likely for prison remittals (57% vs. 77%, $p = .006$), whereas definite presence of historical problems with 'Personality Disorder' (H item 6) was 2 times more likely for prison remissions (40% vs. 20%, $p = .017$). This was expected given the similar findings across primary diagnosis in section 4.3. Interestingly, prison remittals were also 2 times more likely to have definite presence of historical problems with 'Violent Attitudes' (H item 9) (51% vs. 21%, $p < .001$), suggesting that this group were more likely to pose beliefs that support or condone the use of violence. There were no associations between the other 7 historical HCR: 20v3 items and discharge destination (see Table 4.12).

Clinical

The timeframe for coding these factors was the recent past – that is, the 6 months immediately preceding the assessment. Across the clinical items, definite presence of recent problems with items 1, 2, 4 and 5 was more likely for prison remittals.

Prison remittals were over three times more likely to be rated as recently having a lack of insight into their mental disorder, violence risk or need for treatment ('Insight', C item 1) (29% vs. 8%, $p = .004$) and to possess thoughts, plans, or urges to cause harm to others ('Violent ideation or intent', C item 2) (49% vs 14%, $p < .001$). Prison remittals were also 2 times more likely to be rated as having recent problems with maintaining stable adjustment with respect to affective, behavioural or cognitive functioning ('Instability', C item 4) (29% vs. 14%, $p = 0.47$), and over 6 times more likely to have had recent problems with compliance or responsiveness to/with intervention, management or supervision strategies ('Treatment or supervision response', C item 5) (27% vs. 4%, $p = .001$). No association was found between definite presence of recent problems with 'Symptoms of major mental disorder' (C item 3) and discharge destination.

Risk management

The time frame for coding these factors was the near future – that is the 6 months immediately following the assessment. Across the risk items, definite presence of anticipated future problems with items 3, 4 and 5 was more likely for prison remittals.

Prison remittals were almost 3 times more likely to be rated as having anticipated future problems with making arrangements which incorporate personal support ('Personal support', R item 3), (46% vs. 16%, $p = .001$), i.e. they were considered to lack the ability or motivation to make or engage in plans, or there was a lack of appropriate support network available. Prison remittals were also 2 times more likely be rated as having anticipated future problems with compliance or responsiveness to/with intervention, management or supervision strategies ('Treatment or supervision response', R item 4), (40% vs. 18%, $p = .008$), and were 1.5 times more likely to have anticipated future problems with the ability to cope with stressful living circumstances and life events ('Stress or coping', R item 5) (58%, vs. 39%, $p = .033$). No association was found between definite anticipated future problems with 'Professional services and plans' (R item 1) or 'Living situation' (R item 2) and discharge destination.

Table 4.12. Rate Ratio comparisons of HCR 20: V3 individual items - definitely present (*n* = 141)

	<i>n</i> (%)			χ^2	<i>p</i>	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Historical scale (History of problems with...)						
H1 Violence	120 (85)	38 (78)	82 (89)	3.38	.066	1.15 (0.97 - 1.36)
H2 Other antisocial behaviour	85 (60)	26 (53)	59 (64)	1.64	.201	1.21 (0.89 - 1.64)
H3 Relationships	67 (49) a	20 (43)	47 (52)	1.16	.281	1.23 (0.83 - 1.81)
H4 Employment	66 (48) b	19 (40)	47 (52)	1.83	.176	1.31 (0.87 - 1.95)
H5 Substance Use	94 (67)	34 (69)	60 (65)	.25	.617	0.94 (0.74 - 1.20)
H6 Major Mental Illness	91 (65)	39 (77)	52 (57)	7.44	.006	0.71 (0.57 - 0.89)
H7 Personality Disorder	47 (33)	10 (20)	37 (40)	5.464	.017	1.94 (1.08 - 3.61)
H8 Traumatic Experiences	68 (49) c	22 (45)	46 (51)	.49	.484	1.14 (0.79 - 1.65)
H9 Violent Attitudes	55 (40) d	10 (21)	45 (51)	11.47	<.001**	2.25 (1.35 - 4.37)
H10 Treatment or supervision response	83 (59) e	27 (56)	56 (61)	.03	.060	1.08 (0.80 - 1.46)
Clinical scale (Recent Problems with...)						
C1 Insight	31 (22)	4 (8)	27 (29)	8.37	.004	3.60 (1.33 - 9.69)
C2 Violent ideation or intent	51 (36)	7 (14)	44 (49)	15.58	<.001**	3.35 (1.63 - 6.87)
C3 Symptoms of major mental disorder	14 (10)	5 (10)	9 (10)	.01	.936*	0.96 (0.34 - 2.70)
C4 Instability	34 (24)	7 (14)	27 (29)	3.96	.047	2.05 (0.97 - 4.37)
C5 Treatment or supervision response	27 (19)	2 (4)	25 (27)	11.01	.001**	6.66 (1.65 - 26.94)

Risk Management scale (Future problems with...)

R1 Professional services and plans	30 (21)	9 (18)	21 (23)	.38	.538	1.24 (0.62 - 2.50)
R2 Living situation	43 (31)	13 (27)	30 (33)	.56	.455	1.23 (0.71 - 2.13)
R3 Personal support	50 (36)	8 (16)	42 (46)	12.01	.001**	2.80 (1.43 - 5.48)
R4 Treatment or supervision response	46 (33)	9 (18)	37 (40)	6.94	.008	2.19 (1.15 - 4.16)
R5 Stress or coping	72 (51)	19 (39)	53 (58)	4.54	.033	1.49 (1.00 - 2.21)

- a community $n = 47$, prison $n = 90$
 b community $n = 48$, prison $n = 91$
 c community $n = 49$, prison $n = 90$
 d community $n = 48$, prison $n = 89$
 e community $n = 48$, prison $n = 92$

- * Fishers exact test used as 25% of expected count <5, and/or observed counts < 1
 * * Also significant at the Bonferroni corrected alpha, $p < .0025$

4.7.4 *Partial / definite presence*

(Participants rated with a score of '1' or '2' vs. those rated with a score of '0', across all items)

Historical

Partial/definite presence of historical problems with 'Major Mental Illness' (H item 6) and 'Personality Disorder' (H item 7) was not significantly different across discharge destination. This discrepancy between the two analyses is likely due to the suspected/disputed co-morbidity of 'Personality Disorder' and 'Major mental illness' across this population (where there was disagreement with the clinical team, or contradictory evidence in the participants clinical case files in regards to these diagnoses, the item was rated as partially present (score of '1')). Partial/definite presence of historical problems with 'Violent attitudes' (H item 9) was 1.5 times more likely for prison remittals (85% vs. 56%, $p < .001$), as with the definite presence comparison. There remained no significant association for historical problems with the remaining 7 items and discharge destination (see Table 4.13).

Clinical

Those items in the Clinical Subscale which were more likely for prison remissions when compared for definite presence remained so when compared for partial/definite presence across discharge destination (see Table 4.13); Insight (C item 1): 83% vs. 63%, $p = .011$; Violent Ideation (C item 2): 65% vs. 33%, $p < .001$; Instability (C item 4): 65% vs. 31%, $p < .001$; Treatment of supervision response (C item 5): 72% vs. 31%, $p < .001$. Whilst not significant when compared for definite presence alone, partial/definite presence of recent problems with active symptoms of major mental disorder was 1.5 times more likely for prison remittals ('Symptoms of Major Mental Disorder', C item 3) (54% vs. 37%, $p = .046$).

Risk management

Expected future problems with 'Personal Support' (R item 4) and 'Treatment or supervision response' (R item 5) remained more likely for prison remissions when compared for partial/definite presence (Personal Support; 91% vs. 76%, $p = .011$); Treatment or supervision response: 86% vs. 69%, $p = .020$). Whilst non-significant when compared for definite presence alone, partial/definite presence of anticipated future problems with developing general plans that make appropriate use of professional services (e.g. health care, social care, educational, vocational, and criminal programmes ('Professional services and plans', R item 1) was 1.5 times more likely for prison remissions (64% vs. 43%, $p = .015$). Expected future problems with 'Stress or

coping' (R item 5) was not significantly different across discharge destination when compared for partial/definite and there remained no association with partial/definite anticipated future problems with 'Living situation' (R item 2) and discharge destination (see Table 4.13).

Table 4.13. Rate Ratio comparisons of HCR 20: V3 individual items – partially / definitely present (*n* = 141)

	<i>n</i> (%)			χ^2	<i>p</i>	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Historical scale (History of problems with...)						
H1 Violence	136 (97)	47 (96)	89 (97)	1.57	.211	0.97 (0.93 - 1.00)
H2 Other antisocial behaviour	120 (85)	41 (84)	79 (86)	.12	.727	1.03 (0.88 - 1.19)
H3 Relationships	124 (88) ^a	40 (82)	84 (91)	2.82	.093	1.12 (0.97 - 1.30)
H4 Employment	124 (92) ^b	44 (90)	80 (87)	.46	.498	0.96 (0.86 - 1.08)
H5 Substance Use	122 (87)	42 (86)	80 (88)	.04	.837	1.01 (0.88 - 1.17)
H6 Major Mental Illness	126 (89)	46 (94)	80 (87)	1.16	.204	0.96 (0.83 - 1.03)
H7 Personality Disorder	87 (62)	26 (53)	61 (66)	2.37	.124	1.25 (0.93 - 1.69)
H8 Traumatic Experiences	114 (83) ^c	36 (74)	78 (87)	3.75	.053	0.87 (0.98 - 1.42)
H9 Violent Attitudes	103 (73) ^d	27 (56)	76 (85)	14.19	<.001*	1.52 (1.17 - 1.98)
H10 Treatment or supervision response	128 (91) ^e	44 (92)	84 (94)	.01	.942	1.00 (0.90 - 1.11)
Clinical scale (Recent Problems with...)						
C1 Insight	107 (76)	31 (63)	76 (83)	6.54	.011	1.31 (1.34 - 1.65)
C2 Violent ideation or intent	76 (54)	16 (33)	60 (65)	13.64	<.001*	2.00 (1.30 - 3.07)
C3 Symptoms of major mental disorder	68 (48)	18 (47)	50 (54)	3.97	.046	1.48 (0.98 - 2.23)
C4 Instability	75 (53)	15 (31)	60 (65)	15.38	<.001*	2.13 (1.36 - 3.33)
C5 Treatment or supervision response	84 (60)	18 (37)	66 (72)	16.27	<.001*	1.95 (1.32 - 2.88)

Risk Management scale (Future problems with...)

R1 Professional services and plans	80 (57)	21 (43)	59 (64)	5.89	.015	1.50 (1.05 - 2.14)
R2 Living situation	137 (97)	47 (96)	90 (98)	.42	.516	1.02 (1.00 - 1.89)
R3 Personal support	121 (59)	37 (76)	84 (91)	6.55	.011	1.21 (1.02 - 1.44)
R4 Treatment or supervision response	113 (80)	34 (69)	79 (86)	5.46	.020	1.24 (1.01 - 1.52)
R5 Stress or coping	137 (97)	47 (96)	90 (98)	.42	.516	1.20 (0.96 - 1.89)

-
- a community $n = 47$, prison $n = 90$
 - b community $n = 48$, prison $n = 91$;
 - c community $n = 49$, prison $n = 90$;
 - d community $n = 48$, prison $n = 89$,
 - e community $n = 48$, prison $n = 92$

* also significant at the Bonferroni corrected alpha, $p < .0025$

4.8 Structured assessment of protective factors for violence risk (SAPROF)

4.8.1 Assessment total and subscale ratings

Median SAPROF total and subscale ratings were compared across discharge destination to identify any differences in the two discharge groups in regards to internal, motivational and external protective factors to mediate violence risk.

A Mann-Whitney test revealed that SAPROF total assessment scores were lower for prison remittals (Mdn = 13, IQR = 7.8) than for community discharges (Mdn = 15.5, IQR = 9.2), $u = 1492.50$, $p = .001$, indicating that prison remissions had fewer protective factors to mitigate risk of future violence than did community discharges.

Across the SAPROF Internal Factors and Motivational Factor subscale, scores were lower for prison remittals (I-Mdn = 3, IQR = 2; M-Mdn = 4.8, IQR = 5) than for community discharges (I-Mdn = 4, IQR = 2; M-Mdn = 8, IQR = 6.1), Internal Factors: $u = 1269.50$, $p = .006$; Risk Factors: $u = 1137.0$, $p < .001$. This indicates that prison remittals have fewer historical and dynamic internal characteristics which are protective against future violent behaviour, and that they had less motivation for and attitude towards several aspects of treatment and life in general.

However, for the External Factor subscale, scores were greater for prison remittals (Mdn = 6, IQR = 1) than for community discharges (Mdn = 5, IQR = 3), $u = 1492.50$, $p = .001$, suggesting that prison remittals have more environmental factors considered beneficial in offering protection from outside of the individual. This likely reflects the nature and the relational security of the environment to which these participants were remitted.

Table 4.14. Mann Whitney U comparisons of SAPROF scores across discharge destination ($n = 141$)

	Median (IQR) min – max			U	z	p	r
	Total	Community discharge	Prison remission				
<i>Internal Factors</i>	3 (2.7) 0 to 6	4 (2) 0 to 6	3 (2) 0 to 6	1269.50	-2.749	.006	-.23
<i>Motivational Factors</i>	5 (5.8) 5 to 22	8 (6.1) 1 to 12	4.8 (5) 0 to 11	1137.50	-4.846	<.001	-.41
<i>External Factors</i>	6 (1) 2 to 9	5 (3) 2 to 9	6 (1) 2 to 8	1447.50	-3.589	<.001	-.30
<i>Total</i>	14 (9) 4 to 25	15.5 (9.2) 4 to 25	13 (7.8) 5 to 24	1492.50	-3.300	.001	-.28

4.8.2 Final protection judgement

Similar to the HCR: 20 v3, the SAPROF requires the evaluator to provide a final protection judgement. This is derived by the presence of protective factors, but also depends on the interpretation, weighing and integration of the individual items. A final protection judgement is presented as *low*, *moderate* or *high*, and is scored according to the criteria below.

Risk for future violence	
Low	Little to no protection is present
Moderate	A moderate degree of protection is present
High	A high degree of protection is present

Just over a quarter of the participants were rated as having low protection (26%), whilst the proportion of ‘low protection’ participants was higher for remittals, there was no significant difference across discharge destination (see Table 4.15).

However, those participants rated as having ‘high protection’ were 78% less likely to be remitted to prison (8% vs. 35%, $p < .001$), whereas those participants who were rated as ‘moderate protection, were 1.4 times more likely to be remitted to prison (63% vs. 45%, $p = .038$).

Table 4.15. Rate Ratio comparisons of SAPROF final protection judgements ($n = 141$)

Protection	n (%)			χ^2	p	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Low	37 (26)	10 (20)	27 (29)	1.32	.251	1.44 (0.76 – 2.72)
Moderate	80 (57)	22 (45)	58 (63)	4.29	.038	1.40 (0.99 – 1.99)
High	24 (17)	17 (35)	7 (8)	16.61	<.001	0.22 (0.097 - 0.49)

There was no association with 'low protection' ratings across discharge destination and it is possible that this is due to the elevated proportion of participants rated as having 'moderate protection' within the sample, particularly across prison remittals.

Comparison of median scores across the external subscale highlighted that prison remittals were deemed to have more environmental factors considered beneficial in offering protection from outside of the individual, e.g. supervised living conditions and high levels of relational security. Community discharges were scored lower due to being discharged into relatively less secure environments. Therefore this comparison of final protective judgement should be viewed tentatively. It might be that this reflects a required adjustment to the external scale for prison remittals, as whilst it is true that prison is a more secure environment, the nature of the environment itself may not necessarily be conducive to reducing risk of violence.

To allow for further investigation into which key factors may influence higher median ratings across total, internal, motivational and external scales and result in high overall protection judgements the 17 included individual SAPROF items were compared for presence across discharge destination in the following analysis.

4.8.3 *Definite presence*

(Participants rated with a score '2' vs. those rated with a score of '0' or '1', across all items)

Internal (individual characteristics that have a protective effect against future violence)

Definite presence of all included internal items was less likely for prison remittals than for community discharges. Prison remittals were 34% less likely to be rated as having had a 'Secure attachment in childhood' (I item 2) (37% vs. 55%, $p = .036$), and were 70% less likely to be considered to have 'Effective coping strategies' (I item 4) required to protect against stressors in their lives in the time preceding discharge (11% vs. 38%, $p < .001$). Prison remittals were also 55% less likely to be deemed to have the ability to control impulses and repress undesirable behaviours ('Self-control', I item 5) in the time frame preceding discharge (30% vs. 67%, $p < .001$).

Motivational (factors that arise from the motivation to be a positive member of society)

Definite presence of all Motivational Subscale items was less likely for prison remittals in the time frame preceding discharge. Prison remittals were 41% less likely to have been involved in 'Structured leisure activities' (M item 7) prior to remission (33% vs. 55%, $p = .010$) or to have had engaged in work activities with the secure facilities ('Stable work situation' (M item 6) (0% vs. 6%, $p = .040$). They were also 53% less likely to deem treatment as necessary and have the motivation to change their behaviour ('Motivation for treatment', M item 9) (24% vs. 51%, $p = .001$), or to understand the need for their prescribed medication and have the motivation to take it ('Motivation to use medication effectively', M item 12), (39% vs. 61%, $p = .019$). Likewise prison remittals were 60% less likely to be able to tolerate authority and control by others or to commit to imposed conditions ('Positive attitude towards authority' (M item 10) (23% vs. 51%, $p < .001$) and 77% less likely to be rated as having 'Positive life goals' (M item 11) for their future (12% vs. 51%, $p < .001$).

External (beneficial environment factors that offer protection (both voluntary and imposed)

Having access to appropriate and regular 'Professional care' (E item 15) upon discharge was rated as 94% less likely for prison remittals (2% vs. 39%, $p < .001$), who were also 63% less likely to have supportive and stable 'Intimate relationship' (E item, 14) (5% vs. 16%, $p = .037$).

However definite presence of being discharged to living circumstances which are supervised ('Living circumstances', E item 16) was 4 times more likely for prison remittals (96% vs. 25%, $p < .001$) and were, 8 times more likely to be subject to 'External control' (E item 17) upon remittal (98% vs. 13%, $p < .001$). There was no associated between definite presence of 'Social network' (E item 13) and discharge destination.

Table 4.16. Rate Ratio comparisons of SAPROF individual items - definitely present (*n* = 141)

	<i>n</i> (%)			χ^2	<i>p</i>	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Internal items						
2 Secure attachment in childhood	59 (43) a	26 (55)	33 (37)	4.38	.036	0.66 (0.46 - 0.96)
4 Effectively coping strategies	28 (20) b	18 (38)	10 (11)	13.48	<.001**	0.30 (0.15 - 0.59)
5 Self-control	61 (43)	33 (67)	28 (30)	17.75	<.001**	0.45 (0.31 - 0.65)
Motivational item						
6 Stable work situation	3 (2)	3 (6)	-	5.76	.040*	-
7 Structured leisure activities	57 (40)	27 (55)	30 (33)	6.72	.010	0.59 (0.40 - 0.87)
9 Motivation for treatment	47 (33)	25 (51)	22 (24)	10.57	.001**	0.47 (0.30 - 0.74)
10 Positive attitude towards authority	48 (35) c	27 (57)	21 (23)	16.49	<.001**	0.40 (0.25 - 0.62)
11 Positive life goals	34 (26) d	24 (51)	10 (12)	24.84	<.001**	0.23 (0.12 - 0.44)
12 Motivated to use medication effectively	59 (47) e	28 (61)	31 (39)	5.46	.020	0.65 (0.45 - 0.92)
External items						
13 Social network	24 (17)	12 (25)	12 (13)	2.97	.085	0.53 (0.26 - 1.10)
14 Intimate relationship	13 (9)	8 (16)	5 (5)	4.53	.037*	0.33 (0.12 - 0.96)
15 Professional care	21 (15)	19 (39)	2 (2)	33.79	<.001**	0.06 (0.01 - 0.23)

16 Living circumstances	100 (68)	12 (25)	88 (96)	78.51	<.001**	3.91 (2.38 - 6.40)
17 External control	96 (69) f	6 (13)	90 (98)	106.56	<.001*	7.83 (3.70 - 16.55)

- a community $n = 47$, prison $n = 90$
- b community $n = 48$, prison $n = 90$
- c community $n = 47$, prison $n = 92$
- d community $n = 47$, prison $n = 86$
- e community $n = 46$, prison $n = 79$
- f community $n = 48$, prison $n = 92$

* Fishers exact test used as 25% of expected count <5, and/or observed counts < 1
 ** Also significant at Bonferroni corrected alpha, $p < .0033$

4.8.4 *Partial/definite presence*

(Participants rated with a score of '1' or '2' vs. those rated with a score of '0', across all items)

Internal

As with the analysis of definite presence, 'Effective coping strategies' (I item 4) and 'Self-control' (I item 5) remained less likely for prison remissions when compared for partial/definite presence (Effective coping skills: 58% vs. 83%, $p = .002$; Self-control: 78% vs. 94%, $p = .017$). However partial/definite presence of 'Secure attachment in childhood' (I item 2) did not differ across discharge destination (see Table 4.17).

Motivational

Aside from involvement in 'Structured leisure activities' (M item 7) prior to discharge, those items in the Motivational Subscale which were less likely for prison remissions when compared for definite presence remained so when compared for partial/definite presence across discharge destination, ('Stable work situation': (M item 6): 7% vs. 35%, $p < .001$; 'Motivation for treatment' (M item 9): 60% vs. 82%, $p = .008$; Positive attitude towards authority (M item 10): (61% vs. 92%, $p < .001$; Positive life goals (M item 11): 41% vs. 79%, $p < .001$; and Motivated to use medication effectively (M item 12): 73% vs. 100%, $p < .001$).

External

Whilst not significant when compared for definite presence alone, partial/definite presence of a supportive 'Social network' (E item 13) was 24% less likely for prison remittals (65% vs. 86%, $p = .010$), as was partial/definite presence of a stable 'Intimate relationship' (E item 14) (11% vs. 27%, $p = .017$). 'Living circumstances' (E item 16) and 'External control' (E item 17) remained more likely for prison remissions when compared for partial/definite presence (Living circumstances: 99% vs. 84%, $p < .001$; External control: 92% vs. 74%, $p < .001$), however partial/definite presence of access to 'Professional care' (E item 15) did not differ across discharge destination (see Table 4.17).

Table 4.17. Rate Ratio comparisons of SAPROF individual items partially / definitely present (n = 141)

	n (%)			χ^2	p	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Internal items						
2 Secure attachment in childhood	92 (67) a	34 (72)	58 (64)	0.87	.350	0.89 (0.71 - 1.13)
4 Effectively coping strategies	92 (62) b	40 (83)	52 (58)	9.20	.002**	0.69 (0.56 - 0.86)
5 Self-control	118 (84)	46 (94)	72 (78)	5.71	.017	0.83 (0.73 - 0.95)
Motivational item						
6 Stable work situation	23 (16)	17 (35)	6 (7)	18.59	<.001**	0.19 (0.08 - 0.45)
7 Structured leisure activities	114 (81)	43 (88)	71 (77)	2.31	.138	0.88 (0.76 - 1.02)
9 Motivation for treatment	95 (67)	40 (82)	55 (60)	6.94	.008	0.73 (0.59 - 0.91)
10 Positive attitude towards authority	99 (91) c	43 (92)	56 (61)	21.81	<.001**	0.62 (0.53 - 0.74)
11 Positive life goals	72 (54) d	37 (79)	35 (41)	17.70	<.001**	0.52 (0.39 - 0.70)
12 Motivated to use medication effectively	104 (83) e	46 (100)	58 (73)	14.70	<.001**	0.73 (0.62 - 0.84)
External items						
13 Social network	102 (72)	42 (86)	60 (65)	6.71	.010	0.76 (0.63 - 0.92)
14 Intimate relationship	23 (16)	13 (27)	10 (11)	5.74	.017	0.41 (0.19 - 0.87)
15 Professional care	131 (93)	46 (94)	85 (92)	0.11	.743	0.98 (0.90 - 1.08)

16 Living circumstances	132 (94)	41 (84)	91 (99)	12.43	<.001**	1.18 (1.04 - 1.34)
17 External control	128 (91) f	36 (74)	92 (100)	25.16	<.001**	1.33 (1.32 - 1.57)

- a community $n = 47$, prison $n = 90$
- b community $n = 48$, prison $n = 90$
- c community $n = 47$, prison $n = 92$
- d community $n = 47$, prison $n = 86$
- e community $n = 46$, prison $n = 79$
- f community $n = 48$, prison $n = 92$

* Fishers exact test used as 25% of expected count <5, and/or observed counts < 1
 ** Also significant at Bonferroni corrected alpha, $p < .0033$

4.9 Psychopathy checklist revised, screening version (PCLR: SV)

4.9.1 Assessment total and subscale ratings

Median PCLR: SV total and subscale ratings were compared across discharge destination to identify any differences in the two discharge groups in regards to interpersonal and socially deviance indicators of presence of psychopathy.

A Mann-Whitney test indicated that PCLR: SV total assessment scores were greater for prison remissions (Mdn = 13, IQR = 8.2) than for community discharges (Mdn = 7, IQR = 7.7), $u = 990.50$, $p < .001$, suggesting that prison remittals exhibited a higher severity of overall psychopathic symptomatology than did community discharges.

Across the PCLR: SV Interpersonal and Social Deviance subscales, scores were also greater for prison remissions (I-Mdn = 3.8, IQR = 5; SD-Mdn = 9, IQR = 5.2) than for community discharges (I-Mdn = 1, IQR = 3; S-Mdn = 6, IQR = 5), Interpersonal: $u = 1039.0$, $p < .001$; Social Deviance: $u = 1165.0$, $p < .001$, suggesting that prison remittals exhibited a higher severity of both more interpersonal and affective symptoms of psychopathy as well as social deviance symptoms.

Table 4.18. Mann Whitney U comparisons of PCLR:SV scores across discharge destination ($n = 131$)

	Median (IQR) min – max			U	z	p	r
	Total	Community discharge	Prison remission				
<i>Internal Factors</i>	2 (5) 0 to 11	1 (3) 0 to 8	3.8 (5) 0 to 11	1039.00	-4.390	<.001	-.38
<i>Social Deviance Factors</i>	8 (7) 0 to 12	6 (5) 0 to 12	9 (5.2) 1 to 12	1165.00	-3.748	<.001	-.33
<i>Total</i>	10 (10) 0 to 23	7 (7.7) 0 to 19	13 (8.2) 2 to 23	990.50	-4.58	<.001	-.40

4.9.2 Final psychopathy judgement

The PCL-R: SV allows the evaluator to provide a final psychopathy judgement. Scores of 18 and above on the PCL-R: SV offer a strong indication of psychopathy and warrant administration of the full PCL-R, whereas those scoring 13 through 17 may also be considered psychopathic and should be further evaluated, which would also include the administration of the full PCL-R. Those with a score of 12 or below are not considered to be psychopathic.

To examine the presence of participants who are considered to have a strong indication of psychopathy (score of 18+) and those who would require further evaluation, presence of these scores were compared across discharge destination (see table 4.19).

Participants who were not considered to be psychopathic (score of 12 or less) were 43% less likely to be remitted to prison (46% vs. 72%, $p < .001$, whereas those participants warranting further evaluation were 2 times more likely to be remitted to prison (34% vs. 15%, $p = .027$).

Likewise those participants with a strong indication of psychopathy were almost 9 times more likely to be remitted to prison than discharged to the community (20% vs. 2%, $p = .006$. However, the latter risk ratio should be interpreted with caution given the width of the confidence intervals (see Table 4.19).

Table 4.19. Rate ratio comparisons of PCLR:SV final psychopathy judgement ($n = 131$)

	<i>n</i> (%)			χ^2	<i>p</i>	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Score of 0 – 12	90 (68)	37 (72)	40 (46)	15.55	<.001	0.57 (0.43 – 0.74)
Score of 13 – 17	23 (18)	7 (16)	29 (34)	4.89	.027	2.17 (1.03 – 4.55)
Score of 18 +	18 (14)	1 (2)	17 (20)	7.67	.006	8.89 (1.22 - 64.70)

To allow for further investigation into which key factors may influence higher median ratings across total, interpersonal and social deviance scales and results in high overall psychopathy judgements, the 12 individual PCLR: SV items were compared for presence across discharge destination in the following analysis.

4.9.3 *Definite presence*

(Participants rated with a score '2' vs. those rated with a score of '0' or '1', across all items)

The time-line for coding these factors is on the basis of the participant's life-time functioning, i.e. what the participant is like most of the time, in most situations, with most people (as per the manual guidance). Items were not rated solely on the basis of the participant's presentation in the time preceding discharge as their presentation at this time may have been atypical of their usual functioning due to situational factors (i.e. approaching discharge from medium secure services).

Interpersonal

Prison remittals were more likely to be characterised as someone who engages in lying, deception and other manipulations in order to achieve their own personal goals ('Deceitful', I item 3), (12% vs. 0%, $p = .014$) and to have little affective bonding with others ('Lacks empathy', I item 5), (24% vs. 0%, $p < .001$). Prison remittals were also 7 times more likely to be characterised as lacking the capacity for guilt ('Lacks remorse', I item 4), (33% vs. 4%, $p < .001$) and were almost 15 times more likely to be characterised as someone who avoids taking personal responsibility for their harmful behaviour ('Doesn't accept responsibility', I item 6) (34% vs. 2%, $p < .001$), than community discharges. However, the latter risk ratio should be interpreted with caution given the width of the confidence intervals (see Table 4.20). There was no association with definite presence of items 'Superficial' (I item 1) and 'Grandiose' (I item 2) and discharge destination.

Social Deviance

Definite presence of all Social Deviance Subscale items was more likely for prison remissions. Prison remissions were around 2 times more likely to be characterised as someone who acts without considering the consequences of their actions ('Impulsive', SD item 7) (49% vs. 22%, $p = .003$), as someone who can be easily angered or frustrated ('Poor behavioural control', SD item 8) (44% vs. 23%, $p < .001$), and as not have any realistic long term plans and commitments ('Lacks goals', SD item 9) (31% vs. 23%, $p = .024$). Prison remittals were also 2 times more likely to be characterised as someone who exhibits behaviour that frequently causes hardship to others and puts others at risk ('Irresponsible', SD item 10) (41% vs. 19%, $p = .011$), to frequently violate formal, explicit rules and regulations ('Adult anti-social behaviour', SD item 12), (69% vs. 36%, $p < .001$), and were also 1.5 times more likely to be characterised as having serious conduct problems as an adolescent ('Adolescent anti-social behaviour', SD item 11), (55% vs. 36%, $p = .038$).

Table 4.20. Rate ratio comparisons of PCLR:SV individual items - definitely present (*n* = 131)

	<i>n</i> (%)			χ^2	<i>p</i>	RR (95% CI)
	Total	Community discharge	Prison remission			
Interpersonal						
1 Superficial	3 (2)	-	3 (3)	1.07	.280*	-
2 Grandiose	5 (4)	-	5 (6)	2.72	.117*	-
3 Deceitful	10 (8) a	-	10 (12)	6.03	.014*	-
4 Lacks remorse	29 (23) b	2 (4)	27 (33)	12.78	<.001**	7.16 (1.78 - 28.71)
5 Lacks empathy	20 (16) c	-	20 (24)	12.50	<.001***	-
6 Doesn't accept responsibility	30 (23) d	1 (2)	29 (34)	16.22	<.001**	14.84 (2.09 - 105.34)
Social deviance						
7 Impulsive	52 (40)	10 (22)	42 (49)	8.74	.003**	2.20 (1.22 - 3.96)
8 Poor behavioural control	56 (43) e	10 (23)	46 (44)	11.23	<.001**	2.35 (1.32 - 4.20)
9 Lacks goals	46 (36) f	10 (23)	36 (31)	5.08	.024	1.89 (1.04 - 3.43)
10 Irresponsible	43 (34) g	8 (19)	35 (41)	6.52	.011	2.21 (1.13 - 4.35)
11 Adolescent anti-social behaviour	63 (48)	16 (36)	47 (55)	4.32	.038	1.54 (0.99 - 2.38)
12 Adult anti-social behaviour	75 (57)	16 (36)	59 (69)	13.18	<.001**	1.93 (1.27 - 2.93)

a community *n* = 45, prison *n* = 81;
b community *n* = 44, prison *n* = 83;
c community *n* = 43, prison *n* = 82;
d community *n* = 44, prison *n* = 86;

e community *n* = 44, prison *n* = 86;
f community *n* = 44, prison *n* = 84.
g community *n* = 43, prison *n* = 85;

* Fishers exact test used as 25% of expected count <5, and/or observed counts < 1
** Also significant at Bonferroni corrected alpha, *p* < .0042

4.9.4 *Partial / definite presence*

(Participants rated with a score of '1' or '2' vs. those rated with a score of '0', across all items)

Interpersonal

As with the analysis of definite presence, prison remittals were more likely to have partial / definite presence of; 'Lacks remorse' (I item 4) (66% vs. 39%, $p = .002$), 'Lacks empathy' (I item 5), (63% vs. 33%, $p = .001$, and 'Doesn't accept responsibility' (I item 6) (66% vs. 48%, $p = .041$, than community discharges. However, a difference for partial / definite presence of 'Deceitful' (I item 3) was not observed. Interestingly, whilst no difference was observed for definite presence alone, prison remittals were over 2.5 times more likely to be identified as someone who has partial/definite presence of an interactional style which appears superficial ('Superficial', I item 1), (23% vs. 9%, $p = .044$), and to be described as grandiose or as a braggart ('Grandiose' (I item 2), (23% vs. 9%, $p = .044$), than community discharges,

Social Deviance

As with definite presence, partial / definite presence of all Social Deviance Subscale items were more likely for prison remissions, aside from 'Impulsive' (SD item 7) which did not differ across discharge destination ('Poor behavioural control' (SD item 8): 88% vs. 75%, $p = <.050$; 'Lacks goals'(SD item 9): 85% vs. 61%, $p = .003$; 'Irresponsible'(SD item 10): 80% vs. 56%, $p = .005$; 'Adolescent anti-social behaviour'(SD item 11): 80% vs. 62%, $p = .026$; 'Adult anti-social behaviour' (SD item 12): 99% vs. 91%, $p <.028$).

Table 4.21. Rate ratio comparisons of PCLR:SV individual items partially / definitely present (n = 131)

	n (%)			χ^2	p	RR (95% CI)
	Total	Community discharge	Prison remission			
Interpersonal						
1 Superficial	24 (18)	4 (9)	20 (23)	4.07	.044	2.62 (0.95 to 7.19)
2 Grandiose	24 (18)	4 (9)	20 (23)	4.07	.044	2.62 (0.95 to 7.19)
3 Deceitful	34 (27) a	8 (18)	26 (32)	3.01	.083	1.81 (0.89 to 3.65)
4 Lacks remorse	72 (57) b	17 (39)	55 (66)	8.94	.002**	1.71 (1.15 to 2.57)
5 Lacks empathy	66 (53) c	14 (33)	52 (63)	10.78	.001**	1.95 (1.23 to 3.09)
6 Doesn't accept responsibility	78 (60) d	21 (48)	57 (66)	4.17	.041	1.39 (0.98 to 1.96)
Social deviance						
7 Impulsive	98 (75)	30 (67)	68 (79)	2.41	.120	1.19 (0.94 to 1.50)
8 Poor behavioural control	109 (84) e	33 (75)	76 (88)	3.84	.050	1.18 (0.98 to 1.42)
9 Lacks goals	98 (77) f	27 (61)	71 (85)	8.63	.003**	1.38 (1.07 to 1.77)
10 Irresponsible	92 (72) g	24 (56)	68 (80)	8.26	.005**	1.43 (1.08 to 1.91)
11 Adolescent anti-social behaviour	97 (74)	28 (62)	69 (80)	4.99	.026	1.29 (1.00 to 1.66)
12 Adult anti-social behaviour	126 (96)	41 (91)	85 (99)	4.80	.028	1.09 (0.99 to 1.19)

a community n = 45, prison n = 81;

b community n = 44, prison n = 83;

c community n = 43, prison n = 82;

d community n = 44, prison n = 86;

e community n = 44, prison n = 86;

f community n = 44, prison n = 84.

g community n = 43, prison n = 85;

* Fishers exact test used as 25% of expected count <5 and/or observed counts < 1

** Also significant at Bonferroni corrected alpha, p < .0042

4.10 Medium security recidivism assessment guide (MSRAG)

4.10.1 Assessment total and subscale ratings

Median MSRAG total and subscale ratings were compared across discharge destination to identify any differences in the two discharge groups in regards to the likelihood of future acquisitive or serious recidivism.

A Mann-Whitney test indicated that MSRAG total assessment scores were greater for prison remittals (Mdn = 15, IQR = 6.7) than for community discharges (Mdn = 13, IQR = 5.5), $u = 1621.0$, $p = .006$, indicating that prison remittals had greater risk of future recidivism than did community discharges.

Across the MSRAG Acquisitive and Serious subscales, scores were greater for prison remittals (A-Mdn = 8, IQR = 3; S-Mdn = 7, IQR = 4) than for community discharges (A-Mdn = 7, IQR = 3; S-Mdn = 6, IQR = 3.5), Acquisitive: $u = 1703.50$, $p = .016$; Serious: $u = 1621.0$, $p = .006$, indicating that prison remissions had greater risk of both future acquisitive and serious recidivism than did community discharges.

Table 4.22. Mann Whitney U comparisons of MSRAG scores across discharge destination ($n = 141$)

	Median (IQR) min – max			<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
	Total	Community discharge	Prison remission				
<i>Acquisitive</i>	7 (3) 2 to 11	7 (3) (2 to 11)	8 (3) 4 to 11	1703.50	-2.411	.016	-.203
<i>Serious</i>	7 (3) 2 to 11	6 (3.5) 2 to 11	7 (4) 3 to 11	1621.50	-2.749	.006	-.232
<i>Total</i>	14 (6) 5 to 22	13 (5.5) 5 to 22	15 (6.7) 7 to 22	1621.50	-2.749	.006	-.231

4.10.2 Final recidivism judgements for acquisitive and serious offending

The MSRAG allows the evaluator to provide a final judgement for likelihood of acquisitive and serious reoffending. Risk is considered on a 4 point scale ranging from low risk to very high risk (see table 4.23). Prison remittals were 1.5 times more likely to be considered to have high risk of future acquisitive reoffending (52% vs. 35%, $p = .047$) whereas they were 45% less likely to be considered low risk for serious reoffending (12% vs. 24%, $p = .055$). There were no other differences observed across discharge destination for the other risk ratings for both acquisitive and serious reoffending.

Table 4.23. Rate ratio comparisons of MSRAG final recidivism judgements ($n = 141$)

	<i>n</i> (%)			χ^2	<i>p</i>	Risk Ratio (95%CI)
	Total	Community discharge	Prison remission			
<i>Acquisitive</i>						
Low risk	33 (23)	16 (33)	17 (18)	3.58	.058	0.56 (0.31 - 1.02)
Moderate risk	40 (28)	15 (31)	25 (27)	0.19	.666	0.89 (0.52 - 1.52)
High risk	65 (46)	17 (35)	48 (52)	3.93	.047	1.50 (0.98 - 2.31)
Very high risk	3 (2)	1 (2)	2 (2)	0.00	.958	1.07 (0.10 - 11.45)
<i>Serious</i>						
Low risk	23 (16)	12 (24)	11 (12)	3.68	.055	0.49 (0.23 - 1.02)
Moderate risk	63 (45)	24 (49)	39 (42)	0.56	.454	0.86 (0.60 - 1.25)
High risk	41 (29)	11 (22)	31 (34)	1.93	.164	1.51 (0.83 - 2.72)
Very high risk	14 (10)	2 (4)	12 (13)	2.87	.090	3.19 (0.74 - 13.71)

4.11 Violence risk assessment tool summary diagrams

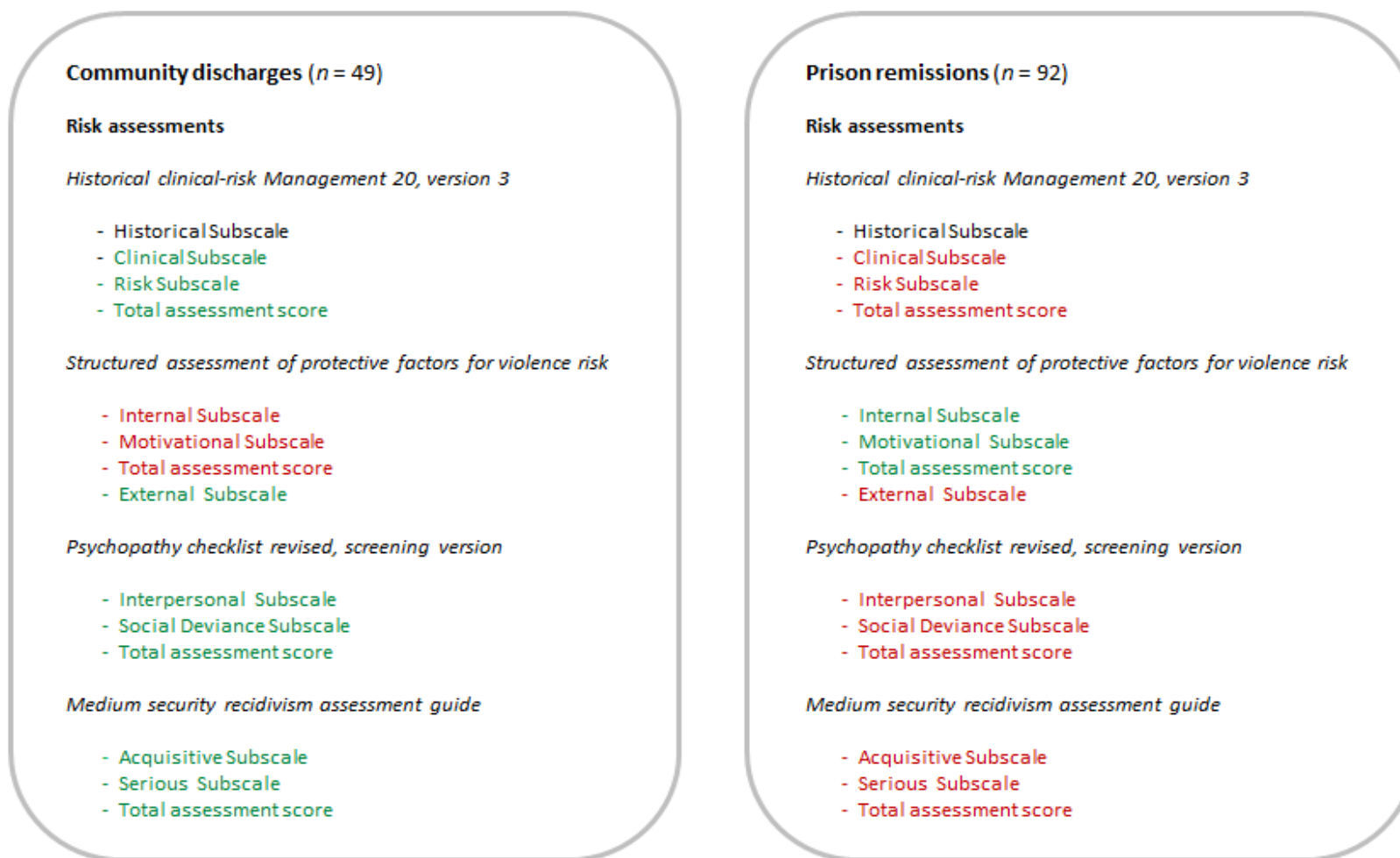


Figure 4.2:
Violence risk assessment average scores
across discharge destination

Significantly higher
Significantly lower
No difference

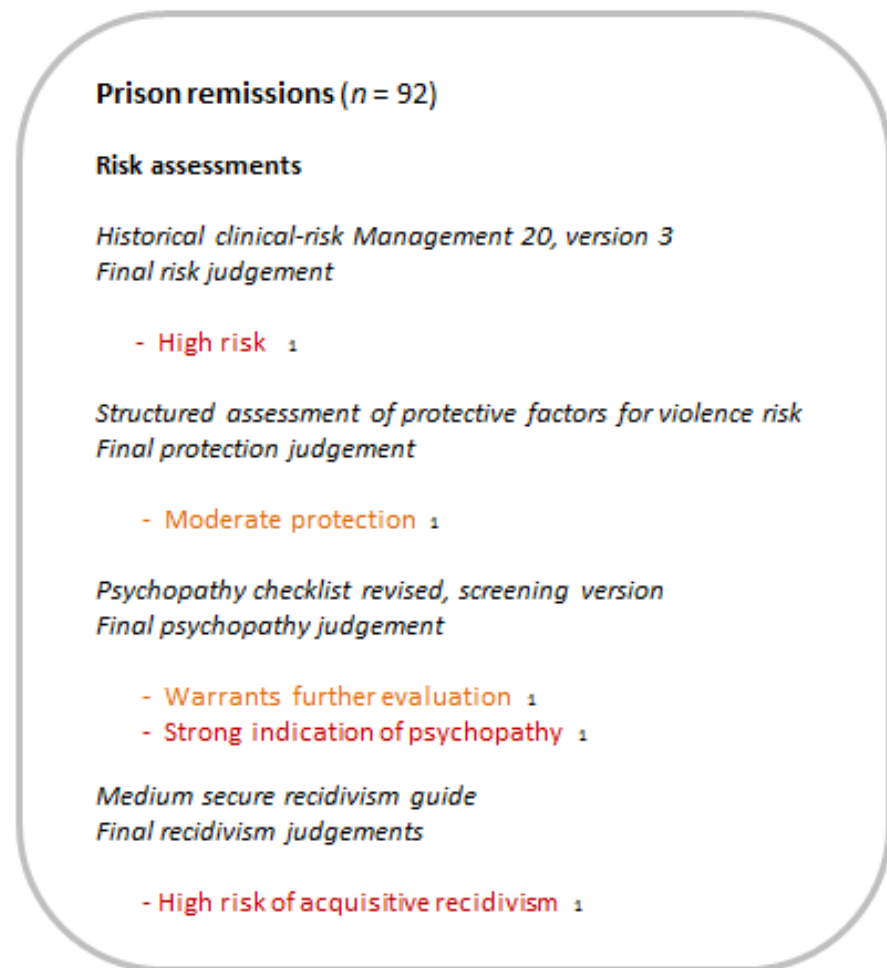
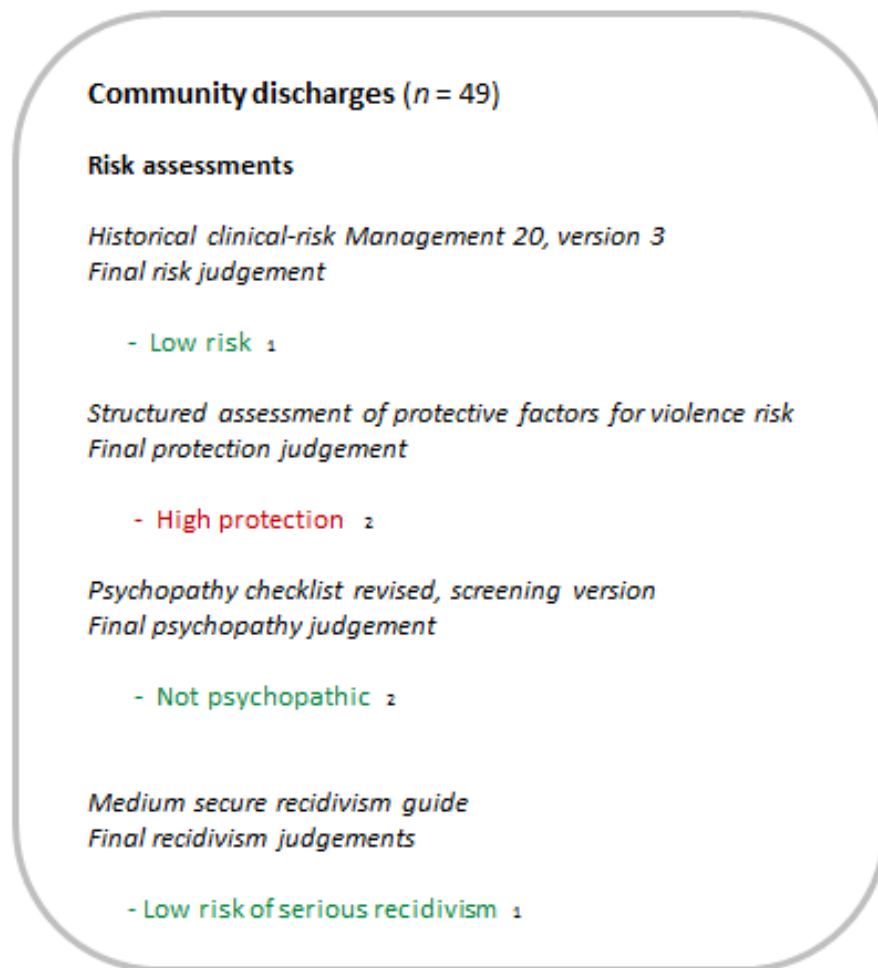


Figure 4.3:
 Violence risk assessment final judgements
 likelihood across discharge destination

¹ Significant at alpha p < .05
² Significant at alpha p < .001

Community discharges (n = 49)

Risk assessments

Historical clinical-risk Management 20, version 3

M5 Major Mental Health

Structured assessment of protective factors for violence risk

- I 2 Secure attachment in childhood
- I 4 Effectively coping strategies 1
- I 5 Self-control 2
- M 6 Stable work situation 3
- M 7 Structured leisure activities
- M 9 Motivation for treatment 2
- M 10 Positive attitude towards authority 1
- M 11 Positive life goals 1
- M 12 Motivated to use medication effectively 3
- E 13 Social network
- E 14 Intimate relationship
- E 15 Professional care 2

Prison remissions (n = 92)

Risk assessments

*Historical clinical-risk Management 20, version 3**

- H7 Personality Disorder
- H9 Violent attitudes 1
- C1 insight
- C2 Violent ideation or intent 1
- C3 Symptoms of Major Mental Illness
- C4 Instability 3
- C5 Treatment or Supervision Response 1
- R1 Professional services and plans
- R3 Personal support 2
- R4 Treatment or supervision response
- R5 Stress or coping

*Structured assessment of protective factors for violence risk***

- E 16 Living circumstances 1
- E 17 External control 1

*Psychopathy checklist revised, screening version****

- I 1 Superficial
- I 2 Grandiose
- I 3 Deceitful
- I 4 Lacks remorse 1
- I 5 Lacks empathy 1
- I 6 Doesn't accept responsibility 2
- SD 7 Impulsive 2
- SD 8 Poor behavioural control 2
- SD 9 Lacks goals 3
- SD 10 Irresponsible 3
- SD 11 Adolescent anti-social behaviour
- SD 12 Adult anti-social behaviour 2

Figure 4.4:
Violence risk assessment individual item presence likelihood across discharge destination

Significant at alpha p < .05
 Green = more likely for both definite and definite/partial presence
 Purple = more likely for definite presence only
 Orange = more likely for partial/definite presence only

Also significant using Bonferroni adjusted alpha levels
 1 For both definite and partial/definite presence
 2 For definite presence only
 3 For partial presence only

163
Bonferroni adjusted alpha
 * p = .0025
 ** p = .0033
 *** p = .0042

4.12 Chapter summary

This chapter describes findings from a population of prisoner-patients detained in medium secure services that were discharged into the community or remitted to prison. There were 153 prisoner-patients discharged from 33 NHS medium secure services in England and Wales over a 6 month period, of which, 141 were eligible for inclusion in the above analysis.

It was identified that prisoner-patients detained in medium secure services have long psychiatric and criminal histories. Clear differences between prisoner-patient community discharges and prison remittals were identified across a range of variables considered for their potential to influence clinical team decisions, with regards to the discharge of this population. Key findings from investigated variables were briefly discussed in section 4.7, which highlighted that prison remittals were a potentially vulnerable group, who were more likely to have had a relatively short length of stay in medium secure services. Prison remittals were also more likely to have had a previous admission to medium secure services (including during their current prison sentence), and to have a history of self-harming (including in the time period preceding their admission), indicating that this is a complex group. Whilst prison remittals were more likely to have a primary diagnosis of personality disorder, community discharges, on the other hand, were more likely to have a psychotic condition, most commonly schizophrenia, and to have been admitted to medium secure services for a longer period prior to discharge. This suggests that community discharge decisions were oriented towards those prisoner-patients with psychotic conditions, although the degree to which these decisions involved consideration of violence risk was unclear.

Investigation into prisoner-patient presentation prior to discharge was conducted using 4 validated assessment tools. Levels of future risk were high, with just under a quarter of the sample being considered high risk for future violence (as assessed by the HCR: 20 v3). These high risk participants were almost 4 times more likely to be remitted to prison than discharged into the community. Overall risk for prison remittals was higher across clinical and future risk factors, with remittals showing more likelihood of issues such as lack of insight into their condition and behaviour, current violent ideation and intent, and evidence of emotional instability. Of particular significance was the proportion of remittals with recent and anticipated future issues with treatment or supervision response, and the proportion anticipated to have future issues with stress or coping. This is compounded by the relatively low presence of all internal and motivational factors considered important for protection against future violence within this group, suggesting that prison remittals are at heightened risk of both relapse and future violence. The finding that remittals are more likely to reoffend across both acquisitive and serious offence types supports this. The high level of suspected psychopathy amongst the prison remissions likely

reflects the prevalence of patients with a primary diagnosis of personality disorder in this group. However, the degree to which these interpersonal and social deviant traits impact upon remittal decisions is unclear. It could be that prison is seen as a safe place for the remittal of these prison-patients due to the secure and controlled nature of the prison environment, however it is unclear why prisoner-patients with an outlook as described would be remitted to services which are typically underfunded and offer limited therapeutic and offence related interventions. There is a clear risk of future violence amongst this group which raises issues of public protection regarding the eventual release of these participants into the community

Whilst patients with a primary diagnosis of severe mental illness (SMI) were 41% less likely to be remitted to prison, than discharged back into the community, a primary diagnosis of SMI was still the most common diagnostic group for prison remittals (40%, $n = 37$), of which 23% had a primary diagnosis of schizophrenia. It may be the case that these participants represent some of the 50 participants deemed to have definite/partial presence of recent symptoms of major mental disorder. It is therefore concerning that these participants might not receive the psychiatric services which they require before eventual release into the community from prison – especially considering the low rates of prisoners who engage with the necessary psychiatric services upon release (Lennox et al., 2012). However, given the prevalence of personality disorder in the prison remittal group (38%) vs. the community discharge group (8%), it might be that some of the observed differences across discharge destination are not representative of all persons remitted, particularly those with a primary diagnosis of SMI. For example, regarding to the presence of Oop items/traits which are known to characterise those with a diagnosis of personality disorder, such as the difference observed across the PCLR: SV or items such as ‘H9 Violent Attitudes’ on the HCR: 20 v3. Likewise some of the characteristics found to be less likely for prison remittals, such as length of stay of more than 24 months, or presence of protective factors which mitigate future violence, may not differ across community discharges and prison remittals among persons with SMI. As such is it currently not clear which characteristics may have the potential to influence discharge decisions for those prisoner-patients with a primary diagnosis of SMI. Therefore, to establish how prison remissions and community discharges with a primary diagnosis of SMI differ, participants were compared across key variable groups and scores across the violence risk assessment tools, according to their discharge destination (Study 1c). Key variables were those found to be associated with discharge destination in the whole sample.

Chapter 5

Results 1 c Factors associated with discharged destination:

Prisoner-patients diagnosed with a severe mental illness

This chapter provides an overview of the characteristics of prisoner-patients with a primary diagnosis of severe mental illness (SMI) that were discharged from medium secure services. A sub-analysis was conducted to establish how prison remittals and community discharges with a primary diagnosis of SMI differ. Participants were compared across key variable groups and scores across the violence risk assessment tools, according to their discharge destination. Key variables were those found to be associated with discharge destination for the study population in Study 1 b). This analysis included 78 prisoner-patients with a primary diagnosis of SMI; 41 community discharges and 37 prison remittals.

Findings are explored and presented under the following headings;

- Legal status and length of stay
- Clinical and criminological characteristics
- Violence risk assessment tools prior to discharge

5.1 Legal status and length of stay

As with the previous analysis, prison remittals were 72% less likely to be remand prisoners than were community discharges (22% vs. 78%, $p < .001$). In terms of length of stay, a Mann-Whitney U test indicated that prison remittals had a significantly shorter length of stay (Median = 207 days, IQR= 362.5) than did community discharges (Median = 748.5 days, IQR= 842.5), $U = 474.0$, $p = .004$. Over three quarters of the patients with a primary diagnosis of SMI had a stay of less than 24 months in medium security ($n = 60$, 77%); a stay of more than 24 months was 78% less likely for prison remissions (8% vs. 37%, $p = .003$).

5.2 Clinical and criminological variables

Fourteen participants (18%) with a primary diagnosis of SMI had a previous admission to medium secure services and, for two participants, this was their second admission to medium secure services during their current prison sentence. A previous MSU admission was over 4 times more likely for prison remittals than community discharges (30% vs. 7%, $P = .010$).

Just under half of the participants with a primary diagnosis of SMI had a documented history of self-harm ($n = 37$, 47%) and, for 24%, self-harming behaviour was documented to have taken place in prison prior to transfer to medium secure services - this was 3.1 time more likely for prison remittals than community discharges (38% vs. 12%, $p = .008$).

Prison remittals with a primary diagnosis of SMI were more likely to have an Index Offence categorised as 'Loss of life', (27% vs. 0%, $p < .001$). However, linear analysis (Mann Whitney U) revealed that median Severity of Index Offence across prison remittals and community discharges did not significantly differ (see Table 5.2). No other associations were observed for patients with a primary diagnosis of SMI across discharge destination for the remaining criminological or clinical characteristics.

Table 5.1 Rate ratio comparisons of prison and community discharges across clinical and criminal characteristics ($n = 78$)

	n (%)			χ^2 *	P	RR (95% CI)
	Total	Community Discharge	Prison Remission			
2 nd or sub < MSU	2 (3)	-	2 (5)	2.27	.131	-
Previous MSU admission	14 (18)	3 (7)	11 (30)	6.63	.010	4.06 (1.23 – 13.44)
History of self-harm	37 (47)	16 (39)	21 (57)	2.45	.117	1.45 (0.90 – 2.34)
Self-harm prior to admission	19 (24)	5 (12)	14 (38)	6.94	.008	3.10 (1.24 – 7.78)
Length of stay (2 cats)						
0 – 24 months	60 (77)	26 (63)	34 (92)	8.88	.003	1.45 (1.23 – 1.86)
24 months +	18 (23)	15 (37)	3 (8)			
Length of stay (5 cats)						
0 – 6 months	24 (31)	9 (22)	15 (41)	3.16	.076	1.85 (0.92 – 3.71)
6 – 12 months	22 (28)	11 (27)	11 (30)	0.08	.776	1.11 (0.55 – 2.25)
12 – 18 months	9 (12)	3 (7)	6 (16)	1.51	.219	2.22 (0.60 – 8.23)
18 – 24 months	5 (6)	3 (7)	2 (5)	0.12	.731	0.74 (0.13 – 4.18)
24 months +	18 (23)	15 (37)	3 (8)	8.88	.003	0.22 (0.07 – 0.70)

Legal status						
Remand	40 (51)	32 (78)	8 (22)	24.79	<.001	0.28 (0.15 – 0.52)
Sentenced	38 (49)	9 (22)	29 (78)			
IPP	7 (9)	3 (7)	4 (11)	0.29	.590	1.48 (0.35 – 6.17)
Severity of index offence						
Non-violent	3 (4)	1 (2)	2 (5)	0.46	.496	2.22 (0.21 – 23.45)
Ambiguous violence	2 (3)	-	2 (5)	2.27	.121	-
Property crime	8 (10)	3 (7)	5 (14)	0.81	.368	1.84 (0.47 – 7.20)
Threats to person	12 (15)	10 (24)	2 (5)	5.38	.020	0.22 (0.05 – 0.95)
Attacks on person	43 (55)	27 (66)	16 (43)	4.02	.045	0.66 (0.43 – 1.01)
Loss of life	10 (13)	-	10 (27)	12.71	<.001	-

* Fishers exact test applied as 25% of expected count <5, and/or observed counts <1

Table 5.2 Mann Whitney U comparisons of prison and community discharges across clinical and criminal characteristics ($n = 78$)

	Median (IQR) min – max			U	z	p	r
	Total	Community discharge	Prison remission				
Length of stay	292 (568.8) 33 to 1912	404 (842.5) 67 to 1912	207 (362.5) 33 to 1562	474.00	-2.85	.004	.32
Severity of index offence	5 (1) 1 to 6	5 (1) 1 to 5	5 (3) 1 to 6	633.50	-1.38	.169	.17

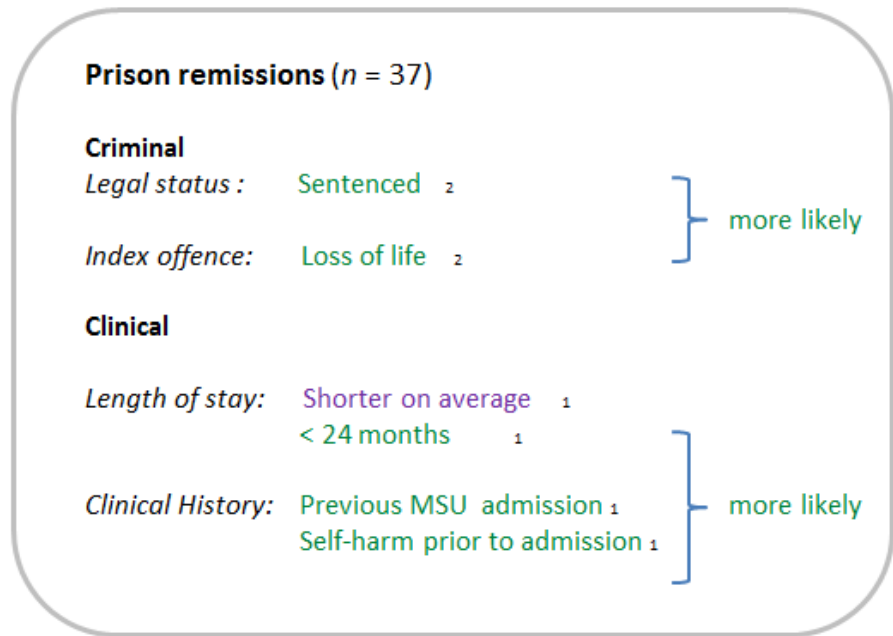
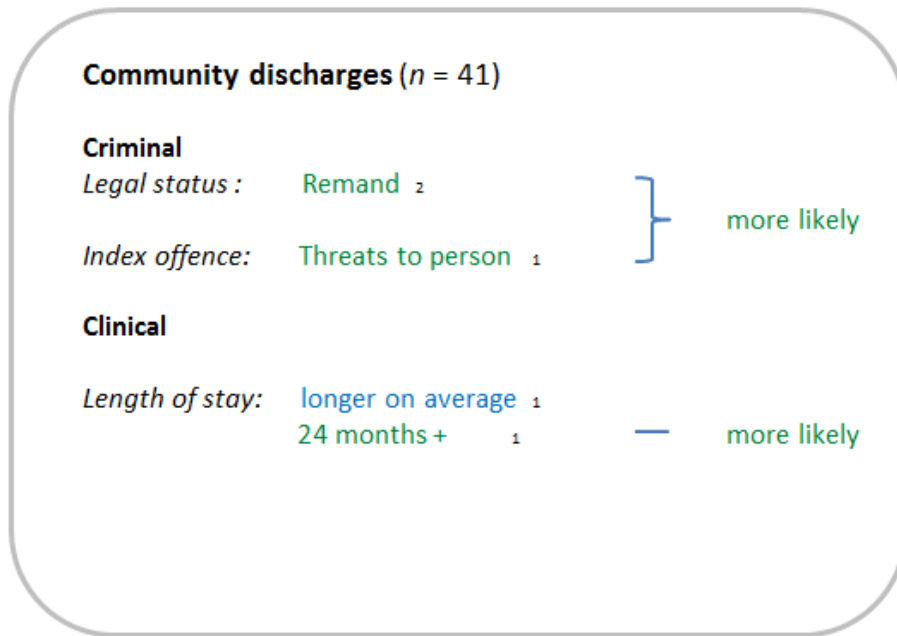


Figure 5.1
 Variable associations across discharge destination
 for participants with a primary diagnosis of SMI

- 1 Significant at alpha p < .05
- 2 Significant at alpha p < .001

5.3 Validated violence risk assessment tools

Patients with a primary diagnosis of SMI were compared across discharge destination for their scores on the validated violence risk assessment tools. Patients were not compared across individual items for the sub-analysis, due to the smaller sample size and therefore reduced statistical power for comparison of items.

5.4 Historical clinical-risk Management 20, version 3

5.4.1 Assessment total and subscale ratings

A Mann-Whitney test indicated that HCR: 20v3 total assessment scores were higher for prison remissions (Mdn = 23, IQR= 13.17) than for community discharges (Mdn = 21, IQR= 11.61), $U = 555.0$, $p = .042$, indicating that prison remissions posed an overall higher risk of future violence than did community discharges. Likewise, across the HCR: 20v3 Clinical Factors scores were higher for prison remissions (Mdn = 4, IQR= 5) than for community discharges (Mdn = 2, IQR= 3), $U = 450.5$, $< .002$. This indicates that prison remittals with a primary diagnosis of SMI were more likely to have had recent problems with psychosocial adjustment in the period preceding discharge, than community discharges.

Table 5.3 Mann Whitney U comparisons of HCR20 scores across discharge destination ($n = 78$)

	Median (IQR) min – max			U	z	p	r
	Total	Community discharge	Prison remission				
<i>Historical Factors</i>	14.4 (5) 4 to 20	14.4 (5) 4 to 20	15 (6.17) 5.56 to 20	701.0	-.577	.564	.06
<i>Clinical Factors</i>	3 (5) 0 to 10	2 (3) 0 to 10	4 (5) 0 to 9	450.5	-3.113	.002	.35
<i>Risk Factors</i>	5 (3) 1 to 10	4.0 (4) 1 to 10	6 (3.5) 2 to 10	582.5	-1.781	.075	.20
<i>Total</i>	22 (12.22) 7 to 35	21 (11.61) 7 to 35	23 (13.17) 9.56 to 35	555.0	-2.038	.042	.23

5.4.2 Final structured risk judgement

There was no significant difference in the proportion of prison remittals and community discharges rated as low, moderate and high risk of future violence for patients with a primary diagnosis of SMI (see Table 5.4). However, whilst the rate ratios presented in Table 5.4 are not close to reaching significance, they follow the pattern of the final structured risk judgements in the previous analysis (See Table 4.11). As such this is evidence of an underpowered analysis in this case.

Table 5.4 Rate Ratio comparisons of HCR 20: V3 final risk judgement ($n = 78$)

Risk	n (%)			χ^2	p	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
Low	34 (44)	20 (49)	14 (38)	0.95	.330	0.77 (0.46 – 1.30)
Moderate	30 (38)	16 (39)	14 (38)	0.01	.914	0.97 (0.55 – 1.70)
High	14 (18)	5 (12)	9 (24)	1.94	.163	1.99 (0.73 - 5.41)

5.5 Structured assessment of protective factors for violence risk

5.5.1 Assessment total and subscale ratings

Across the SAPROF Motivational Factor subscale, scores were lower for prison remissions (Mdn = 5, IQR = 5) than for community discharges (Mdn = 8, IQR = 6.2), $u = 470.5$, $p = .004$. This indicates that prison remittals with a primary diagnosis of SMI had less motivation for and more negative attitudes towards several aspects of treatment. Likewise for the Internal Factor subscale, scores were lower for prison remissions (Mdn = 3, IQR = 3) than for community discharges (Mdn = 4, IQR = 2), $u = 516.5$, $p = .014$, indicating that prison remittals had fewer historical and dynamic internal characteristics which are protective against future violent behaviour, than did community discharges. However, for the External Factor subscale, scores were greater for prison remissions (Mdn = 6, IQR = 1) than for community discharges (Mdn = 5, IQR = 3), $u = 481.5$, $p = .005$, suggesting that prison remittals have more environmental factors considered beneficial in offering protection from outside of the individual. There was no difference observed across total SAPROF scores.

Table 5.5. Mann Whitney U comparisons of SAPROF scores across discharge destination ($n = 78$)

	Median (IQR)(min – max)			<i>U</i>	<i>z</i>	<i>p</i>	<i>r</i>
	Total	Community discharge	Prison remission				
<i>Internal Factors</i>	4 (2) 0 to 6	4 (2) 1 to 6	3 (3) 0 to 6	516.5	-2.458	.014	.28
<i>Motivational Factors</i>	7 (5.25) 0 to 12	8 (6.2) 2 to 12	5 (5) 0 to 10.8	470.5	-2.892	.004	.33
<i>External Factors</i>	5.5 (2) (2 to 8)	5 (3) 2 to 8	6 (1) 4 to 8	481.5	-2.835	.005	.32
<i>Total</i>	15.3 (7.55) 6 to 25	16 (9.35) 7 to 25	15.2 (8.5) 6 to 23.8	585.5	-1.734	.083	.20

5.5.2 Final protection judgement

Just over a quarter of the participants were rated as having high protection, these participants were 71% less likely to be remitted to prison than discharged into the community (11% vs. 37%, $p = .008$). There was no significant difference in the proportion of prison remittals and community discharges rated as having moderate and low protection for participants with a primary diagnosis of SMI.

Table 5.6. Rate Ratio comparisons of SAPROF final protection judgements ($n = 78$)

Protection	<i>n</i> (%)			χ^2	<i>p</i>	Rate Ratio (95% CI)
	Total	Community discharge	Prison remission			
Low	11 (14)	3 (7)	8 (22)	3.29	.070	2.95 (0.85 – 10.32)
Moderate	48 (62)	23 (56)	26 (66)	1.67	.196	1.25 (0.89 – 1.76)
High	19 (24)	15 (37)	4 (11)	7.01	.008	0.29 (0.11 – 0.81)

5.6 Psychopathy checklist revised, screening version

5.6.1 Assessment total and subscale ratings

A Mann-Whitney test indicated that PCLR: SV total assessment scores were greater for prison remittals (Mdn = 10.5, IQR = 11.9) than for community discharges (Mdn = 6, IQR = 7), $U = 395.5$, $p = .003$, suggesting that prison remittals exhibited a higher severity of overall psychopathic symptomatology than did community discharges. Across the interpersonal subscale scores were greater for prison remittals (Mdn = 2, IQR = 6.5) than community discharges (Mdn = 1, IQR = 2), $U = 421$, $P = .006$, as were scores of the Social Deviance subscale, (Prison Mdn = 9, IQR = 6.3, Community Mdn = 6, IRQ = 4.1; $U = 423.5$, $p = .007$). This indicates that prison remittals exhibited a higher severity of both more interpersonal and affective symptoms of psychopathy as well as social deviance symptoms.

Table 5.7. Mann Whitney U comparisons of PCLR:SV scores across discharge destination ($n = 73$)

	Median (IQR) min – max			U	z	p	r
	Total	Community discharge	Prison remission				
<i>Interpersonal Factors</i>	1.2 (4) 0 to 11	1 (2) 0 to 6	2 (6.5) 0 to 11	421.0	-.261	.006	.03
<i>Social Deviance Factors</i>	6 (6.5) 0 to 12	6 (4.1) 0 to 11	9 (6.3) 1 to 12	423.5	-2.685	.007	.31
<i>Total</i>	8 (9) 0 to 23	6 (7) 0 to 13	10.5 (11.95) 2 to 23	395.5	-2.989	.003	.35

5.6.2 Final psychopathy judgement

Participants who were not considered to be psychopathic (score of 12 or less) were 38% less likely to be remitted to prison (56% vs. 89%, $p = .001$), whereas those participants with a strong indication of psychopathy were more likely to be remitted to prison (19% vs. 0%, $p = .005$).

Table 5.8. Rate ratio comparisons of PCLR:SV final psychopathy judgement ($n = 73$)

	<i>n</i> (%)			χ^2	<i>p</i>	RR (95% CI)
	Total	Community discharge	Prison remission			
Score of 0 – 12	53 (73)	33 (89)	20 (56)	10.38	.001	0.62 (0.45 – 0.85)
Score of 13 – 17	13 (18)	4 (11)	9 (25)	2.51	.113	2.31 (0.78 – 6.84)
Score of 18 +	7 (10)	-	7 (19)	7.96	.005	-

5.7 Medium security recidivism assessment guide

5.7.1 Assessment total and subscale ratings

A Mann-Whitney test indicated that MSRAG total assessment scores were greater for prison remissions (Mdn = 16, IQR = 6) than for community discharges (Mdn = 12, IQR = 5.5), $U = 474$, $p = .004$, indicating that prison remissions had greater risk of future recidivism than did community discharges. Across the MSRAG Acquisitive and Serious subscales, scores were greater for prison remissions (A-Mdn = 8, IQR = 3; S-Mdn = 8, IQR = 3) than for community discharges (A-Mdn = 6, IQR = 3; S-Mdn = 6, IQR = 3), Acquisitive: $U = 441.0$, $p = .004$; Serious: $U = 443.50$, $p = .001$, indicating that prison remissions had greater risk of both future acquisitive and serious recidivism than did community discharges.

Table 5.9. Mann Whitney U comparisons of MSRAG scores across discharge destination ($n = 78$)

	Median (IQR) min – max			U	z	p	r
	Total	Community discharge	Prison remission				
<i>Acquisitive</i>	7 (3) 3 to 11	6 (3) 3 to 11	8 (3) 4 to 11	474.0	-2.880	.004	.33
<i>Serious</i>	7 (3) 2 to 11	6 (3) 2 to 11	8 (3) 3 to 10	441.0	-3.208	.001	.36
<i>Total</i>	14 (6.2) 5 to 22	12 (5.5) 5 to 22	16 (6) 7 to 20	443.50	-3.165	.002	.36

5.7.2 Final recidivism judgements for acquisitive and serious offending

Prison remittals were 1.8 times more likely to be considered high risk of future acquisitive reoffending (51% vs. 29%, $p = .047$) and also 68% less likely to be considered to have low risk of future acquisitive reoffending (11% vs. 34%, $p = .015$).

Table 5.10 Rate ratio comparisons of MSRAG final recidivism judgements ($n = 78$)

	<i>n</i> (%)			χ^2	<i>p</i>	Rate ratio (95% CI)
	Total	Community discharge	Prison remission			
<i>Acquisitive</i>						
Low risk	18 (23)	14 (34)	4 (11)	5.97	.014	0.32 (0.11 – 0.88)
Moderate risk	27 (35)	14 (34)	13 (55)	0.01	.927	1.03 (0.56 – 1.89)
High risk	31 (40)	12 (29)	19 (51)	3.96	.047	1.75 (0.99 – 3.10)
Very high risk*	2 (3)	1 (2)	1 (3)	0.01	.941	1.10 (0.07 – 17.09)
<i>Serious</i>						
Low risk	17 (22)	11 (27)	6 (16)	1.29	.257	0.60 (0.25 – 1.47)
Moderate risk	34 (44)	22 (54)	12 (32)	3.56	.059	0.60 (0.35 – 1.04)
High risk	21 (27)	6 (15)	5 (41)	0.27	.604	1.38 (0.40 – 4.77)
Very high risk*	6 (8)	2 (5)	4 (11)	0.96	.326	2.22(0.43 – 11.40)

* Note the 'very high risk' stratum is considerably underpowered for both acquisitive and serious offending.

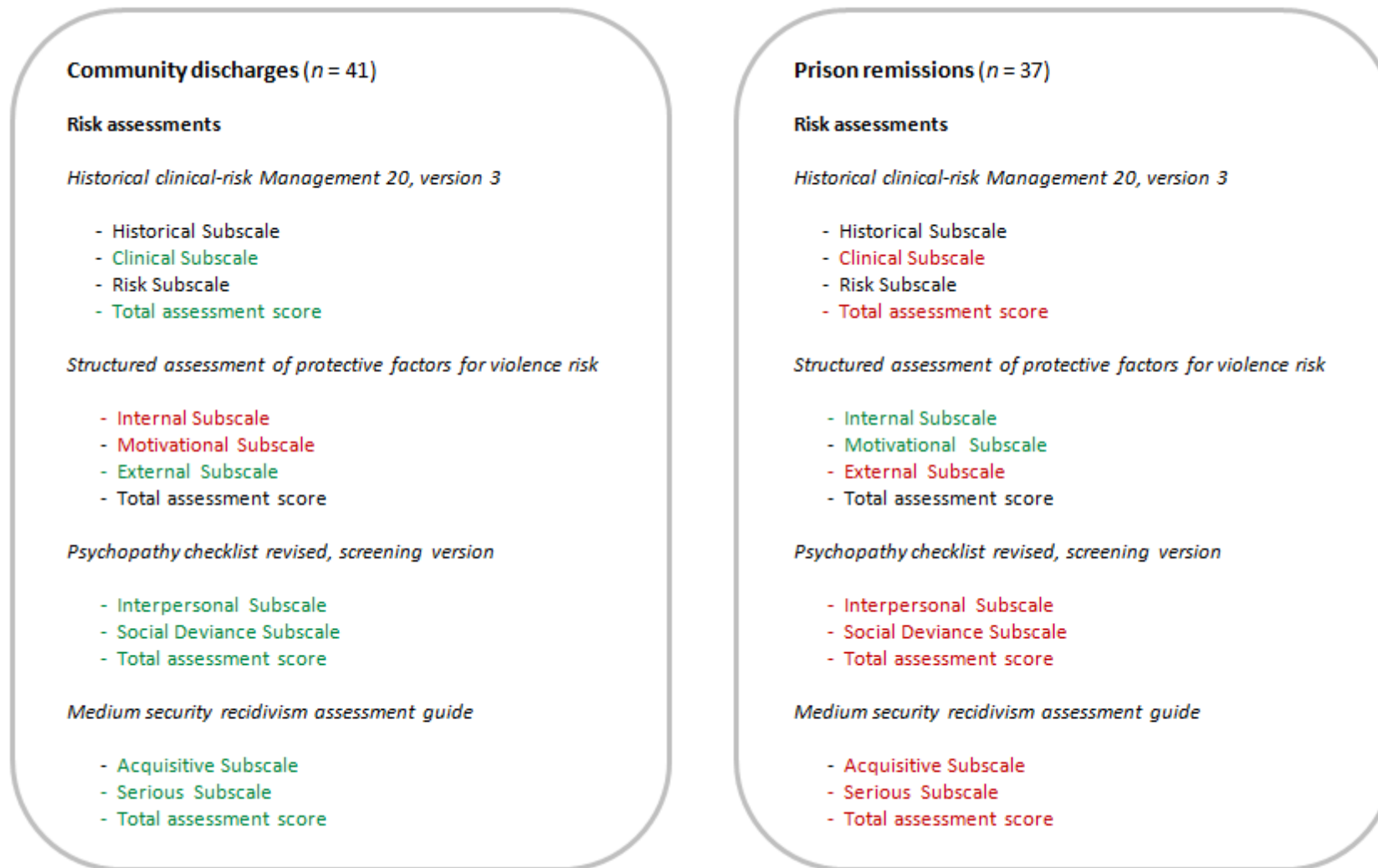


Figure 5.2: Violence risk assessment average scores across discharge destination for patient with a primary diagnosis of SMI

Significantly higher
Significantly lower
No difference

5.8 Pathways for participants with a primary diagnosis of SMI

To gain more of an understanding as to why some participants with a primary diagnosis of SMI are discharged into the community, and others remitted to prison, discharge circumstances for prisoner-patients with a primary diagnosis of SMI are described below. Tables 5.11 – 5.13 present these findings according to legal status at baseline.

Table 5.11 presents patients' legal statuses at admission and baseline from medium secure services for both community discharges and prison remittals, highlighting any changes in legal status that occurred during a patient admission. The implication of these legal status changes to patient discharge pathways are discussed in the chapter summary.

5.8.1 Community SMI discharge circumstances

Over half of the community discharges with a primary diagnosis of SMI were discharged under the powers of their Responsible Clinician after completing treatment ($n = 21$), whereas 13 were discharged under the Mental Health Act 1983, with the support of their Responsible Clinician (see Table 5.12). The remaining 7 were discharged following criminal court proceedings, also with the support of their Responsible Clinician. Over half of the community discharges with a primary diagnosis of SMI were liable to recall to hospital ($n = 21$); either on a Community Treatment Order or on subject to a Section 41 restriction order (see Table 5.13). Twenty-two of the persons discharged back into the community with SMI were discharged to supported accommodation or a bail hostel. Twelve were discharged to a family/home with partner and 5 were discharged to single occupancy accommodation; 2 patients had no fixed abode upon their discharge.

5.8.2 Prison SMI remittals discharge circumstances

The majority of prison remittals with an SMI diagnosis were discharged due to completion of treatment, ($n = 26$); 4 of whom returned to complete the work needed to apply for parole and 6 were documented as close to their earliest release date. Eight patients were remitted to prison due to not engaging with treatment/therapy ($n = 4$) or due to presenting as too 'high risk' to continue to be detained in the medium secure service ($n = 4$), and one patient was discharged due to the clinical team not detecting evidence of severe mental illness or symptomatology that would warrant detention in medium secure services. The remaining 2 patients were remitted due to court proceedings with the support of their Responsible Clinician (see Table 5.14).

Table 5.11 Legal status at admission and baseline from medium secure services (SMI)

Discharge destination	Legal status at baseline	Legal status at admission				Total	
		Sentenced	Remand / pre-sentence				
		s. 47/49	s. 35	s. 36	s. 38		s. 48/49
Prison remissions	Sentenced						
	s. 45a	-	-	-	2	1	3
	s. 47/49	29	-	-	-	-	29
	Remand/ pre-sentence						
	s. 35	-	1	-	-	-	1
	s. 38	-	-	-	1	-	1
	s. 48/49	-	-	-	-	3	3
Community discharges	Sentenced						
	s. 37n	6	-	-	-	-	6
	s. 37	-	-	1	-	7	8
	s. 37/41	1	1	-	1	9	12
	s. 47/49	2	-	-	-	-	2

Remand / pre-sentence						
s. 38	-	-	-	1	1	2
s. 48/49	-	-	-	-	5	5
Civil						
s. 3	-	-	-	-	5	5
Informal	-	-	-	-	1	1

Table 5.12. Discharge circumstances by section at baseline for community discharges with SMI (*n* = 41)

Section at baseline	RC	Other MHA				Court proceedings		
	Treatment complete	Parole Board	MHRT	HMH	NR	Recall – sentenced	Recall – bailed	Charges dropped
Sentenced								
s. 37	7	-	1	-	-	-	-	-
s. 37n	3	1	2	-	-	-	-	-
s. 37/41	7	-	5	-	-	-	-	-
s. 47/49	-	2	-	-	-	-	-	-
Remand / pre-sentence								
s. 38	-	-	-	-	-	1*	1	-
s. 48/49	-	-	-	-	-	3**	1	1
Civil								
s. 3	3	-	1	-	1	-	-	-
Informal	1	-	-	-	-	-	-	-

* *Community sentence*

** *1 community sentence, 1 suspended sentence and 1 time served whilst on remand*

Table5.13. Legal status at baseline (criminal and MHA) and circumstances post-discharge into the community for SMI (n = 41)

Section at baseline	Legal Status at community discharge			Living circumstances upon discharge				
	s. 41 Restriction	CTO	MHTR	Supported accom	Bail hostel	Family/ partner	Single occ	NFA
Sentenced								
s. 37	-	5	-	2	-	5	1	-
s. 37n	-	2	-	5	-	1	-	-
s. 37/41	12	-	-	6	4	1	1	-
s. 47/49	-	-	-	1	1	-	-	-
Remand/ pre-sentence								
s. 38	-	-	-	-	-	2	-	-
s. 48/49	-	-	-	-	-	2	1	2
Civil								
s. 3	-	2	-	1	1	1	2	-
Informal	-	-	-	1	-	-	-	-

CTO = Community Treatment Order, MHTR = Mental Health Treatment Requirement, supported accom = supported accommodation, Single occ = Single occupancy accommodation; NFA = No fixed abode

Table 5.14. Discharge circumstances by section at baseline for prison remissions with SMI (*n* = 37)

Section at baseline	Responsible clinician							Court proceedings	
	Treatment complete				Engagement / risk issues		Other	Recall	
	Complete sentence/ await trial	Patient request	Await deportation	Await PIPE	Not engaging	High Risk	No SMI	Sentenced custodial	Re-remanded
Sentenced									
s. 37n	-	-	-	-	-	-	-	-	-
s. 45A	3	-	-	-	-	-	-	-	-
s. 47/49	15*	3	3	-	3	4	1	-	-
Remand / pre-sentence									
s.35	-	-	-	-	-	-	-	-	1
s. 38	-	-	-	-	-	-	-	1	-
s. 48/49	1	-	1	-	1	-	-	-	-

* Four of these returned to complete the work needed to apply for parole and six were documented as close to their Earliest Release Date

5.9 Chapter summary

This chapter describes comparisons of discharge circumstances and key characteristics across community discharges and prison remittals with a primary diagnosis of SMI. There were 78 prisoner-patients with a primary diagnosis of SMI and there were differences observed between the two groups. These were similar to the findings from the main analysis conducted across all diagnostic groups combined in Chapter 4.

5.9.1 *Community discharges*

The majority of community discharges with SMI were remand prisoners at admission to medium secure services, and criminal court proceedings directed the discharge pathways for all of these patients. Over half of these patients received hospital treatment orders at court recall during their admission. The remaining remand prisoners received non-custodial sentences, were bailed into the community or had the charges against them dropped at court recall during their admission. Six of these patients remained in medium secure services detained under civil sections of the Mental Health Act following court recall, as their responsible clinician believed they still required treatment. The rest were released from court into the community as their responsible clinician did not consider further treatment in the MSU to be required. Therefore remittal to prison following treatment was not a discharge pathway option for any of these patients on date of discharge. This was also the case for seven of the community discharges who were sentenced at time of admission. These patients had remained detained in the medium secure service beyond their sentence expiration and became notional hospital orders (one reverted back to a previous 37/41). There were just two community discharge patients who were eligible for both community discharge or prison remittal at time of discharge. These were sentenced prisoners at admission and both remained in medium secure services up until their earliest release date when they were discharged via the Parole Board.

From the comparative analysis it is clear that community discharges with SMI represent a different population to those who are remitted to prison. Community discharges had a lower degree of recent problems with psychological adjustment, were considered to be a low risk of future recidivism, and had a higher degree of factors deemed to provide protection against future instances of violence, compared to patients with SMI who were remitted to prison. These protective factors included discharge arrangements. Over two-thirds of the community discharges had post-discharge supervised community accommodation arranged ($n = 28$), and over half had discharge conditions that included mandatory engagement with community mental health teams

($n = 21$). Therefore non-engagement or breach of other discharge conditions could result in recall to inpatient services for these patients. Such arrangements may in part account for the longer length of stay observed for community discharges, as community discharge is often met with the delays when waiting for appropriate aftercare and community accommodation to be finalised (Doyle et al., 2014). However it was unexpected that just under 50% of community discharges with SMI had a length of stay of less than 12 months (as did over 70% of remittals), as a stay in medium secure services of less than one year has been speculated as unlikely to confer significant therapeutic benefit (Alexander et al., 2006; Halstead et al., 2001).

5.9.2 *Prison remittals*

Just eight of the prison remittals with SMI were remand prisoners at admission to medium secure services. For six of these patients, a community discharge pathway was not an option due to criminal court decisions⁸, whereas 2 were remitted solely at the discretion of the responsible clinician; one following treatment to await trial and one due to not engaging with treatment on the unit. The majority of prison remittals with SMI were sentenced prisoners at admission, three of whom could only be remitted to prison as they were awaiting deportation. However the remaining sentenced patients were remitted solely at the discretion of their Responsible Clinician ($n = 26$). Eighteen patients were remitted to complete their sentence following treatment, ten of whom were documented as working towards parole or close to their Earliest Release date at time of discharge.

The final seven sentenced patients were remitted due to not engaging with treatment on the unit or for being too high risk to remain within the service. Given the deficits of current mental state and functioning apparent in the SMI prison remittal group as a whole, and their apparent risk for future violence and reoffending, it is unclear why these patients were discharged to an environment where they might not receive adequate follow-up from mental health inreach services. This group were highlighted as being less motivated to engage in treatment, and unlike many of the community discharges, there are no safeguards in place post-remittal to ensure mandatory engagement with medication and treatment for these patients. Prison is not recognised under the Mental Health Act as a designated hospital environment and therefore clinicians cannot practice forced treatments as in medium secure services. There is also currently no equivalent conditional discharge safeguard similar to a CTO or s.41 restriction that would activate hospital recall for prison remittals. Therefore, it could be that these patients are released

⁸ 3 x s. 45A hybrid Hospital orders, 1 x custodial sentence I, 1 x re-remanded, 1 x deportation

into the community from prison untreated and symptomatic, raising significant public protection concerns.

5.9.3 *Conclusions*

It was anticipated that the observed differences in characteristics across discharge groups in the main analysis (of all prisoner-patients irrespective of their diagnosis) may not be representative of prisoner-patients with a primary diagnosis of SMI, due to the proportion of patients remitted to prison with a primary diagnosis of personality disorder. However, overall, the key differences across discharge destination remained the same for patients with SMI, particularly in regards to the patients' presentations at time of discharge, as measured by the dynamic items on the violence risk assessment tools. Given the degree of problems with psychosocial adjustment in the period preceding discharge, prison remittals with SMI represent a potentially vulnerable group, especially when we consider that these patients were also more likely to be documented as self-harming in prison prior to their current admission.

It is interesting that prison remittals had a higher degree of psychopathic traits, both in terms of interpersonal traits and social deviance, as it was assumed that this finding in the 'all diagnoses combined' main analysis might also be due to the proportion of remittals with personality disorder. This finding could be in part due to the nature of the relationship between the patient's SMI and their offending behaviour. The majority of community discharges were those who either did not require a custodial sentence due to less severe index offences, or those who had received a hospital treatment order in place of a custodial sentence as their SMI was deemed to contribute to them having committed their offence. In contrast, almost all of the prison remittals were persons serving custodial sentences for more severe offences whom had become unwell during their stay in prison.

5.9.4 *Outstanding research questions*

The following areas of interest remain outstanding;

- It remains unclear to what extent the observed differences in characteristics across community discharges and prison remittals may impact on discharge pathways decisions made by clinicians.
- It is also unclear why some sentenced patients were remitted to prison just prior to their earliest release date, and the implications of this are as yet unknown as other individuals remain in medium secure services and are discharged into the community with aftercare arrangements in place.
- All but four patients with a primary diagnosis of personality disorder were remitted to prison and therefore meaningful comparison of characteristics across discharge destination for these patients could not be conducted. As such, why patients with a primary diagnosis of personality disorder are more likely to be remitted to prison is not known at this point.
- Prison remittals spent less time in medium secure services before discharge and were rated as having more recent problems with psychological adjustment and functioning in the time prior to discharge. In the same vein, some patients were remitted to prison due to not engaging with treatment or because they were considered too high risk. This is a finding which has not previously been discussed in the literature and therefore reasoning behind these decisions can only be speculated upon.

These outstanding questions could not be addressed adequately through this observational study alone; therefore alternative qualitative methodology was utilised in Study 2. Qualitative methodology allowed understanding of the nature of the observed pathway decisions to be sought, and provided a position to address the emerging exploratory research questions, principally;

- 1) How do clinicians account for apparent differences between those patients remitted to prison and those discharged into the community?

- 2) What are the experiences of clinicians when opting to remit patients back to prison from medium secure services?

It was the intention that research attempting to answer question 1) would add substantially to baseline findings and help to embed the observational data in clinical context. Addressing question 2) would provide information regarding clinical and policy decisions pertinent to remitting patients back to prison, alongside narratives of the hospital-prison care pathway and aftercare arrangements from the clinical team perspective.

Chapter 6

Methodology 2:

Qualitative investigation of clinicians' experiences of managing and discharging prisoner-patients from medium secure services

This chapter provides an overview of the methodology used for Study 2. The qualitative design, data collection and analysis methods will be discussed alongside the need for reflexivity.

6.1 Study objectives

The objectives of Study 2 were to;

- Gain insight into clinicians' experiences of receiving, managing and discharging prisoner-patients within medium secure services.
- Gain understanding of the processes which guide prisoner-patient pathways through medium secure services
- Explore how clinicians' account for the differences in characteristics for those discharged into the community and those remitted back to prison

6.2 Design considerations

As discussed in Methodology 1, a pragmatic approach to research design was adopted for the studies outlined in this thesis, where the phenomena of interest directed the research methodology used (Flick, 2002). As such the use of qualitative methodology was considered most appropriate for Study 2, given the nature of the outstanding areas of interest in Study 1. Qualitative methodology allows exploration of how individuals experience events in the context which they occur, alongside the meanings they ascribe to those events (Corbin & Strauss, 2008). Therefore it was anticipated that this approach would allow for in-depth exploration of clinicians' experiences of managing the care of, and discharging prisoner-patients from, medium secure services.

Qualitative methodology offers multiple data collection techniques to explore such complex issues, which can be used in conjunction with one another to add depth to research findings (Morse, 2002). A combination of a focus group and a series of semi-structured individual interviews were selected as the data collection method for this study. The use of both methods allowed for a broad and in-depth conceptualisation of clinicians' experiences and triangulation of these two data sources enhanced the subsequent analysis, and acted as a method for increasing the quality of the analysis (Creswell, 2003). The rationale for the chosen techniques, and the impact of data combination, are discussed below.

6.2.1 *Focus group*

For the first stage of Study 2 a group interview was selected with the intention of exploring a range of views across forensic psychiatrists. Consideration was given to the different formats for group interviews (See Table 6.1 for summary), and a focus group interview was deemed most appropriate to access a broad range of ideas and topics. Whilst similar to individual interviews in practice, a focus group allowed access to and prompted group interaction and discussion on the research topic. Discussion amongst attendees allowed for use of the interaction data between participants (e.g. questioning one another, passing comment on another's experiences) to increase the depth of my understanding and to unveil aspects of prisoner-patient management and discharge which were not accessible within the quantitative study alone. This process allowed for access to a range of perspectives and unique insight into areas of similarity and differences across clinicians' experiences.

Focus group attendees were all forensic psychiatrists to ensure a degree of associational context (Hollander, 2004), yet were also purposefully invited from across forensic mental health services to produce varied discussion (Hollander, 2004). This included inviting psychiatrists who were prison based or medium security based only, and also psychiatrists who acted as both the prison and medium security psychiatrist in their local prisoner-patient care pathway. This allowed for a breadth of experience in the management and discharge of prisoner-patients from both the secure estate and prison estate clinical perspective.

Consideration was given to how to recruit for the focus group interview. It was anticipated that it might not have been feasible to have a national sample of psychiatrists travel to one location to take part in the interview. In this case it was expected that uptake would have been poor and therefore only a limited range of perspectives would have been represented. Therefore the focus group was conducted in a place where psychiatrists from across the United Kingdom had already arranged to meet for a national annual conference. This increased the opportunity to maximise attendance at the group interview. In this case, however, the degree of relational context between the attendees could not be controlled. The extent of prior acquaintance across attendees may have impacted on the information they were willing to disclose (Kidd & Parshall, 2000), as there may well have been clinicians within the focus group who refer and discharge to one another's care within clinical practice. It was also recognised that this could be advantageous if it promoted lively debate. Whilst this focus group allowed for considerable information to be produced in a fairly short space of time, the attendees' opportunity for depth of personal narrative was reduced (Kitzinger, 2013). However, it was the intention that the focus group would identify key issues in the management and discharge of prisoner-patients, which would guide subsequent exploration in the individual interviews, which in turn, would further enrich the data from the focus group (see figure 6.1).

It is important to note that, whilst this sampling strategy ensured full focus group attendance, the nature of the conference may have biased the subsequent analysis. Those in attendance were likely to be professionals who were engaged in research and knowledgeable of the key policy pertinent to forensic psychiatry at the time. These attendees may not be representative of the average forensic psychiatrist, therefore this should be acknowledged when reading and drawing conclusions from the focus group data.

Table 6.1 Coreil's typology of group interviews

Interview type	Features	Typical use
Consensus panel	Often composed of key informants or experts. Seeks group consensus or normative reactions. More narrow, closed-ended stimulus material	Agreeing clinical protocols, resource prioritisation
Focus group	Participants selected to meet sampling criteria. Seeks broad range of ideas of open-ended topic. Formal, controlled pre-arranged time and place. Usually audio-recorded and	Testing health promotion materials, exploring service users' views
Natural group	Group exists independent of the research study. Format formal or informal. Interview guide loosely followed. Usually recorded by written notes	Ethnographic data collection (informal), social research (formal)
Community interview	Open to all or large segments of a community. Usually recorded by written notes	Project planning, programme evaluation

From Green and Thorogood (2014) *Qualitative methods for health research*, Chapter 5, p.127, adapted from Coreil (1995) *Group interview methods in community health research*.

6.2.2 *Semi-structured interviews*

For the second stage of Study 2 a series of semi-structured interviews was selected for elucidating in-depth clinical views and experiences of forensic clinicians. Consideration was given to the different formats for individual interviews (see Table 6.2), and semi-structured interviews were deemed most appropriate to further examine in detail the ideas and topics which arose in the focus group and the outstanding areas of interest from Study 1. This format allowed for the development of an interview guide to help ensure the intended topics of interest were discussed (see 6.7), yet had a good degree of flexibility; there was a set agenda for the topics to be covered but the interviewees response was able to determine the way in which the interview was directed.

Unlike in the focus group, the one-to-one nature of the individual interviews offered a higher degree of confidentiality and opportunity for engagement. The absence of other clinicians allowed interviewees to provide in-depth personal narrative, due to both the time available and the lack of relational context between attendees. Likewise, the use of individual interviews allowed for more control of who took part as clinicians were contacted directly which ensured a breadth of experiences based on the clinicians' profession, their place of work (prison or medium secure services) and their geographical location.

Table 6.2 Individual interviews

Interview type	Features
Unstructured	No pre-determined structure. Open ended themes/questions
Semi-structured	Pre-determined open-ended questions. Delivery is flexible and can be directed by the interviewees response
Structured	Predetermined questions delivered to all respondents in the same order

Information taken from Fielding (1994)

6.2.3 Data combination

Although individual interviews and focus groups are commonly used singularly in research, their combination in the same study can be advantageous, as data integration can result in complementary findings (Lambert & Loiselle, 2008). In my study, both methods were used for the same purpose and the data thereby generated were treated with equal importance. The focus group proved most useful for capturing a range of clinical experiences, but it also helped to identify pertinent issues to be explored in the individual interviews (in the same way that each individual interview may identify new issues to be explored in the next consecutive interview). The individual interviews enabled interviewees to provide more personal experience than did the focus group, which facilitated a complex depth of understanding to be gained as regards key issues. As such both, sets of data added to the interpretation of the findings and allowed for a coherent and nuanced understanding of clinicians' experiences of managing and discharging prisoner-patients. The combination of these two qualitative approaches also enhanced the methodological rigour of the study and enriched the trustworthiness of the findings (Lambert & Loiselle, 2008).

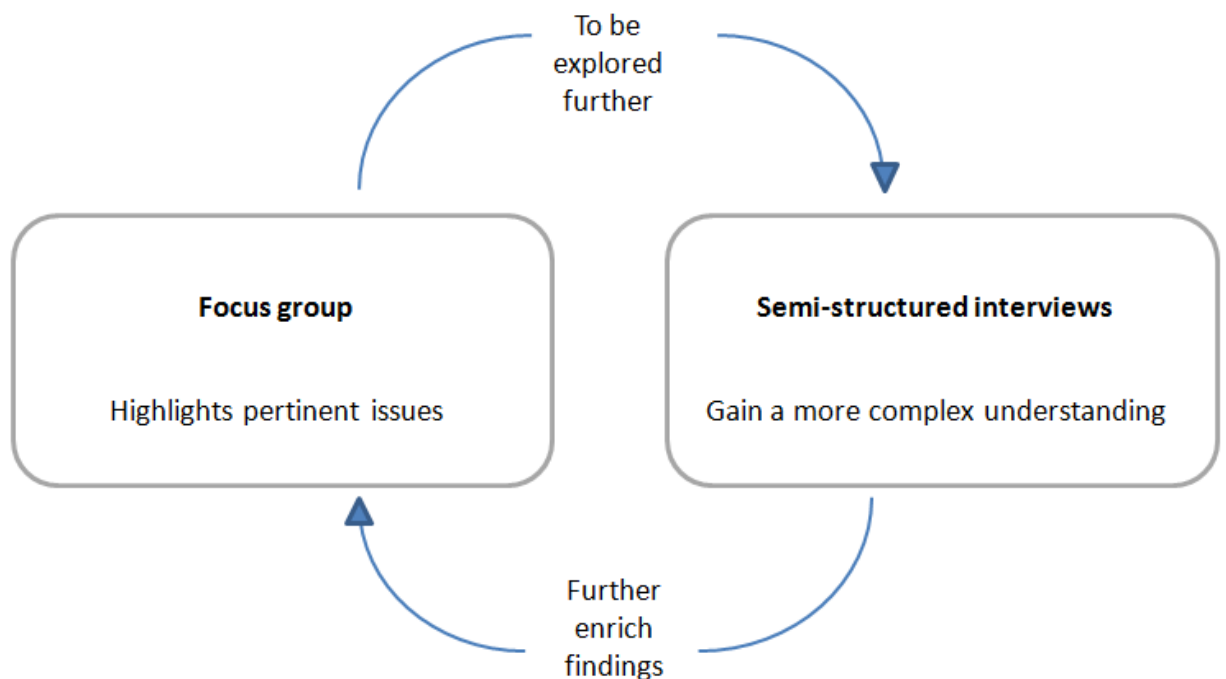


Figure 6.1 Focus group and semi-structured interview data combination

6.3 Sample and settings

6.3.1 Focus group

Clinicians were eligible to take part in the focus group if they were currently working with prisoner-patients in medium secure services or worked in prison mental health services and therefore managed prisoner-patients admission and remission from medium secure services. It was the intention to have a mix of psychiatrists attending who worked solely in prison mental health or medium secure services, and some who had a dual role across both services. In the weeks prior to the focus group, key clinicians were systematically contacted via email to establish whether they would be attending the event and to ask for their participant in the focus group. Five clinicians were contacted and 3 agreed to take part. As this was an exploratory study, it was decided that the remaining attendees would be a convenience sample of psychiatrists attending the event. It was anticipated that the supervisory team's involvement and standing in the psychiatric community and the importance of the topic would encourage attendance, along with the potential benefits for attendees of sharing their experiences with colleagues and gaining more insight into the area.

The focus group took place at a 3 day annual meeting of forensic psychiatrists in Glasgow, on 2nd March 2016 (Royal College of Psychiatrist Forensic Faculty Annual Conference). It was arranged with the conference organisers that the focus group would be conducted over the lunch time session in one of the breakout seminar rooms. Leaflets advertising the focus group were placed on the registration desk and exhibition stands on the first day of the conference and an announcement promoting the focus group was made in conference preliminaries and prior to lunch break by the conference facilitator.

All attendees were psychiatrists who were at various stages of their psychiatry career, with one having recently retired. A total of 13 psychiatrists took part in the focus group. Whilst there was little control over which clinicians attended, there was a good mix of roles as intended. This included six psychiatrists who predominantly worked in prisons, four psychiatrists who predominantly worked in medium secure services, and two psychiatrists whose role was equally split between prison and medium secure services. There is no ideal number of participants in a focus group. It is suggested that smaller groups of 5/6 work well to foster a good degree of interaction between attendees (Green & Thorogood, 2014) yet a sample size of between 8-12 has been suggested to promote more lively discussion amongst attendees (Stewart and Shamdasani, 2015). The group of 13 in this study was manageable and a good level of interaction was present, although it was noticed that some attendees took more of a spectator role within the group but

spoke briefly to show agreement with other attendees. Once the focus group had started, a further 8 clinicians attempted to participate. It was agreed with the co-facilitator prior to the event that if this was to happen, she would explain that the focus group was now full but provide them with participant information sheets for the future individual interviews if they wished to take part in those.

6.3.2 *Individual interviews*

As with the focus group, clinicians were eligible to take part if they were currently working with prisoner-patients in medium secure services or had worked in prison mental health services and managed prisoner-patients' admission and remission from medium secure service. Participants were conveniently sampled based on the relationships formed during data collection at baseline medium secure services sites. These clinicians also acted as contacts to recruit further clinicians in their service.

In addition to psychiatrists, clinicians from other professions within forensic mental health services were also eligible to take part in the individual interview, to gain more insight into the challenges of managing and discharging prisoner-patients in medium secure services. Therefore nurses, social workers and psychologists were also invited to take part. It was anticipated that the nursing perspective would provide more information with regards to the day-to-day management of prisoner-patients and the social work perspective would produce data in regards to care-coordination and aftercare arrangements, given that these are some of the key duties in these professions (although just one social worker agreed to take part). Psychologists were invited to take part based on their expertise in risk assessment, although none of the psychologists who were approached to take part agreed to be interviewed. Likewise, nursing staff from mental health in-reach services were also invited to take part, to provide the nursing perspective on issues raised by prison-based psychiatrists. There was little uptake from prison in-reach nurses and the two interviews that were arranged failed to go ahead due the staff shortages on the day of interview. It is unfortunate that the clinicians from professions other than psychiatry were not adequately represented for the purpose of this study. Therefore this should be acknowledged when reading and drawing conclusions from the interview data.

The majority of clinicians were contacted directly via email to invite them to participate (n = 7), whereas others were recruited by clinicians who had taken part in the interview themselves (n = 4) (i.e. snowball sampling).

The individual interviews took place between March 2016 and August 2016. Interviews were conducted in private rooms at the interviewees' work place to ensure that the interviewee could talk freely and that confidentiality was maintained (Green & Thorogood, 2014). Most often this was in the clinicians' private office space, and where the clinician was a member of nursing staff, a unit consultation room was utilized. A total of 11 clinicians took part in the individual interviews. This included; four nurses, six psychiatrists and one social worker. A group of six to 12 individual interviews is suggested as adequate for applied work on a niche research question (Guest, Bunce, & Johnson, 2006). In addition, many would advocate that appropriateness of sample size is contingent upon an iterative process of gathering and analysing data until you achieve 'saturation' of data (Corbin & Strauss, 2008). As such, this sample was sufficient for key and recurring themes to emerge so that saturation was achieved. Saturation was considered to be achieved when data from interviews produced little or no changes to the study coding structure.

Table 6.3. Interviewee and focus group attendees

	Prison based	MSU based	Dual role
Psychiatrists			
Consultant*	8	3	6
Junior	1		1
Nurses			
Ward based	-	1	-
Managerial	-	3	-
Social worker	-	-	1

MSU = medium secure services

*one consultant psychiatrist was retired at time of interview

6.4 Ethical considerations

6.4.1 Research Ethics Committee

As Study 2 was conducted in conjunction with Study 1 and 3 which involved access to patient data, the National Research Ethics Committee requested that ethical approval be sought under a substantial amendment application. A substantial amendment to protocol was submitted to the National Research Ethics Committee on 06/11/2015 and approval was received to conduct Study 2 on 12/11/2015

6.4.2 Staff consent

All participating clinicians were provided with a Staff Information Sheet prior to the interviews/focus group that outlined the purpose of the study, their involvement, the ethical approvals obtained and their ability to withdraw from the project at any opportunity. During the interviews/focus group, staff received a full explanation of the study rationale, relevant approvals and nature of staff involvement. Verbal consent was also confirmed for the interview/focus group to be audio recorded at the start of each interview.

6.5 Materials

6.5.1 Interview guides

An interview guide was developed to facilitate both the focus group and individual interviews (see appendix H and L). The guide was based on outstanding areas of interest highlighted in Study 1. A list of outstanding issues was developed which were reworked as open-ended questions and prompts to be used in interviews. It was the intention that this guide would not be relied on extensively but used as a tool if the areas of interest did not occur in conversation naturally.

The areas of discussion outlined in the interview guide were centred on five main themes;

1) Introduction

Interviewees were thanked for their participation in the study and had the study objectives and their involvement re-explained. Interviewees were reminded that the interview would be recorded and their verbal consent was obtained.

2) Role and responsibilities

This section had prompts for interviewees to describe their professional role within forensic mental health services. This included prompts in regards to; their current role, their professional history in psychiatric services, their key responsibilities, any areas of special interest they might have and their involvement in research.

3) Prisoner-patients in medium secure psychiatric services

This section covered the interviewees' experience of working with prisoner-patients in medium secure services with prompts covering experiences of; managing mental health problems, the impact of patients' criminal justice status and any particular challenges or successes in the area.

4) Experiences of prisoner-patient discharge

This section covered the interviewees' experiences of discharging prisoner-patients from medium secure services. This included prompts for interviewees to explain: the process of prisoner-patient discharge including specific examples/recent experiences, factors which influence discharge from the service and discharge destination, and criteria applied to community discharges and prison remittals.

5) Attitudes towards prisoner-patient discharge pathways

This section was designed to elicit the interviewees' views on the discharge pathways available to prisoner-patients. Prompts were included which explored if/how discharge destination impacted on services provided whilst detained in secure services, and service received post discharge. Interviewees were also asked to share experiences of; remitting patients back to prison (including follow-up), criminal justice procedures and examples of what does and does not work well.

6.5.2 *Vignettes*

Vignettes are a flexible and practical tool for studying factors which may influence clinical decisions and act as a tool for researching sensitive or controversial perspectives which an interviewee might not feel comfortable in disclosing (Hughes & Huby, 2001). As such informal clinical case vignettes were used throughout the individual interviews to allow for clinical judgements to be explored with interviewees in a less personal or threatening way. Traditionally, a vignette is a brief description of a clinical situation designed to stimulate key features of a real world scenario (Alexander & Becker, 1978) and therefore should resemble real people and be relatable and plausible (Gould, 1996). Concerns are often raised that vignettes do not accurately reflect real-world phenomena (Evans, Roberts, Keely, Blossom, Amara, & Garcia, et al., 2015), therefore in this study, real scenarios from the Study 1 baseline data were described to the interviewees to elicit comment and discussion. Vignettes were used if a scenario of interest occurred naturally in conversation and it was deemed appropriate for discussion at that point in the conversation, or to challenge assumptions of the clinicians and gain insight into some of the unexplained scenarios within Study 1 baseline data. Scenarios were discussed in both past and present tense to elicit comment on pathways and issues present in the baseline findings, or to prompt considering of how the clinician thought they may act if in a similar situation. To maintain anonymity of participants, care was taken to ensure no identifiable information was included in the vignettes.

Baseline scenarios discussed included:

- Examples of key differences observed across community discharges and prison remittals
 - E.g. Significant differences across demographic, clinical and criminological characteristics, alongside differences across validated violence risk assessment tool ratings.
- Examples of court discharge decisions made against responsible clinician's advice
 - E.g. Re-remanding of prisoner patients, custodial sentences in the absence of an interim hospital directive.
- Examples of differing criteria applied to community discharge and prison remittal
 - E.g. patients remitted to prison due to non-engagement or high risk behaviour

Whilst these scenarios were highlighted as topics of interest prior to the interviews taking place, they were presented to interviewees' informally through conversation rather than in written format for formal consideration. This decision was made so as to not damage the rapport developed with the interviewee, as formal vignette presentation may have made the interviewees feel as though they are under pressure to say the right thing. Clinicians have a natural propensity towards presenting themselves as competent professionals (Veloski, et al., 2005) and recognise their inclination to justify their clinical decisions by giving the 'right' answer (Taylor, 2006).

6.6 Procedure

6.6.1 Focus group process

It is good practice to have a co-facilitator in attendance at a focus group (McLafferty, 2004). The co-facilitator for this focus group was a fellow PhD student who was also a nurse working in medium secure services. Her role was to take notes of any key issues that arose and to join in the discussion to help guide the conversation. The chairs in the seminar room were arranged in a semi-circle so that all attendees could see one another and the co-facilitator and I were placed amongst the participants.

Once attendees were seated they were asked to read the participant information sheet and to sign the consent form provided. At this point there was an opportunity for attendees to ask any questions. I then introduced myself and the co-facilitator to the attendees, re-explained the study and their involvement and established oral consent for the purpose of the audio recorder. Ground rules were briefly explained to attendees (namely not to talk over one another, to respect the opinion of others and the confidential nature of the meeting). The audio recorder was then turned on and attendees were asked to introduce themselves and to describe their role within forensic mental health services as an 'icebreaker' and to foster interaction (Stewart & Shamdasani, 2015).

Both the co-facilitator and I had a participatory role within the focus group to allow for a more natural discussion. Prompts detailed on the interview guide were used flexibly to guide the discussion, although this was kept to a minimum as the discussion stayed on topic and was lively throughout. Clinicians shared their experiences of the prisoner-patient care pathway and then discussion was brought to a close by me asking if the interviewees had anything else to add before we ended, as the room was due to be used for a conference session. The audio recorder was then turned off and attendees were collectively debriefed and thanked. Some attendees wanted to continue discussion after the focus group re. issues which had not been raised during

the focus group. This took place in the conference social space and written notes were made in regards to these interactions afterwards.

6.6.2 *Individual interview process*

Participant information sheets and consent forms were emailed to interviewees at initial contact and invitation to take part. Once they agreed to take part, a suitable date and time for the interview was arranged. Travel to each of the interviewee's place of work was arranged and meetings took place in their office or a clinic room. Interviewees were provided with another participant information sheet and consent form. The study was reintroduced to interviewees at the start of the interview to allow an opportunity for the interviewee to ask any outstanding questions. Interviewees were reminded that the interview would be audio recorded and were asked to confirm their consent for audio recording. Interviewees were invited to talk freely and were reminded that they could stop the interview at any time. It was explained that the interview guide was for reference and prompt only, and that it would not be used to structure the interview.

Each interview began by asking the interviewee to explain their role within forensic mental health services and the conversation was allowed to naturally develop from there. Where appropriate, the patient vignettes were described to the interviewees informally for comment. All interviews were closed by asking whether they had anything else to add or outstanding questions. All interviewees were thanked for their participation.

6.6.3 *Note taking*

Extensive notes were not made during the focus group and interviews so as to not damage rapport although hand written notes were made intermittently when necessary. These notes covered thoughts on key issues highlighted by clinicians or details such as specific legislation mentioned during the interview to be researched afterwards. Notes were, however, made after the focus group and each interview on key issues arising and personal reflections. After the focus group and each interview audio recordings were re-played and additional notes were typed. All three note sources were then collated to make a coherent set of notes and saved onto NVivo as memos prior to data transcription. This allowed for a degree of data familiarisation prior to the formal transcription process.

6.7 Transcription

Transcription is an integral part of the analysis process which immerses the researcher in the collected data (Burman, 1994; Riessman, 1993). I transcribed each of the audio recordings myself. Each transcription took between 3 to 6 hours to complete. Recordings were transcribed verbatim, including slang words, stutters, hesitations and interruptions. However, more detailed nuances of talk such as rising and falling intonation or lengths of pauses were not recorded in transcripts, as this level of detail was not appropriate for this study. There is no one set of guidelines when producing a transcript for thematic analysis, yet transcription was conducted using the suggested conventions outlined by Green and Thorogood (2014). Each transcription was uploaded to NVivo and each saved as an individual source. Each source had an accompanying memo saved under the same name containing the previously collated notes. Where possible each interview was transcribed prior to conducting the subsequent interview.

6.8 Data analysis

Thematic analysis was chosen as the most appropriate approach to analysing the data generated in this study. This is an accessible method for identifying and reporting key themes within qualitative data (Braun & Clarke, 2006) which can produce a rich and detailed understanding of health related phenomena (Green and Thorogood, 2014). This approach to analysis is not theoretically bounded or tied to a particular epistemology and therefore was ideal for exploring the key issues and concerns of forensic clinicians in regards to the management of prisoner-patients.

In order to ensure efficient management of the qualitative data, Nvivo Version 12 computer assisted qualitative data analysis software was utilised. This allowed for all data analysis to be organised and managed in one place, and for the process to be thorough and systematic.

6.8.1 *Data analysis procedure*

The approach to thematic analysis was guided by the steps outlined in both Braun and Clarke (2006) and Green and Thorogood (2014) (see figure 6.2). It was anticipated that these steps would yield clear findings that would be accessible to practitioners, and policy makers. The focus group transcript and the 11 individual interview transcripts were all analysed using the following approach;

1. Becoming familiar with the data

The transcription of audio recordings and associated notes was the first stage of data familiarization which helped to develop a thorough understanding of the collected data. Following this I immersed myself in the data by practicing 'repeated reading' where I re-read the transcripts in an active way, searching for meanings and patterns. At this point I started making notes and initial codes that I could come back to during the formal coding process. This involved developing a list of ideas about what I could see in the data and why it was interesting.

2. Generating initial codes

Codes were labels attached to portions of text. These were assigned to data extracts using the Nvivo coding tool which allowed me to save codes as 'nodes'. Each code/node was assigned a title and brief description. Coding was approached both deductively (data were examined with the outstanding areas of interest outlined in Study 1 in mind) and inductively (codes which emerged from the content of the raw data). During this phase I began to arrange codes into meaningful groups to create a rough 'node structure' on Nvivo.

3. Searching for themes

Once all data has been coded I continued to meaningfully group codes - this process included consideration of how different codes might combine to form an overarching theme. This is where interpretative analysis began. Codes were sorted into themes firstly by reorganising the node structure, and then by using the 'maps' function in Nvivo to visually represent each emerging theme. Each map included a brief description of the potential theme and then had 'arms' leading to codes/nodes which appeared to correspond. This allowed me to begin to give detailed consideration to the relationship between individual codes and also the relationships between emerging themes and sub-themes. At this point I could consider whether individual codes were

more appropriate as sub themes and I began to get a sense of the significance of individual themes.

4. Reviewing themes

I then began to refine themes by separating and collapsing some of the emerging themes in step 3 to make a 'thematic structure' of the main identified themes. This provided an opportunity to consider whether these themes provide an accurate representation of issues present in the dataset as a whole.

5. Defining and naming themes

At this point I began to write a synopsis of what each theme represented and how it related to the research questions outlined in section 6.2. At the end of this phase I was able to clearly define the scope and content of each theme to develop the written analysis presented in the following chapter.

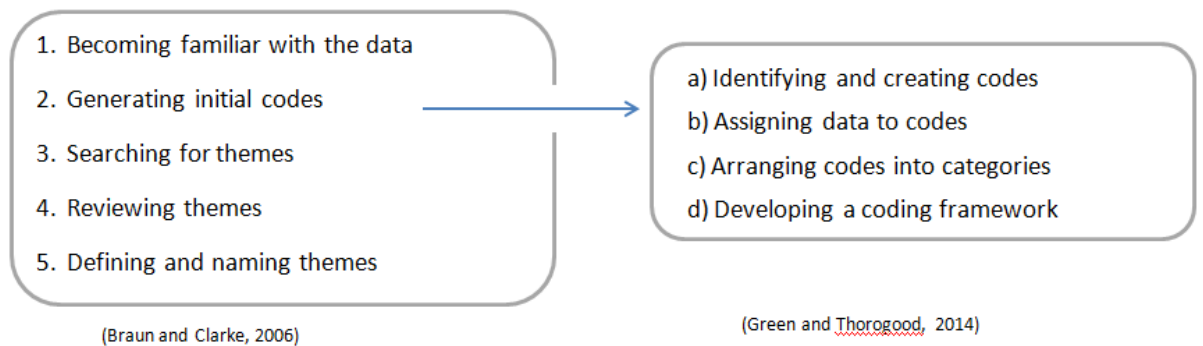


Figure 6.2: Approach to thematic analysis used in Study 2

6.9 Reflexivity

Whilst qualitative methodology is broad in orientation, all approaches have a recognised commitment to reflectivity; the principle that the researcher should subject their own research practices to the same critical analysis that is utilised when studying their research question (Green & Thorogood, 2014). Therefore it is necessary for me to consciously reflect on the process of this research and to recognise how my assumptions and experiences will have inevitably impacted on the data produced (Charmaz, 2006). Such bias is part of qualitative research and as such, reflexivity should extend to all aspects of the research process. In particular, researchers should consider their influence on both the data produced at interview, and the subsequent analysis. It is not possible to be fully aware of the subconscious way in which I may have shaped the research interviews. However, during both the design phase and the interview process I tried to consider ways in which I might have influenced the data produced. This involved examining my role as the interviewer and self-questioning my interview practice. Ways in which I may have influenced the data produced during interview are discussed below.

1) Access to quantitative data

The theoretical starting point and assumptions guiding the focus group and individual interviews were intentionally informed by findings from the baseline analysis in Study 1. Individual interviewees were made aware of the relationship between Study 1 and 2 and were provided with informal case vignettes of scenarios present in the baseline findings for discussion during the interview (see section 6.7.2). It was the intention that the qualitative data would add context to the quantitative data yet access to this data may have caused me to unduly influence the structure of the interviews and the data produced. Clinicians may have felt tested in some way as I had access to the full data and they did not. As a result, I tried to be as overt as possible and remind clinicians that I was interested in *their* experiences and opinions with regards to the management and discharge of prisoner patients.

2) Prior experience of prisoner-patient pathways

As I was an Independent Mental Health Advocate prior to starting my PhD programme, I have brought my own experience and knowledge of prisoner-patient care pathways to this study. This experience is likely different from many of the people I interviewed. The interviewees' professional roles involved managing the care of prisoner-patients, which involved making best interest decisions which were sometimes in opposition to the patient's wishes. My role as an

advocate, however, was not as a best interest's worker, but to represent the views and uphold the rights of prisoner-patients. As such I remained aware that my subconscious values may have been in opposition to some of the views presented by the clinicians in this study. I was mindful to ensure that this did not come to the surface in interview; this was particularly difficult when the subject of 'undeserving' and 'inappropriate' patients was discussed. However, my familiarity with secure psychiatric services, in particular my knowledge of the Mental Health Act and criminal justice pathways, helped to foster engagement during the interview, as I was able to discuss the fine details involved in patient care pathways and challenge clinicians assumptions where appropriate.

These issues may also have had an impact on the way I analysed the qualitative data. Likewise at the analysis stage, I also began to have access to the follow-up data for Study 3. At this point I was tracing and accessing information with regards to prison remittals and therefore had an overview of the outlook of those remitted to prison from MSU. Therefore I ensured that I was self-checking and implementing the bias management techniques below.

- Double coding - the supervisory team was provided with copies of the focus group transcript and two individual interviews each for coding. These codes were used to double-check my coding framework and areas of similarity were noted. This also allowed for new codes to be considered which may not have been present in the coding framework. This process is described as 'peer debriefing' within the literature and is described as a strategy to enhance the accuracy of the coding process (Creswell, 2003).
- Field diary – a personal reflective field diary was kept throughout Study 2, from the design phase to the analysis phase. This was a tool for me to reflect on the issues described above, and for me to document any thoughts around the concepts and themes that were being generated.
- Bias log – throughout the coding and theme generation process I kept a log of any biases that I felt might be present at that time. This acted as a prompt for me to self-check re-read segments of transcripts reflectively to challenge any coded extracts which I had flagged.
- Regular supervision – the issues described above were also taken to meetings with the supervisory team which offered more opportunity for discussion and reflection.

6.10 Chapter summary

This chapter has provided an overview of the qualitative design and methodology adopted in Study 2. Findings for Study 2 are presented in Chapter 7.

Chapter 7

Results: Qualitative study of clinicians' experiences of managing and discharging prisoner-patients from medium secure services

This chapter provides an overview of clinician's experiences of managing and discharging prisoner-patients from medium secure services. A thematic analysis was conducted to 1) explore clinicians' accounts of the institutional factors and working practices that influence prisoner-patients pathways through medium secure services, and to 2) provide more insight into which prisoner-patient characteristics have the potential to influence discharge decisions. Key findings are described in text and extracts from anonymised participant transcripts are provided in support of each insight. The study generated a vast amount of data which is explored and presented under 3 distinct themes and their corresponding subthemes;

- 1) Maintenance of throughput and multi-organisational context
 - Economic and policy pressures – *External expectations and prison mental health services*
 - Multi-organisational relationships – *'System' communication and healthcare providers*

- 2) Clash of two systems
 - Remand and pre-sentenced offenders – *clinical recommendations and court procedures*
 - Custodial sentenced prisoner-patient transfers – *length of tariff and sentence type*
 - Indeterminate sentence for public protection (IPP) – *stuck in two systems*

- 3) Desirable and undesirable patients
 - 'True forensic patients' vs. unwell prisoners – *culpability and risk responsibility*
 - Nature of presentation – *staff attitudes towards ward based behaviour*
 - Nature of the mental disorder – *diagnosis and services available*

7.1 Roles of participants

Participants' identification number, profession and work base are listed in the table below for reference.

Table 7.1. Clinician and focus group attendees by profession and work base

	Psychiatrist	Nurse	Social worker	Prison based	MSU based	Dual role
P1		x			x	
P2	X			x		
P3	X				x	
P4	X				x	
P5		x			x	
P6			x			x
P7		x			x	
P8	X					x
P9	X					x
P10		x			x	
P11	X					x
FG1	X			x		
FG2	X			x		
FG3	X					x
FG4	X					x
FG5	X			x		
FG6	X			x		
FG7	X			x		
FG8	X					x
FG9	X					x
FG10	X			x		
FG11	X			x		
FG12	X				x	
FG13	X				x	
	19	4	1	9	7	8

MSU = medium secure services

7.2 Theme 1 Maintenance of throughput and multi-organisational relationships

The first theme captures the economic and policy influences perceived to drive the pressure on service throughput, including the 'patient flow' between medium secure services and the prison estate. Clinicians described the constraints present in the care and management of prisoner-patients, and how they perceive and respond to these. This included detailed discussion of commissioning pressures, service models, and the nature of relationships with prison mental health services – all of which were described as having shaped clinicians' pathway decisions for individual prisoner-patients.

7.2.1 Economic and policy pressures – *External expectations and prison mental health services*

External expectations

Clinicians discussed how economic and policy trends influence their clinical practice and the role of their service within the forensic mental health system. In particular, clinicians described commissioner expectations and how this had an impact on their clinical autonomy. Pressures for services to admit prisoner-patients and expectations in regards to length of stay were discussed; length of stay was described as a key performance indicator for services regardless of the patients' discharge circumstances;

'Commissioners have always talked about length of stay. I know a couple of years ago it might have been one of the CQINS⁹ they wanted us to look at or keep performance indicators but they still look at it now. There was a drive to get the length of stay down on all the wards but when they're looking at length of stay, that's all they're looking at – if the person going into the community or they're going back to prison'. P5

'No one should stay in hospital any longer than they need to so if their needs are met, then that's it, it's the end of the admission, you don't need to keep them here. The commissioner might starting saying 'well why on earth are you keeping them'... and you know, that's a fair question'. P3

Across the interviews there appeared to be an inbuilt assumption from commissioners about flow in the relation to the prisoner-patient care pathways. Care and treatment of prisoner-patients was described as a circular pathway, where the expectation is that these individuals should

⁹ CQUINS – stands for commissioning for quality and innovation. It is an initiative introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements and innovations in specified areas of patient care.

receive treatment for the shortest time possible and then be returned to their starting point as a prisoner;

'I think that it's money that is the issues. I think that there's a lot of pressure from commissioners to bring in people from the prison system but we're bed blocked because we have 4 wards in our hospital...

... I think that in the way that commissioning works, there's 12 week assessment periods and I think that at some point the ICU were trying to get people through on 12 weeks assessment period from prison. Do the 12 weeks and bounce them straight back. For a while that's kind of how they were getting their money really.' **P1**

In large, clinicians stated that they adhered to these commissioning requirements yet this was not a practice which they were entirely comfortable with. Some clinicians expressed concern that this does not take into account the patients' psychiatric condition or best interests;

'The commissioners pressure, a number of times the commissioners have mention that the proportion of discharges back to prison is low and it is an arbitrary statement without any actual regard to the medical condition of the patient.' **FG9**

Clinicians reported how at times they resist these pressures when they consider that continued care and discharge via a community care pathway would be more advantageous for the prisoner-patient;

'I mean we have received a lot of advice in recent years, and a lot of pressure from commissioners to remit patients to custody, so to treat patients as if they were in the community, so prison is their home, that's where they go back to, so you'd admit, give treatment for the shortest amount of time then discharge and that discharge is back to prisons. I think mental health professionals, me included, have often resisted that. Something doesn't feel quite right about remitting a patient to prison, discharging someone to prison, both ethically, but also if someone is at the end of their sentence, I think we are more successful in terms of reintegrating patients successfully into the community if we hold onto them. But we are being told by commissioners and managers, probably for the last three or four years, 'no, when your episode of care has finished you should remit'. We don't always do that, but that is definitely an economic pressure.' **P9**

The conflict between commissioner expectations and prisoner-patients' needs appeared to be mediated by the demand for and availability of beds. Clinicians recognised that some remitted prisoner-patients would benefit from a longer period of treatment in medium secure services, yet many described how premature prison remittal was seen as necessary in order to free up beds, which can subsequently be offered to other acutely unwell prisoner-patients who require admission;

'There's always pressure for beds, so if you can get someone stable and connect them with an appropriate service back in jail, that's an option.' P10

'If he responds very quickly we will probably get him back to prison partly because pressure on beds. So we've got people waiting in prison that we haven't got bed for, so in some ways while it might be in the patients here best interests to be discharged from here, if they're well and can be managed quite well in prison, you're probably best getting someone who's acutely psychotic in and using the bed that way.' P11

In light of the increased pressure on beds, clinicians explained how some services have had space for innovation and have optimised provision through the design of new ward models which act as a dedicated pathway for prisoner-patient turn-around;

'It works very smoothly and we also set up a special ward in the MSU for prison transfers so that we can, currently the waiting list, we've got 19 people in PRISON waiting for a medium secure bed – waiting to get transferred out. We have tried to work innovatively, we set up this ward just to manage prisoners and send them back speedily – it varies in the success I suppose.' FG9

Some clinicians appeared able to justify these pathway decisions, however many also expressed concern that this may become standard practice and highlighted that this could be a 'dangerous' solution to bed shortage. In particular, it was suggested that this can put remitted prisoner-patients at a disadvantage when they are released into the community;

'I understand why they might want to do that if it's gonna free up a bed for someone who needs an urgent bed but then they go back to prison for a couple of months and just get shown the door and they might not have that support around them in the community. It's worrying. I guess it comes down to pressure on beds and that need to get somebody who is acutely unwell from the prison into a hospital bed.' P5

Despite commissioning and bed pressures, clinicians also shared instances of where they had they enforce their clinical autonomy and prolong length of care within medium security for some individuals. Clinicians highlighted the importance of ensuring that patients receive all treatment deemed necessary, and how clinical needs of the patient carry more importance than their prison transfer status;

'Well the commissioners, obviously, are interested in length of stay, full stop... so long as you have a clear reasoned argument for why you're doing what you're doing they're usually okay. I mean this other, you know, both of the cases I'm talking about, to be fair, the commissioners haven't kicked up a fuss about either of them because if they asked I think I could provide a good clinical justification for why they're here you know it's not simply because they're a prisoner and they got transferred in, there are clinical reasons for why they're in hospital.' P3

Prison mental health services

Clinicians explained how pathway decisions are at times constrained by their reluctance to remit prisoner-patients back to the care of prison mental health services. Since 2002 responsibility for prison mental health service provision has shifted from the Home Office to the Department of Health. Whilst many clinicians discussed positive changes as a consequence, the economic pressures which impact prison inreach teams were also outlined. Inreach services were described as both underfunded and poorly resourced in comparison to their workload. Inreach teams were considered to have little therapeutic value and almost all clinicians shared negative experiences of patient outlook upon remittal. These included examples of prisoner-patients that clinicians felt were vulnerable post-remittal due to the impact of the prison environment, alongside examples of poor access to mental health care;

'Apologies if this sounds controversial, our experience of treatment within the prison system hasn't always been positive. We've gone to see patients and they might have had one dose of their antipsychotic in a week at follow-up, so generally patients stay with us because of that.' P7

'They'll be under you know someone's case load, but the reality is that they have big caseloads so they can't be spending long one-to-ones everyday with them so the reality is that they don't get that. So they don't, I don't think, they don't get the equivalent of care they would get in hospital at all. You know they get popped in on when they can, they get seen by a psychiatrist when they can, they normally just end up spending the whole time in their cell because they can't be brought out really, they get more isolated, there are

risks of bullying, you know they're kind of noticeable aren't they? - so it's not where they should be. And that really is difficult for the RMN's because they feel that they are not being given the care that they want and they find that very stressful but they can't really.' P4

Many expressed concern that services upon remittal are not yet able to offer care that is equivalent to that which is provided by community mental health teams (CMHT), and that there was no evidence of targeted support or resources for those returning to prison from a psychiatric inpatient stay;

'I think the community services and prison inreach services offer the same thing in theory. They're all CPN's, they all go to the service user, they basically just check that they're taking their meds and bugger off again. They don't actually do any therapeutic work whereas in the community I think they have more access to it but I don't necessarily think that it's great. But no in the community they would have more support. Prison inreach is a very very overstretched and limited service.' P1

These concerns extended beyond prison-based aftercare provision and onto access to care at eventual release from custody. Continuity of care between inreach and CMHT services post-release was described as poor in comparison to aftercare arrangements at discharge from medium secure services. Many described instances where they had been reluctant to request remittal, on the basis that a release into the community from secure care was more advantageous for the individual than release from custody;

'So, there has always been a personal reluctance probably shared by others, about sending patients to prison but you have to have a cut off somewhere, and sometimes with patients, one just knows that they will do much better, if they are discharged from hospital where they'll remain within a caring environment. And we organise accommodation and we supervise them in the community, and we organise their aftercare, whereas you are remitting to custody, yes there are inreach teams, and if it is a local prison we would have links so it's a lot better, but if you are remitting somebody further afield, as used to happen fairly often, you didn't know what services they were going to receive and then it would be more difficult in terms of the offender manager organising the community care, so on that basis I think there was a reluctance to do it. So even though someone was well enough, and wouldn't technically require hospital at that point we would have kept them on. I think we still do to a certain extent but less so.' P9

7.2.2 Multi-organisational relationships – ‘System’ communication and healthcare providers

The nature of relationships between medium secure services and prison mental health service providers was reported to influence prison remission decisions. Lack of a positive working relationship between medium secure and prison inreach service providers was highlighted as a hindrance to prisoner-patient pathway decisions.

‘System’ communication

In order to ensure effective remittal of prisoner-patients, clinicians stressed the importance of maintaining positive relationships and communication with individual prison governors and management teams. Poor communication was described as hindering clinical remittal decisions, with clinicians describing instances of prisons refusing to accept the transfer of prisoner-patients. Clinicians felt that there is a lack of understanding from the prison estate as to the circumstances prompting and the purpose of remittal. Many described instances where prisons had assumed a prisoner-patient’s remittal was due to a management issue within medium secure services, as opposed to treatment completion;

‘I don’t know. I was a bit puzzled by it I have to say. He, yes he caused problems within the ward but I think he would have probably responded to a prison style of structure and boundaries and things like that so I think it was possibly fear from the prison that he would, I think there was a perception that people being remitted back from a secure unit to a prison had failed in some way – we can’t handle them so we’re sending them back to prison and that kind of thing. I can’t tell you exactly, because I think it was, I don’t even know if they’d even received any information about him before refusing.’ P8

However some prison based clinicians also noted that they too are not always fully aware of why a patient has returned to their care. These clinicians described how the necessary clinical information is not always transferred with the patient. At times this can lead to assumptions on the part of the inreach teams about the prisoner-patient’s presentation when detained in medium secure services;

‘It’s sometimes very difficult to understand or to put into context why the person has been returned, you can often see why they’ve gone in the first place, it’s often very difficult and you’re left reading between the lines of the transfer back to prison and usually my surmise is that they’ve been difficult,

they haven't cooperated, they've become disruptive and they get returned.'

FG4

Clinicians described that prior to discharge; the 'Section 117 aftercare meeting'¹⁰ is an opportunity to ensure that relevant information is exchanged and to confirm arrangements for mental health care post-remittal. This meeting should therefore act as a safeguard to avoid situations like those above from occurring. From the medium security perspective, successful Section 117 discharge planning meetings were described as a result of positive relationships held with prison mental health teams and professionals from the prison estate. Similarly prison clinicians described how the presence of both inreach clinicians and discipline staff at 117 meetings results in aftercare which focuses on both offence management and the individual's mental health care needs;

'When we're invited to section 117 discharge planning meetings I or one of our team will go with a member of the offender management unit from the prison who can sort of work with the prison issues and I'll work with the health issues and together we can hopefully plan what some of those obstacles might be.' **FG1**

Whilst the advantages of this integrated approach are clear, both medium security and prison based clinicians described how these arrangements are not always conducted in line with good practice guidance. Clinicians described the difficulties in engaging their counterparts in the 117 process, with medium security clinicians describing difficulties when attempting to arrange for a member of the prison inreach team to attend the discharge planning meeting prior to transfer. However, from the prison clinician perspective, many described how the 117 meeting was at times an arbitrary process; the results of which have little impact on the patient's care post-remittal;

'Some of the nursing team go and I don't think it works quite well, so the problem seems to be that they go to a 117 and there isn't a lot of communication with the rest of the team about "this person is coming back, this is what is happening, let's make a plan before they come" it's almost like they go "oh right okay, that's interesting" and then just get on with their lives and suddenly this person appears. So I think that's a problem...They should be on CPA and that CPA should be transferred across and there should be a written handover but for some reason the system is really bad.' **P4**

¹⁰ 'Section 117 aftercare' is a legal duty that is placed on health and social services to provide after care services for individuals who have been detained under qualifying sections of the Mental Health Act 1983. This entitlement is relevant to those detained under Section 47, 48 and 45a who are remitted to prison following treatment.

Experience of poor discharge planning practice was particularly evident in the focus group interaction where prison clinicians expressed surprise at the hand-over arrangements described by other attendees. Some described how their hand-over does not resemble a formal process, but that in the interest of satisfying the requirements of the Ministry of Justice, 117 meetings are documented as having taken place. Alarming, one clinician described how they had never had communication with the Ministry of Justice in regards to the appropriateness of a prison remittal;

'This 117, I'm surprised to hear you have that many meetings and stuff – for us sometimes it's literally as case of somebody will pick up the phone, whichever nurse picks up the phone and they'll just tell them and then report to the MOJ that we've had a 117 and they just give that person's name – that's all they have to do isn't it, we don't have to go there' FG8.

'I've been working in prisons for 22 years and I have never ever had the Ministry of Justice phone me and ask me if it's OK for somebody to come back.' FG11

Healthcare providers

Mental health inreach service providers vary nationally. Whilst the NHS assumes overall responsibility for the delivery of healthcare in prisons on a national level, individual inreach services can be contracted in from local NHS services. These may or may not be the same NHS provider as the local medium secure service, or can be contracted in from a private healthcare provider. Throughout the interviews, medium security based clinicians described how they felt a lack of control in regards to ensuring continuity of care post remittal. This appeared to be exasperated if there had been recent changes to inreach service providers, or the patient was returning to a privately funded prison;

'It used to be much easier when we had the contract for PRISON because we'd just continue to follow-up our own patients so it was dead easier, you could make sure that everything was being done that needed to be done and you had continuity of care but that's all gone.' P11

Sharing the same provider was reported to encourage a positive and trusting relationship between medium secure and prison mental health services. There was a view that this provided assurance that prisoner-patients were remitted to 'high quality' mental health professionals and services;

'And, as it happens, our trust also runs the healthcare at PRISON as well. And as a result, because we get most of them in there we know the staff at the prison quite well, the same trust, you know, it's actually, when it's that prison it works reasonably well.' P3

'So in our local prisons, it isn't too bad, because we have some decent trust employed staff who will go in, and we've just inherited some perhaps less skilled staff from prison teams so I think there is a lot of work to do in terms of bringing the level of care up in prison, but locally we are slightly better off because we have trust employees going in.' P9

Many clinicians provided positive examples of how this works in practice, including how in some regions, this has resulted in efficient reciprocal relationships, and innovative ways of communicating;

'Our consultants work into the local prisons so we tend to – they know the issues, they know the people who are on the horizon before they actually referred in a way to us and we work very closely with certain – you know PRISON – we know the individuals who work in healthcare there so we have a good relationship. If we're saying we need somebody to go back, they understand that and if someone needs to come in, if we've got beds.' P5

Well it certainly helps, for example we've got, we do, because its cross-site, we have like a weekly video-link meeting between here and PRISON to discuss bed management issues. And the prisons are able to dial into that because they're all on our own internal network.' P3

Some of the clinicians explained how they were the consultant psychiatrist for both the medium secure services and their local prison; therefore they essentially remit prisoner-patients back into their own care;

'For us in XXXXXX which is a MSU, I'm a consultant in the medium secure and I run the clinic at the local remand prison which is – I'm the person they'll get back to and it works very smoothly.' FG9

'We're XXXXXX healthcare Trust and we are one of the largest providers in England for offender care and most of the days that really comes in handy because obviously we have me, I work in XXXXXX MSU and I also work in local remand prisons and transfers, like you said, it's handing patients back to myself which I suppose really work.' FG8

However, one clinician highlighted the conflict of interest this arrangement might pose and suggested that remittal decisions in this case might still be a result of the pressures and needs of

the wider mental health system, as opposed to reassurance of the quality of post-remittal services as suggested by others;

'I think that it's sort of makes sense doesn't it that, that if you're working in both settings that the pathways would be better, however I think that prisoners end up being disadvantaged because of that because I think the advocacy about prisoners being in hospital is a little bit lost by the necessity to make sure that your beds are flowing appropriately. So actually I think a purer model is to have psychiatrists not working in medium security too but working solely in prisons doing that referral and advocacy work. So I think it's an advantage that I don't have beds in medium security because then I don't have to think about how this, I can purely be focussed on this persons best interests rather than the needs of the system and the flow of patients through it. It's just a different take on it.' **P2**

Theme 1: Maintenance of throughput and multi-organisational context
 Describes the constraints present in the care and management of prisoner-patients, and how clinicians' perceive and respond to these

a) Economic and policy pressures

- External expectations

(Commissioning guidelines, length of stay targets, maintenance of throughput, avoiding bed blocking)

Clinicians recognised these pressures and their impact on remittal decisions. Clinicians believed these to be important issues but also highlighted that these expectations can conflict with patient needs.

- Prison mental health services

(Underfunded, poorly resourced, non-equivalent, poor continuity of care post-release)

Clinicians described how at times they have been reluctant to remit an individual due to the limited care available upon remittal. It was felt that discharge from medium secure services was more advantageous to ensure referral to CMHT.

b) Multi-organisational relationships

- 'System' communication

(Importance of clarity around remittal circumstances and meaningful section 117 aftercare arrangements)

The nature of relationships between medium secure and prison mental health service providers was reported to influence prison remission decisions. Poor information sharing and uncertain aftercare arrangements hinder the remittal process.

- Healthcare providers

(Changes to inreach providers, private providers, shared provider vs. separate providers)

A shared NHS provider across secure and prison mental health services was reported to encourage a positive and trusting relationship which provides assurance for clinicians when remitting patients. However, it was recognised that this model may also present conflicts of interest.

Figure 7.1: Theme 1 summary

7.3 Theme 2 Clash of two systems

The second theme centred on the integration of the mental health and criminal justice system (CJS), specifically the ways in which court-based decisions, and therefore the patient's legal status, can impact on the responsible clinician's authority to direct the care pathways and discharge destinations for some prisoner-patients. Clinicians described that whilst the clinical team have responsibility for prisoner-patients' care and treatment, in many instances, admission and pathway decisions are at the discretion of the criminal court. At times this was described as taking place irrespective of clinical recommendations.

7.3.1 Remand and pre-sentenced offenders – *clinical recommendations and court procedures*

When the issue of mental disorder arises during the trial process, criminal courts are required to consider the 'most suitable method of disposing of the case' before passing a custodial sentence¹¹. This can involve remanding defendants for assessment and treatment to inform sentencing decisions. Clinicians described their role in assessing and treating remand and pre-sentence prisoners within medium secure services, and how the court is required to consider the medical evidence provided by the medium secure clinical team prior to passing a custodial sentence. This included examples of how court disposal decisions had been made in opposition to their clinical recommendations which had subsequently limited the discharge options available to the clinical team for these individuals.

Multiple examples were provided of conflicting court decisions for patients who clinicians had returned to prison to await criminal trial due to not detecting evidence of mental disorder or need for treatment in medium security. One clinician described how their service had provided a report detailing no evidence of mental disorder to the court, irrespective of which the court had ordered a detention for treatment in lieu of a custodial sentence. As such the patient returned to

¹¹ In the disposal of mentally disordered offenders criminal courts have the powers to:

- a) Remand prisoners to hospital for a medical report (s.35) or treatment (s. 36), or by making an interim hospital order (s.38) in order to **inform** their sentencing decision
- b) Order a detention for treatment in hospital in lieu of prison in order (s. 37 or s.37/41) to **divert** the offender from punishment
- c) Make a hospital direction (s. 45A) in order to **combine** hospital treatment with a prison sentence
- d) Pass a custodial sentence if hospital treatment is not considered suitable (Ministry of Justice, 2008).

the service with a legal status which stipulated their release via a community care pathway after receiving treatment;

'He presented as quite erratic in prison, he was transferred to us for assessment prior to sentencing and as the clinical teams, on all the wards, we felt that he, there was no evidence of any mental illness...

... it was a unanimous decision the doctors, the social workers, psychiatrists, nurses, you know, really there was nothing that we saw that indicated a paranoid illness and when we went to, we reflected that and he went back to prison but when he was sentenced, the other expert witness, they felt that he was, that he was unwell and had Paranoid Schizophrenia and he ended up getting a 37/41. So he came back to us and that's been very difficult because it's been a decision that isn't entirely comfortable with the clinical team.' **P1**

Likewise, clinicians shared similar experiences of independent clinicians providing conflicting evidence to that from the medium secure service, resulting in a court-directed readmission to the service for further assessment;

'I think sometimes the issues can arise if people are diverted through courts and what we've noticed and what we've had quite a few time is individuals who are not on our caseload, not on our radar, or sometimes individuals who are, who have been referred to us but following assessments and our opinion is that they don't need anything more other than a behavioural programme because of their PD issues and what not and yet they manage to find clinicians who would then come into the court, they would recommend an interim hospital order or something to get them an assessment section and they come to hospital when we have said that they are not suitable. Quite a few times what that has led to is that within the hospital there are incidents of violence or incidents of aggression.' **FG8**

Clinicians also shared examples of cases where they had recommended to the courts that a prisoner-patient would benefit from or required a hospital order for treatment yet the court opted to pass a custodial sentence, deeming a hospital disposal unsuitable. Clinicians described how this can lead to court directed remittal to prison which is outside of the clinical team's control. In these circumstances patients often return to prison and wait to be re-referred for admission as a sentenced prison transfer,

'I do know cases where judges have not been comfortable giving a restrictive order because they don't think that it is restrictive enough. And they've

actually said, 'well I think this patient should have a life sentence instead' and that's what they've done, so I'm aware of that happening and I know of cases here where that has happened. And then there's been a lot of argy bargy about what should happen next, and often the patient have had to go to prison, at least for a while and then been brought back again.' P3

However, the court's ability to add a hospital direction alongside a custodial sentence allows a prisoner-patient to return to secure services from courts to receive the necessary treatment. Clinicians are required to remit the patient to complete their custodial sentence following treatment; one clinician described how this is advantageous to both the secure service and the criminal justice system;

'Now you've got these 45A decisions available that does make it a lot easier, there was, you would certainly find situations, to be honest, where you might think the patient ought to stay in hospital but you didn't want them to be on a hospital order and in that situation all you could do was to prepare them to go back to prison and immediately get them back again... But now you've got these 45A orders you can say to the court 'okay, you make one of these orders, give him the sentence as well, and as soon as he's finished the treatment he can go' and I think, I've never used one of those, but I think that it would help, that would help reassure everyone, I mean as a consultant to know that the patient that you can't get rid of, or that they're stuck in hospital, and then the court can be assured that they're getting a sentence that is proportional to their offence and that should make everyone more comfortable, I think.' P3

Throughout the interviews it was clear that these issues varied across both individual cases and regional areas. Some clinicians described how they had good relationships with the local courts and they had not encountered court decisions which had contradicted their clinical recommendations;

'I would say it happens a great deal, our doctors work very closely – so we get somebody in on a 38 for reports – the doctor will do the reports and the judge is making that decision but there doesn't tend to be a great deal of disagreement. You know if we're saying 'this person needs hospital' – the judges or the doctors might disagree but I haven't heard of any great discrepancies. If we believe 'this person needs to be in hospital' 'it's a tough call for them just to say 'well I don't think so, I think they should go back to prison.' P5

Clinicians also described their experience of times where the pathways of prisoner-patients has been shaped by courts not following correct procedure. For a court to divert an offender using a hospital disposal they are required to obtain evidence from the service and clinician who is to direct the patient's care that arrangements are in place for the patient to be admitted. It was described that in some cases, clinicians are faced with unexpected hospital disposals for prisoner patients who they have not assessed for suitability or been made aware of;

'Yeah, we've had, well we've certainly had cases where judges have just made orders without reference to anybody which are often not legal. For example, something you already know, there are 37 hospital orders or whatever and you've got to have confirmation of a bed. I mean certainly I've had cases where orders have just turned up at the door one day and the prison has been on the phone saying 'Right when are you going to be admitting this patient?' and you know. And when you go into it, you discover that one consultant – or even two – make a recommendation, often without telling us, that's the other thing that happens is that you get these independent doctors who will see somebody, say they need a hospital order, recommend that to court, but then do nothing else. And if the judge isn't well informed they can look at this, and they can believe that they have everything that they need and they can make the order. Actually, it's not a legal order, because they probably haven't, they won't have had a representative of the hospital managers, you know, who guarantees a bed, and they make the order anyway.' P3

The same clinician described how if the service cannot accommodate the unexpected prisoner-patient, courts are able to make further discharge decisions to dispose of the case;

'Occasionally you know the judge might just get fed up of this and say well you know 'I've had enough of all this waiting around, I'll do something else, I'll discharge them, I'll conditionally discharge them, or they can go to prison. Especially with a minor offence, the time they were on remand is already longer than what they would have served. You do find some situations where the judge will say 'I've had enough of the whole thing, well that's it, I'll give him six months, he's already served and he can go' and they walk out of court.' P3

7.3.2 Custodial sentenced prisoner-patient transfers – length of tariff and sentence type

A sentenced prisoner can be transferred to medium secure services for psychiatric treatment by warrant of the Secretary of State at any time during their custodial sentence. Decisions on the release of transferred sentenced prisoner-patients are governed by the prisoner-patients tariff, unless their sentence lapses during their psychiatric detention, then their community discharge is at the discretion of the responsible clinician. All clinicians discussed to some degree the ways in which the remaining tariff on a prison-patient's sentence can impact on both the timing of discharge, and at times their discharge destination.

Clinicians discussed how sentenced prisoner-patients with particularly long outstanding sentence tariffs can pose difficulties for medium secure services. Clinicians explained these patients often require remittal to prison as the service cannot justify keeping them detained to complete the remainder of their custodial sentence;

'One of them's got quite a long sentence so the chances are he will go back to prison just because if he makes good progress we couldn't justify keeping him here for another few years.' P11

'And I think sometimes if they've got a long tariff and the task from the very beginning is – they'll come to hospital, get treated, and we'll send them back. That decision is usually made early on with a lot of people because it's just about getting them back to prison, getting them treated and getting them on a regime.' P6

However some clinicians described how this can result in revolving door cases; patients who have multiple admissions to medium secure services during their custodial sentence. Clinicians described how some patients stop taking their medication upon remittal or become reactively unwell once back in custody and therefore require readmission;

'I think for his sake, you know, it's a better experience I supposed sending back to jail you know, but unfortunately he just reaches transfer back – one of the guys who I'm thinking of even though he was settled, there were no problems, he just became unwell again so we had to transfer him back to a hospital, hopefully he'll settle down and we'll send him back out again.' FG9

'Occasionally yeah, there are some revolving door patients, some with psychosis go back to prison, stop medication, become unwell, come back... But some of the patients, perhaps if they are life sentence prisoners with a twenty year tariff, I can think of one, you get to the point where he is mentally very well and then will go into custody, stop medication, and deteriorate and come back.' P9

This prompted consideration of how to manage these patients and whether it would be more advantageous to keep cases once they have returned to medium secure services to prevent a repeat pattern;

'So in all likelihood they'll be referred back again in a worse state than they left you in due course, so no one has benefitted from that. And I think this is one of these cases that I've had that have been repeatedly transferred to and fro but that's been rather different but this has been a case of someone who has got better in hospital, has been returned back to prison and has stopped treatment and the fairly typical revolving door pattern. And I think sometimes you have to take the view of saying, although in theory they should send them back, we know it's going to fail so there's no point in doing it.' P3

Interestingly some clinicians also described receiving prisoner-patients in medium security that were mid custodial sentence at transfer, who they believed should have received a hospital order disposal. One clinician described how this led to the prisoner-patient remaining detained in the medium secure service to complete their sentence, followed by transition into the community;

'So we don't know really what happened but I suspect that, I mean the case, the patient himself has long standing mental illness because I know which we knew anyway, and I think, looking at it all, he was very likely ill at the time but I don't think any psychiatric evidence was requested but I don't know but I can't find any trace of any. Had it been, they probably, if it had been me I would have said he needed a hospital order truthfully. And so what ended up happening was he was in prison, not long after his sentence, and was really ill and obviously needed to come to hospital, so we brought him here, initially thinking we would send him back, but it became apparent that he wouldn't cope and so he ended up serving out his sentence in hospital instead.' P3

Discussions around how to manage sentenced prisoner-patients who have short amounts of time remaining on their tariff or are close to their earliest release date uncovered a breadth of clinical opinion and experience. Many clinicians discussed how prisoner-patient routes into the community from medium secure are often slow and difficult to achieve. As such, for prisoner-patients who are close to the end of their prison tariff and earliest release date, remission to prison was often described as a quicker route into the community.

'In some ways that's a better reason to go back - because it's quicker.' P10

'Actually they will be back out into the community quicker than what they would be if they stayed with us. We have had quite a few patients, probably over, I've managed XXXXX ward for maybe about 3 and a half years now, where they went back to prison and are back out into the community where if they'd stayed with us and went to our rehab ward they would have been in the system longer.' P7

This was a belief that appeared to be shared by both the clinicians and the patients themselves, as clinicians described a sense of concern amongst patients that they would get stuck within the mental health system if not remitted to the criminal justice system prior to sentence expiration;

'And one of the lads actually really wanted to go back to prison, so it; like he thought 'I'm gonna be here for years, I'll try me luck back in prison and go to the Parole Board.' P6

'Some transferred prisoners will want to go back because they want their release date, and there is clarity around that in prisons. So for that side of things, you will get some people asking to go.' P9

With some patients presenting as unmanageable in order to prompt a quicker return;

'Sometimes that's actually what they want to do. You know if they've got a tariff dates or a date of release sometimes it's beneficial for them that they want to go back... We can have individuals who are adamant that they just wanna go back to prison to the point that their behaviour will deteriorate if they think it's gonna get them back quicker. So obviously we will say 'right fine' and we will try and get them back as quickly as we can – that might be the next day if the behaviour is deteriorated that badly.' P5

However, others described how remittal of patients close to tariff is not a practice they partake in and questioned whether this is good practice. There was a belief that it is more useful to keep the patient detained within medium secure services to ensure they continue to comply with their medication and complete the treatment they need prior to community discharge/release;

'And if they were towards the end of their sentence we would almost certainly keep them, because they are only under the Mental Health Act in hospital and you can assure people comply with medication, and if we know that that is crucial to maintaining health then we would keep that person longer.' P9

'Particularly if they're too close to tariff, what's the point? Get them the help they need, give them the rehab, give them the knowledge, the psychology – all that sort of stuff, and let's give them the tools to get back into the community and survive... so if somebody's close to tariff then we're stuck with them, and then when they go past tariff they become a Notional [Hospital Order] and then that's it we've got them, that's simple.' P6

Others also commented on how it can be advantageous for a prisoner-patient close to release to be converted to a Notional Hospital Order (Section 37N) as this results in the patient's discharge being solely at the discretion of their Responsible Clinician and therefore ensures there is more clinical control over treatment completion prior to community discharge. Likewise, for many clinicians there appeared a preference to keep patients in services to ensure effective discharge into the community and facilitation of necessary follow-up support, which they believed could not be ensured if these patients were to be remitted to prison;

'If we're looking at maybe not a long tariff on them or a long sentence it might be beneficial for them to stay with us move through, maybe onto the recovery ward or rehabilitation ward... they would usually stay – they'd become notional 37's. Because what you want is to complete the treatment that they're on. You wouldn't want to send somebody back. You can see the patient wanting to go back because he knows he's going to be out, but if he's on a notional 37 he's still at the discretion of the RC. But just because somebody's come in close to tariff or close to earliest date of release, we wouldn't be sending them back to prison because of that. We'd be very much looking at work they need to be done, what is the best route for them.' P5

'No but if they're really very close I think we would keep them here and discharge from here rather than, you know, if you know that they're gonna go into the community and they're gonna need a lot of support you're probably better if it's a matter of weeks actually doing it from here and making sure it's properly sorted out.' P1

It was felt remittal close to release could also impact the individual's opportunity to address their offending behaviour, whereas remaining in medium secure services for the remainder of their tariff was described as a safeguard to avoid further offending;

'I think that he; by going back to prison he probably did exactly what he's always done. He was due for release very soon after, he's probably out now, he's probably doing exactly what he did before because he's had no interventions and nothing has changed for him, whereas I do believe that, he might have been with us a little longer which he didn't want, but I think that we could have got it right for him. He's young, he's incredibly bright, we were

building great relationships. I think that he could have been with us an extra year and we could have turned his life around really, and then discharged him into the community.’ P1

‘I wouldn’t say that is a practice that we do because that would – not setting people up to fail, but is that really giving them the support for when they get into the community? I understand why they might want to do that if it’s gonna free up a bed for someone who needs an urgent bed but then they go back to prison for a couple of months and just get shown the door and they might not have that support around them in the community – and they’re more likely to get that support when they’re coming through the healthcare system... I would certainly think that there would be more reoffending or more distress for that individual if they just went back to prison and went straight out and didn’t have the support – if we discharge through here into the appropriate housing and accommodation... whereas if that person had just gone back to prison they would be out of that loop.’ P5

However it appeared that retention of these individuals was not always practical; particularly when prisoner-patients do not wish to engage with the treatment process;

‘some of those patients that have gone back, to become a prisoner I suppose, when they’ve gone back out into the community we see them again, we hear about them again... reoffending yeah. So I think that raises the question of whether or not do those patients who, did they need further work? Was that the right time for them to do that [be remitted] I don’t know because I think that is a question, but maybe that’s one of the things we need to think about as well is maybe thinking and maybe identifying, for those patients who do want to go back to prison, what is that about? So is it about them just wanting to get back to prison in order to get back out into the community and not address any of their offending, or should we be more proactive in that, in maybe not sending somebody back to prison because we think that there’s more work for them to do? – and the difficulty with that is if we have someone who is adamant that they want to go back to prison then how effective is some of that psychological work with them? How well are they going to engage with that process?’ P7

7.3.3 Indeterminate sentence for public protection (IPP) – stuck in two systems

The majority of sentenced prisoners will remain detained in medium secure services as a civil patient if their sentence expires during their detention for treatment. However for a prisoner-patient subject to an IPP sentence¹², the risk they pose determines release decisions, which are made exclusively by the Parole Board. Across the interviews the treatment and discharge of prisoner-patients serving IPP sentences was described as problematic. Clinicians described their experiences of IPP patients who they believed were ‘stuck in the system’ – referring to both the criminal justice and mental health systems;

‘Really, the trouble is, yeah I mean they’re in the worst, I mean they’re in a bad position anyway irrespective of hospital, but I think IPP prisoners in hospital are in the worst possible position actually because you know the hospitals aren’t well equipped to deal with it but the patients can’t be dealt with in prisons properly.’ P3

It appeared to be the consensus that clinicians believed it to be in an IPP prisoner’s best interests to be remitted to prison following treatment in order to meet the criteria for release. This was deemed a more practical route to satisfy the conditions for the parole board and receive a release date, as well as for linking with offender management services pre-release;

‘It would be much better for them to go back to prison because at least the prison is set up to deal with the probation officers and the courts because it’s all in place, and even parole boards, were not really geared up for that kind of system. I mean you can have parole board hearing in hospital, and the parole board doesn’t really know what to make of them either because they are slightly out of their depth. I think it all makes for a very, it makes it all rather more difficult than it otherwise would be... so it’s very, again my advice to anyone, to the patients, is you know, you’re far better off going back to prison, sticking it out because at least you’ve got a better chance of getting out whereas in hospital you’re just making it more difficult than it already is.’ P3

For many of these patients parole decisions were described as dependent upon prisoners completing the necessary offence work related to the conditions of their IPP sentence. However, some clinicians highlighted the problems in accessing and completing these courses posed for IPP prisoner-patients who enter medium secure services. Whilst medium secure services do provide

¹² IPP sentences were abolished in 2012, however, currently over 3000 prisoners remain detained subject to the same sentencing conditions. Figures from 2016 highlight that 81% of these prisoners have served their minimum tariff, just under 400 of which have served more than five times their minimum tariff (House of Lords, 2015).

similar courses (for example 'violence reduction programmes'), clinicians described how at times criminal justice agencies can be 'formulaic', and require patients to complete specified accredited programmes. As such, many IPP patients face remittal to ensure access to these resources;

'The problem was, was that he couldn't do the groups that he needed to do within medium security in order for his tariff, anything to go towards his IPP. In order to get off an IPP you have to have done certain work that you can only do in prison, you can't do it in hospital. So with the IPP patients it's a real problem because they might need to be with us for treatment but anything they do in hospital even if they're in there for years won't have any influence on the IPP. So he was bounced back to prison. This happened two or three times and each time that he needed to come to hospital for treatment, his behaviour became more problematic I guess.' P1

In spite of this, clinicians also described further instances of IPP patients also being 'stuck' upon remittal due to issues such as unavailability of the required courses or patients not being able/wanting to complete them;

'IPP prisoners who just can't move forward. Either they, they're either vulnerable, sometimes they've got maybe IQ problems, sometimes they've got low grade symptoms that prevent their progress through the offender behaviour programmes and so on but they feel a bit stuck in the prison system so therefore you refer them onto hospital to try and unstick that and it works for a while but then of course they come back into the prison system where many times they're still unable to go through these offender behaviour programmes so they're still stuck in a sense. I have come across it, it's difficult.' P2

And that is a real worry for me, I can think of a few patients like that, who won't complete the offending behaviour work and could potentially could be in prison much much longer than they should be. Once the tariff has expired...' P9

Clinicians also described instances of IPP patients who they believed were suitable for discharge into the community, yet they were prevented from doing so due to the views of the Parole Board. As such clinicians expressed their frustrations with the restricted pathways for IPP patients, with some questioning the morality of such sentences;

'And we have had patients in the unit, who have been ready and we would have judged them to be ready to go to the community then the parole board has come along and said no. And under those circumstances they have had to be remitted to custody even though we would have kept them because only in a custodial setting would everyone, the offender manager, offender supervisor and parole board be satisfied that they have completed the prescribed offending behaviour programmes, so that has happened on occasions.' P9

'It's terrible, I mean hopelessness is the right word, in the case I'm thinking of, it feels like that and really, if it were up to me I'd discharge him from hospital tomorrow because, you know, there are risks, but there are and I suppose you get into all this trouble of this whole moral thing of what's right and wrong and whether these sentences are morally right and you know that a lot of people have got off on appeals. But also I've discovered that legal aided barristers aren't interested in taking the appeal cases for IPPs on because they don't think it's worth their while. But privately, if you can fund your own case, you've got a pretty good chance of getting them off at appeal. If you can't fund your own case you haven't because the barristers just won't take them on. And that feels a bit unjust as well.' P3

Theme 2: Clash of two systems

Described how court-based decisions and patients' legal status impact on the responsible clinician's authority to direct the care pathways and discharge destinations for some prisoner-patients

a) Remand and pre-sentenced offenders

- *Clinical recommendations*

(clashes with courts, conflicting clinical opinions, incorrect procedures, hybrid hospital orders)

Described how their clinical recommendations are not followed during the sentencing process and that courts do not allow the correct procedures as outlined under the Hospital Orders. This can cause the remittal of prisoner-patients outside of the clinicians' control.

Indeterminate sentence for public protection

- *Stuck between two systems*

(courses, morality)

Described how release and discharge decisions are made for IPP patients, which makes it difficult to get a sentence of public protection. All clinicians believed that remittal is in an IPP patient's best interests practically, to get them into the courses and offence related work. Many expressed their frustrations and provided examples of how they had wished to be discharged into the community but were prevented from doing so. There was concern about the

b) Custodial sentenced prisoner-patient treatment

- *Length of tariff*

(Lengthy tariffs, disagreement on practices for patient's earliest release date)

Clinicians stressed the importance of sentence tariff and discharge decisions. Remittal is usually a treatment for individuals with a lengthy remaining sentence that was recognised to result in 'revolving door' cases.

There was debate on the correct practice when a patient is remitted to the community. Remittal is described as a quicker route into the community at the patients' preference. However, discharged via the care pathway was described as more advantageous as it ensures re-referral to CMHT - at the end of the care pathway - and ensures a longer length of admission beyond release date.

Figure 7.2: Theme 2 summary

7.4 Theme 3: The desirable and undesirable - choosing between 'appropriate' patients

Theme 1 and 2 centre around the ways in which clinical discharge decisions can be shaped by external expectations and economic pressure, or due to the constraints imposed by court sentencing decisions. Theme 3, however encapsulates the discretionary pathway decisions medium secure services make when prioritising prisoner-patients for continued inpatient treatment. This included discussion on how clinicians view the role and function of medium secure services within the wider forensic mental health system, and therefore the types of patients that are deemed 'appropriate' for the service. Clinicians described the varied characteristics within the prisoner-patient population, and in particular how staff perception of these characteristics can shape an individual's pathway and discharge destination.

7.4.1 'True forensic patients' vs. acutely unwell prisoners – Culpability and risk responsibility

Culpability

The nature of a prisoner-patient's mental disorder and its relevance to their offending behaviour were described as key contributors to an individual's 'appropriateness' for continued care and supported discharge via a community care pathway. In many instances, the criminal courts' disposal of a prisoner-patient's case at sentencing guides how clinicians view the nature of the relationship between an individual's mental disorder and offending. The general consensus was that patients subject to a hospital treatment orders are those whose mental health and offending are linked, whereas patients transferred to medium secure services post-sentence are viewed as offenders who have become acutely unwell in prison;

'I think that's a sentencing decision but again seems to come down to how ill you are. So the offence pattern tends to be very similar but if there was a level of calculation, premeditation then they will tend to stay in prison. If they are deemed again to be unwell at the time of the offence then they will go for a 37/41 at which point they are treated in the hospital and they go out. It's about how well they can be medically treated.' **P1**

'Of course, with a hospital order we've got both bits of it then because we're saying we think their risk and their mental illness are closely related. Whereas, with transferred prisoners that's completely different.' **P3**

Prisoner-patients whose mental disorder is deemed to contribute to their offending behaviour were considered to be 'true forensic patients'. For these patients, the key roles of medium secure

services were described as providing treatment, rehabilitation and reintegration into society via a community care pathway;

'I suppose if their psychotic state is linked to their offending then I think the best route for them would be out through the secure unit so then they could have all of the appropriate follow-up and the stuff from that...

... if someone is clearly shown to offend because of their psychotic state and then you've just released them back to prison then I would say that's potentially dangerous and not good care.' **P8**

However, for prisoner-patients whose offending behaviour is not considered to be related to their mental disorder, treatment followed by remittal to prison was described as the typical treatment pathway. These patients were not considered to have 'forensic issues' but were described as the 'general psychiatric population' who happen to be in prison;

'Forensic populations aren't new populations, they don't come out of nowhere, they are often general adult patients who have gone on to offend... There is an argument that forensic services shouldn't take over patients who would ordinarily come under the general psychiatry, so if a person had become unwell at a later, or another point in their pathway, they would be a general psychiatry patient. And there would be no question of them coming to forensic services, just because they happen to become unwell in prison, so if there aren't forensic issues then, they'd be looked after by our general adult psychiatry colleagues.' **P9**

Clinicians also highlighted that some prisoner-patients recognise this distinction themselves, with some viewing their identity as a mental health patient as stigmatising and preferring to be recognised as prisoners;

'First of all he really didn't want to stay in hospital, so that was one big thing. He didn't want to be labelled as a nutter. So he didn't mind being a bit 'off his face' as he put it and going back to prison. Being discharged from prison is very different from being discharged from mental institute as they see it, that's just how they see it. It's still quite cool to be released from prison.' **P1**

'I suppose the pathway options are built around response, because a lot of them do see themselves as prisoners and want to go back to complete their sentence and move on.' **P10**

This absence of a relationship between mental health and offending and therefore the degree to which the prisoner-patient is deemed to be culpable for their actions was described as eliciting a punitive response from members of the clinical team. It was suggested that some team members view these prisoner-patients as inappropriate and undeserving of continued care within medium secure services;

'The sick people are the patients who will work much more thorough the normal hospital system. So for me that's how it's always divided, it's the mad and bad thing. The mad people are the ones who haven't been prosecuted of criminal offences, they come through the traditional hospital route as opposed to the ones who come from prison who are the bad people'... I think it'd be very easy to create a hierarchy of people who do deserve mental health care and who don't.' **P1**

Staff were described as looking more favourably towards prisoner-patients who had committed serious offences within the midst of mental disorder;

'I think it's' 'well actually they're bad so they should be in prison' but if somebody's mad then they should be in hospital'. And I think there's still that there. I don't think it's really obvert and I don't think it's a gross problem but I think it is there for some people which I think can determine the way that someone is managed... I think particularly if we have had patients who have come to us where it's provokes a certain feeling for people that it has caused difficulties within the team dynamically because somebody might have offended away from mental illness but then they go to prison and then become unwell in prison and that provokes a different set of challenges for staff... and it's really, because then we have other people who might have come to us and, you know might have stabbed somebody or whatever and it doesn't provoke the same response... And then people, staff can find that easier to manage and to deal with rather than patient who just commits lots and lots of crimes of varying degrees, goes to prison and then becomes unwell in prison.' **P7**

However, one clinician suggested that these attitudes were evidence of an institutional effect within the medium secure estate. Services were described as increasingly 'looking inwards' and setting boundaries in order to protect their function (as they view it) within the wider forensic mental health system;

'I'm going to have a view about that which is, medium secure units were built for a number of reasons, one of which was to help prisons. Core functions of

medium secure units is to be there for prisoners and to help acutely mentally disordered prisoners in time of need... so some medium secure units in a few areas have no prisons anymore in their patch or that they serve and I think that over time that leads to a sort of misplaced view of what they there to do, so they become self-serving rather than serving the prisons that they're meant to serve actually. So they start to see their own functions as the most important one rather than serving the needs of the populations.' **P2**

Risk responsibility

For patients whose offending and mental disorder are considered linked, both mental health treatment and ensuring that the patient's risks are reduced prior to discharge into the community are described as service priorities. However for 'reactively unwell' prisoner-patients, offence related or risk reduction work was deemed neither necessary nor the responsibility of medium secure services. For these patients, the role of medium secure services was described as to provide mental health treatment only;

'I think if you get somebody in from prison you know they're going back. You don't feel obliged to do the offence focused work, because you're not dealing with the risk you're just treating their illness.' **P11**

'My job as a psychiatrist is to manage the mental illness... so I think the decision to return to prison is a much simpler one actually because it's really, for me is based around the fact, are they well now and do I think they're well enough to cope out of hospital. Because the reason they're in hospital is because they're ill, and you're here to treat their illness and get them better and at the end of that treatment...it would be kind of muddying, if you were to try to do risk reduction as well, it would sort of muddy the waters a bit, because if they finish their treatment in hospital then they don't need to be in hospital anymore.' **P3**

This distinction was proposed, in part, to account for the differences in length of admission across these patient groups;

'6 months is probably enough time to get medication and all that under control and then it's about what further input you can provide. Obviously if you're looking to release someone from or discharge someone from this unit not only do they have to be on medication but they have to have all of the other appropriate support and index offence work and that kind of stuff as well so inevitably that would take longer whereas if it's someone who has, whose offences aren't necessarily related to their mental state and it's just a question of, you know, they're a prisoner they've developed a mental illness under a mental health act, once that's treated they can go back again.' **P8**

'That's why it's quicker because the long bit is not getting them well, it's actually addressing their risk.' P11

There was little description of meaningful use of standardised violence risk assessment tools to inform prison remittal decisions of this type. Clinicians described how these tools are used as part of the generic assessment process in medium secure services and are a useful exercise to collate multiple sources of information in regards to a prisoner-patient's clinical and criminal history, but are not used to assess the appropriateness of an individual's remittal;

'So the use of specific tools and all the rest of it, I mean yeah, I think it's a bit less of a consideration funnily enough because they're going back to a custodial setting, which is designed to deal with risk so the pressure is off a little bit.' P3

Whilst not used to *inform* decisions, one clinician however highlighted the ways in which the risk assessment process can be manipulated to *influence* a prisoner-patient's care pathway, and to justify clinical decisions after a care pathway has been agreed;

'I think that the risk assessment can be made to fit what pathway you want them to have. I think that the advanced risk assessment that we used which is the HCR-20 can be manipulated to serve whatever purpose you want it to. I think that you can frame offending, and behaviour, and illness, and everything in terms of treatability or not, so if you believe that somebody should go back – if as a clinical team you believe that they should go back to prison – you can frame the HCR-20 in terms of, that they aren't treatable and that they're too high risk to go to lower security. Whereas if you believe that someone will be reasonably easy to pass through hospital and into the community then you can make a risk assessment tool reflect that.' P1

Descriptions of risk management and reduction for prison remittals were minimal and limited intervention was discussed. Whilst it was acknowledged that these prisoner-patients may still pose a risk to the public at time of discharge, remittal to the prison estate was described as a place where the patient's risk remains contained.

'I think there is very much an opinion that they are going into an institution where they will be safe and other people will be safe from them. Whereas in the community they're not. So you know, it comes down to public protection. You know, what we see our role as in the medium secure unit.' P1

As such, from the medium security perspective, there was consensus that it is the role and responsibility of the prison estate to address issues of risk prior to release into the community for these patients. Clinicians described how they felt at ease with this arrangement as it absolves medium security based clinicians of public protection responsibilities;

'And I suppose, maybe this is a bit simplistic but I kind of see, it is that largely that's the prison's job to handle all the risk and all the rest of it... the risk issues are what they are. But I wouldn't, I don't know, it depends on the case of course, but generally my view would be, that the prison is the place to deal with risk reduction.' **P3**

'I'd be more comfortable sending someone to prison than a community placement, one because you could argue that the same risk may be there, but it's contained in prison, and you're not, I suppose it's easier because they go, and if they get a service or not it's not really your fault if they do or they don't; you make your recommendations that they do get something.' **P10**

However prison-based clinicians described how such risk issues are not always addressed by the prison estate upon remittal. Concern was raised that these prisoner-patients are returned to the care of prison mental health services that do not have the resources to implement the required risk reduction work prior to release. The outcome for these patients is tenebrous, with some going on to offend and re-enter custody;

'So we get people and we send people back who are still at extremely high risk of violence to others that they wouldn't be discharged on those grounds alone. So you'd be so frightened they'd do something horrible so you'd never send them back to the community, because you couldn't, but because they're sending them back to prison they're not worried about risk. So that risk doesn't seem to come into it, so we get people coming in who are at really high risk of violence to others which is okay, I suppose in terms of that you can manage that in prison but I'm also thinking about release and I'm thinking, 'what are we gonna do they're going to be released in six months' time, and they're still high risk and it does relate to their mental illness. So what would you like me to do, so what should we do about that? ...we just see people coming back all the time, into prison. You know, they're released and then they're back in a fortnight, so you know that they've done something.' **P4**

7.4.2 Nature of presentation – staff attitudes towards ward based behaviour

The nature of the prisoner-patient's presentation whilst detained in the medium secure services and any emerging 'undesirable' behaviours were described as contributing to the length of the individual's admission and their subsequent care pathway. There was much discussion of the ways in which staff interpreted these ward based behaviours, and how these attitudes can result in 'team split'. Clinicians stressed that clinical teams needed a clear and shared view of the nature of an individual's mental disorder and the treatment required. However issues such as malingering, non-compliance/disengagement and high risk behaviours were described to be of particular concern.

Malingering and absence of mental disorder

Clinicians explained how medium secure services are often concerned that prisoner-patients may be fabricating symptoms to gain an admission to the service. Some felt that prisoners see a stay in medium secure services as more desirable than completing their sentence in a custodial setting;

'Those from prison tend to come in because they're unmanageable in prison and that presents in a very different way. So that presents as, it always come across much more that they've done it to get into hospital and that they've done it for a cushy ride or something like that.' P1

Some patients are also suspected of feigning active symptoms of their mental disorder to avoid remittal to prison, whilst others have been found trying to influence a re-admission to medium secure services, which clinicians felt is motivated by personal gain;

'I suppose going back to these revolving doors and whether you keep people, the other factor that you kind of have to bear in mind is that a lot of prisoners prefer to be here than in prison and some of them stop their medication to get back but it's not a choice that really that they can be making themselves. I went to see somebody recently that had been re-referred and he said 'I would be much better in XXXXX MSU, it's got sky TV and I can have my PlayStation' and while I accept that they are nice diversional activities it's not a reason for readmission and use of a bed.' P11

Medium security-based clinicians stressed the importance of responding to suspected instances of malingering, as this can have important clinical and legal consequences. For example; consequences to the individual such as the receipt of unnecessary treatment and potential

misdiagnosis, alongside the inappropriate use of a medium secure bed. However prison based clinicians described how in some instances prisoner-patients simply become settled quickly upon arrival to medium secure services after their period of acute illness in prison. As a result these patients can be assessed as not having a diagnosable mental disorder by inpatient clinicians and can be remitted on this basis, the results of which can have a detrimental impact on prison mental health service;

'I've got one guy who was very disturbed and was very violent and he ended up in segregation and was refusing food and fluids and was naked and was smearing faeces everywhere and assaulted a prison officer really really badly with a weapon, was very paranoid and was really difficult to manage and took up a lot of RMN time... it took a long time to get him assessed by an MSU. And so they finally came to see him and they said "yes okay we'll take him" and there was finally a bed and he's gone. And I heard from the consultant that they don't think he's unwell and they're going to send him back and I told the staff this and they were just saying "oh my god what are we going to do, what are we going to do?" and I just said "well we're going to have to almost say well they've assessed him and they don't think he's unwell so he can go back on the wing. And I mean what do we do? Because it's all happening again. So apparently he's settled in hospital but there are some things going on, I mean I'm just thinking now "how am I going to manage this man?"' P4

Management problems – non-engagement

Lack of compliance with medication and non-engagement with the therapeutic intervention offered within medium security were deemed to have a considerable influence on the 'success' of a prisoner-patient admission. Successful prisoner-patients were described as those who comply with their medication/intervention and therefore are permitted to continue to receive treatment in medium secure services. For those who do not comply, remittal to prison was sometimes considered the appropriate pathway;

'For someone to successfully stay in medium security as a prisoner-patient they will be – they won't be a management problem. So they will affectively go along with the rules and take their tablets and do all those things, go to the groups, participate in treatment. It's the ones that don't do that who go back.' P1

'I'm trying to think 'would we send somebody back who is...' – we might send somebody back and say 'look, they're not taking their medication but they can function in prison'. That's might be the opinion we'd say, 'we've looked at them, they're never gonna take their medication however their mental health is as such that they can function and can be nursed if you like in the prison system'. That might be the case.' **P5**

There was strong opinion across medium security-based clinicians that once individuals have stabilized via medication, staying in medium secure services beyond this point is appropriate only if the prisoner-patient is deemed to be engaging with and benefitting from the other treatment interventions available;

'And the other thing is, I've had people that essentially you're only bringing them in for medication as you can't medicate them in prison, they don't engage in anything here, they don't do the psychology, they're not getting any benefit apart from -you can medicate them so if you get to a point where they're taking their medication, their symptoms have gone but actually they're just doing nothing apart from staying in their bedroom all day – they can do that in prison, you don't feel that they're actually benefitting from the regime or what's on offer here.' **P11**

Clinicians described how they are less likely to consider remittal for prisoner-patients who are also engaged in the therapeutic interventions outlined in their care plan. For these patients, opportunity for a longer admission was available and discharge via a community discharge pathway was more likely;

'So I think well, we probably keep them longer because they're engaging within the process. If we got to a point where those patients weren't engaging and people weren't then I think we'd be a bit more in tune with 'I think maybe you do need to go back to prison, but I think it's because the patients are actually working with us, there isn't that desire or necessarily the drive to do that because actually the patients are working with us, it seems to be okay.' **P7**

'Now if he had engaged with us and had a go, I would have probably been in mind to keep him in and get him through that [community] route.' **P8**

Clinicians felt that a prolonged stay in medium secure services is a valuable opportunity. Therefore remittal of non-engaging prisoner-patients is at times conducted with the intent to give other prisoner-patients the opportunity to be admitted to the service;

'So they just weren't engaging with the rehab – off you go. We couldn't do anything with them; they were taking up important, valuable beds so they went back to prison...

... we're not gonna have somebody here who's not gonna take an opportunity, grab that chance while they can – no, we'll get you out and we'll get somebody in who wants that chance. And if they don't want that chance as well, then we'll send them back. There's a waiting list a mile long to come here so go back.' **P6**

For non-engaging prisoner-patients remittal was also felt to be more appropriate to avoid the possibility of getting 'stuck in the system' once their sentence has expired;

'Again he was someone who wasn't, I think there certainly was the will from our team to try and engage him in treatment but he just wasn't in a place to be able to do so unfortunately so again there wasn't too much more we could offer him at the stage and he wasn't really engaging in any therapy and was subverting security and making the area unsafe and we thought 'if he's not able to engage in such therapies, he's someone who could potentially get stuck in the system' so he was again transferred back to prison.' **P8**

However other medium security based clinicians felt that it was not good practice to remit prisoner-patients who had not been 'successfully treated';

'I'm of the view that you know, you have to be holistic, you can't just say 'well I've treated that bit so now I'll ship them off to somewhere else' so I think generally speaking we would do our best to facilitate them to progress them through the service that would be our first way I wouldn't just say 'off you go to somewhere else.' **P8**

Some stressed that it is the role of medium secure services to work holistically to ensure that patients complete all necessary treatment, regardless of the difficulties they present, and highlighted their concerns in regards to the patients outlook post remittal;

'The trouble is, we have had the issues before where we have had transfer prisoners on the wards who are hard work, for whatever reason because their behaviour, and what tends to happen is people start saying to me well you know 'why don't you just send them back to prison? They shouldn't be here, their causing trouble, you need to send them back' you know, which is a kind of a natural response when things aren't going well. But to my mind, especially if they're ill that can't be the right response, because you know

presumably someone thought they needed to be in hospital in the first place because they're ill, if they're still ill and in hospital sending them back to prison isn't going to make them any better, it might make them worse. Whilst it might be hard work looking after them in hospital that's what you're there to do, I would have thought. I, I mean for me, I would only consider sending someone back to prison if they were well enough that they didn't need hospital and I realistically thought they would do well enough in prison. If I thought they were going to be, you know, too ill to go to prison, I wouldn't send them you know.' **P3**

Likewise prison based clinicians also shared their experiences of prisoner-patient remittal under these circumstances. It was highlighted that patients whose pathway is via a community trajectory would not be considered appropriate for community discharge if they shared the same presentation. Threshold for discharge appears to vary across discharge destination and it was felt that prisoner-patients would receive prolonged support from medium secure services if the service was responsible for their eventual release into the community;

'So my clinical, my impression is that, prisoners you get on top of their acute psychosis and you send them back. And their Psychology, their other criminogenic needs isn't really assessed, but what we get in the discharge is discharge summary of the communications: "this person wouldn't engage, this person wouldn't engage with anything so they're coming back. They're taking antipsychotics, but they didn't engage in psychology so there you go." Whereas I think "well there are quite a lot of people in medium security who don't engage but you don't send them into the community do you? You don't go "oh well, then there you go." They stay and they keep them in long-term, you accept that it's going to be a long time, maybe send them to a long-term medium secure, but you don't just bounce them back to prison and it's almost like "well what do you think we're going to do in prison?" is it somehow that they're safe in prison? Is it like a pseudo-hospital? Because it's not.' **P4**

Management problems – high risk behaviour (ward based)

High risk behaviour such as violence towards staff members was presented as a common reason for remittal of prisoner-patients;

'You could certainly be remanded back for assault, but if it was mental health, if it was behaviour and we thought there was nothing, purely behaviour and their mental health was stabilized and they'd attached a member of staff – yeah we'd remand them back.' P5

In these circumstances ward security and the safety of clinicians and other patients was deemed a priority, regardless of the prisoner-patient's engagement with treatment;

'Yeah, I mean if they're being risky on the ward then yeah, that's another reason why they'd go back to prison. Yeah they might be attending groups and all that but if they're gonna be risky on the ward and they're making threats to staff – well yeah, then they'll go back to prison as well. It's not just because they're not able to be rehabbed.' P6

Clinicians felt that it is the role of the prisons and not the medium secure services to manage this behaviour, and a shift in overall risk responsibility was described;

I think that what tends to happen is if they display difficult behaviours, if they push the system if they are violent if they become assaultive – any of those things, then the first thing that will be said is that they should go back to prison. So that's, I think people are just very quick to wash their hands of them, it's 'this isn't our problem, we're not paid enough for this, we don't know how to work with people like this' it's that kind of this really...

... I think that when you're full time and you're in the ward and you're getting battered every day and you think that someone is in control of their behaviours and they're already on a prison sentence, I think the temptation can be a lot more that they, you know, 'they're already being dealt with, they're a write off just bounce them back to prison.' P1

It was felt that remittal of these prisoner-patients is necessary not only to protect the nursing staff, but to also ring fence the role and function of medium secure services;

'The nursing staff are nurses and they're not prison wardens, they're not here to be assaulted, they're not here to be intimidated, to be threatened – that's not what they're here for. They're here to help, they're nurses. Sorry, if you're gonna threaten nursing staff, now I'm being straight with you here, if you're gonna threaten nursing staff and you're not gonna join in the rehab process, then why are you here? Go back to prison, service your time. You've got a chance here, you've got an opportunity to get intensive support to help you with your mental disorder, if you're not gonna take that opportunity and you choose to threaten nursing staff – they're not prison wardens, they're not police – and you threaten them, you intimidate them, you attack them then go back to prison. It's got to be that way, it has to be that way, it can't be any other way otherwise the mental health system would just become a prison.'

P6

Interestingly, one clinician described how they were able to negotiate a block on a prisoner patient returning to the service if they required further treatment, due to their level of violence;

'He's become extremely violent, he goes on hunger strike and he just before Christmas he severely assaulted 3 of our staff members requiring hospital admissions, surgery, that kind of thing. Erm, and at this point he was transferred back to prison again for what has been agreed with the commissioners for the final time that he won't come back to us again because of the nature of these assaults were so bad.' **P1**

However some medium security-based clinicians suggested the correct response to a prisoner-patient who is too high risk to remain within a medium secure service is to make a referral for admission to a high secure hospital;

'If they were still unwell and were high risk we would refer them to high secure. We've had a number of people go to high secure, I've never – I mean you'd only send them back if you were confident that you had dealt as far as you could with their mental disorder and if they're presenting with risk behaviours that weren't related to that then you might think about sending them back early but you wouldn't if you had not finished their treatment.'

P11

'I can't think of anybody who has become so violent and aggressive and they haven't been able to manage them and they have sent them back for that reason. They're clearly unwell. What's the point, what's the point? You've got to manage them. Or it becomes a 'grave and imminent' and they go off to high secure, make a referral to high secure, that happens.' **P5**

Likewise prison based clinicians described how high-risk prisoner patients had been remitted to prison to await assessment for a high secure placement. These clinicians felt that prison was being judged inappropriately as a 'safe' discharge destination;

'Okay if someone is a risk to the medium secure unit, should we equally make an argument that they're a risk when they're in the prison environment?. I don't buy that as a reason for discharge, I have come across a few cases. There was one case recently of a guy who was transferred back to us... [information omitted due to sensitivity]... the next day with no CPA, no handover, nothing and I thought that was poor actually because they were discharged back but also the same time a recommendation was made for an admission to maximum security. So I think you can't be on the one hand saying that somebody needs conditions of maximum security and needs to be in hospital but in the mean time they should be admitted to prison to wait for it. I think that was poor practice actually so it does happen around about risk, around about the ways of managing risk in medium security but I'm not sure that it should.' P2

'It's almost like prison is a safe place, which is so far from the truth.' P4

7.4.3 Nature of the mental disorder and services available

The nature of prisoner-patients' mental disorder and their primary diagnosis were described by all clinicians as a key characteristic which can determine discharge destination. In particular, clinicians had strong views about the admission and treatment of prisoner-patients with a primary diagnosis of personality disorder, and the appropriateness of caring for these patients in a medium secure setting. Clinicians described how there is reluctance from both the secure services and prison estates to manage the care for these patients, and how once secure services have identified the presence of a personality disorder in an individual, they are often remitted to prison on that basis;

'Nobody wants a personality disorder [patient]. Prison don't want them, the hospitals don't want them.' P1

'So they might do the assessment and once they're kind of 'right okay this person's got X personality disorder type' then they kind of get moved or go back to prison.' P7

For many this was described as due to the ward disruption an individual with personality disorder can cause (such as the engagement and risk issues described above);

'On the odd occasion, of course, we have had people admitted from prison for an assessment who have then turned out to have personality disorder and wrought havoc on the mental illness wards and it can be very difficult.' P3

'Yeah so I think in terms of managing personality disorder, obviously they're much trickier to manage on the ward first off so I think probably there is a reaction and that happens with a lot of, with both of our guys actually, there was a kind of a view, you know, 'get him off this ward' kind of thing.' P8

It was recognised that patients with diagnoses of severe mental illness can also cause ward disruption and present as unmanageable. Clinical response to these patients was described as the continuation of non-consensual treatment as opposed to remittal to prison, suggesting that it is not simply the prisoner-patient's presentation alone which can impact their pathway but the way in which the nature of their disorder is viewed;

'It's slightly different for the mentally ill – 'the normal business as we call them' which is stigmatising if anything, but the with the PD cases I think that the thinking is different. It's like we're saying, 'if you're mentally ill we can give you treatment whether you want it or not. If you're PD, you've got to be buying into it at some level to have treatment'. If you're mentally ill, and you're fighting against your treatment, you're more likely to stay but if you're PD and you're fighting against your treatment, you're likely gone, because you're not engaging with it.' P10

Staff explained how the clinical approach and tolerance of unmanageable behaviour was dependent on the prisoner-patients' primary diagnosis. Those with severe mental illness were described more favourably and the clinicians' inclinations were to care for and nurture these individuals. Whereas this drive was not present if the patient had a primary diagnosis of personality disorder;

'Mental health, more so...you do develop attachments to some patients and you see the life that they've had.' P10

I don't know whether it's the nature of the illness or what, the kind of relationship you develop with the patient when someone's acutely unwell and you're trying to get them better and then when you do get them better I think that there's a tendency to want to look after them a little bit – not more that's the wrong, not more, I don't really mean it like that but, I think there's just that nurturing to keep them well, where maybe there's not that [with PD]. I think when you work with personality disorder I think sometimes it tend to be 'well we've identified what the problem is so we'll work on that somewhere else.' P7

There was consensus that medium secure services are not an appropriate environment for managing those with personality disorder. Some clinicians stated that they would not admit a prisoner-patient to their service on the basis of personality disorder alone. This was largely due to previous experience of patients who had remained 'stuck' on the ward, either due to being unable to treat the patient's disorder or to being unable to ensure adequate risk reduction for community discharge;

'In the sense of admitting people into hospital, there's certain people that get flagged up as 'do not admit this person, they're PD, it's not gonna help them, do not admit them'. You become aware of these people.' P6

'As far as I understand we don't admit anyone who had a pure personality disorder. Because all the evidence would say that they don't do particularly well in hospital, if anything they do worse in hospital because they fall victim to the trap of ending up in hospital under a notional 37 and becoming undischARGEABLE... and now certainly if I'm assessing people in prison, I wouldn't admit anyone, certainly not to any of our wards, if I thought their problem was primary personality disorder.' P3

For the same reasons, clinicians also described how they adapt their recommendations to criminal courts in regards to sentencing decisions based on the presence of a primary diagnosis of personality;

And similarly when recommending hospital orders, I certainly wouldn't be recommending hospital orders for somebody who had a primary personality disorder. I mean you might use a 45(a) or one of these hybrid orders or you might even say they need a prison sentence and they can be transferred back in for treatment and sent back when complete. But I think you have to be very careful with personality disorders in hospital, you can't modify it very easily and people run the risk of being trapped in hospital for very very long periods which isn't helpful for anyone.' P3

Many described how prison is a more appropriate environment than attempting to admit a patient to a service that has no provision for personality disorder. Prison was described as more advantageous for prisoner-patients with personality disorder as the bounded regime is suited more to their needs;

'But, of course, in prison, you're, the regime is much more about punishment and reward and boundary setting which of course often is the right kind of

approach in personality disorder and that's harder to do in hospital where you've got a therapeutic regime. So it's not really based around rewards and punishments and times and stuff, its more based around sort of therapeutic goals and getting well, and of course, sometimes if you've got people with personality disorder they're not likely to get any better so if your regime is based on people getting better and you've got people who aren't going to get better then they're disadvantaged.' **P3**

Whilst some dedicated services exist, there is currently little national provision within the medium secure estate which is designed for the treatment of prisoner-patients with personality disorder. Clinicians described how these services currently operate to tight admission criteria and are notoriously difficult to negotiate admission to;

'Trying to get into patients PD services is very very difficult, I find... I l've started referring them to PD MSU and none have been accepted yet but l've decided that l'm just going to keep referring and see what happens because I don't have anything else I can do with these men and I feel like I have to do something. So this is my new...they're going to really hate me but l'm thinking, 'maybe one in ten gets accepted', I don't know what else to do so I just refer, refer, refer, not everyone but if they're appropriate. Because some people go "oh there's no point because they won't be accepted, don't bother" but I just think 'no because even if they're not accepted they have to know the demand's there, they have to be aware of it, they have to think about changing the service to meet it or can they' – so you have keep banging on the door.' **P4**

These services were described as for individuals with personality disorder who are ready to engage in the services and complete the required piece of work. However the discharge pathway out of these services remains remittal to prison post-treatment;

'One ward is a personality disorder ward, which deals predominantly with 47/49's whose pathways will be going back to prison... to come to the PD ward it's, the formulation has got to identify that at that period of time that patient is ready to do that piece of work. Because if they're not, it's pointless trying to get them to do it.' **P5**

As such, concern was expressed about the limited services available for these patients post-remittal;

'On our personality ward we'll do a piece of work and we might identify that that person would benefit from doing further work which can be carried out in prison, in a PIPE or something like that, it can be frustrating if then we hear they go back to prison and that work because of the availability of the treatment doesn't happen for a period of time. So that can be frustrating because we've done what we've needed to do to get them on that pathway and then suddenly it stops and that can be problematic for them.' P5

Theme 3: Desirable and undesirable patients

Describes the discretionary pathway decisions medium secure services make when prioritising prisoner-patients for continued inpatient treatment

a) True forensic patients vs. unwell prisoners

- *Culpability*

(Legal status, mental health and offence link)

Nature of mental disorder and its relevance to offending were described as key contributors to pathway decisions. Remittal was described as the appropriate pathway for 'unwell' prisoners, whereas those subject to a Hospital Order by virtue of being discharged into the community, were described as evidence of an 'institution effect'.

- *Risk responsibility*

(Role of medium secure services, length of stay)

Medium secure services were described as designed for 'true forensic patients'. It was deemed the role of prison mental health services to address these needs for remitted 'reactively unwell' prisoners. Prison clinicians highlighted that this is not what happens in practice and concerns for public protection were described.

b) Nature of presentation

- *Malingering*

(Inappropriate referrals, fabrication of symptoms)

Clinicians described the importance of recognising patients who do not have a mental disorder; malingering. Prison clinicians, however, provided such remitted patients who they believed still require secure care.

- *Management problems*

(Non-compliance, non-engagement and high risk behaviours)

Clinicians described behaviours which are not accepted as a result in remittal. A stay in medium secure services was described as a valuable opportunity. 'Successful' patients who comply and are subsequently discharged to the community care pathway. Prison clinicians describe concerns for public protection and concerns for public safety were described.

c) Nature of mental disorder and services available

- *Personality disorder*

(mad vs. bad)

Clinicians described how the degree to which 'management problems' are tolerated depending on the individual diagnosis. Patients with SMI were described more favourably and a paternalistic role for medium secure services was described. Medium secure services were described as an inappropriate environment for this with Personality disorder. However, deficit in medium security and prison service provision for these individuals was identified.

Figure 7.3: Theme 3 summary

7.5 Chapter summary

This chapter describes the findings from a sample of forensic mental health clinicians who have experience of managing and discharging prisoner-patients from medium secure services. This involved 11 individual interviews and a focus group of 13 members with clinicians from the psychiatric, nursing and social work professions, from both medium secure and prison-based mental health services.

Restriction of clinician autonomy

Criminal working practices and institutional factors were described as having a gross impact on prisoner-patients' care-pathways and discharge destinations; however there was an important distinction in regards to which issues restrict clinical autonomy in these pathway decisions and which do not. Clinicians described the nexus between the criminal justice and mental health systems and how court disposal decisions and the nature of particular custodial sentences can restrict the pathways available to individual prisoner-patients¹³. This included discussion of the frustrations felt by medium security clinicians when they deem an alternative pathway to be more appropriate and concerns in regards to the outlook of prisoner-patients post-remittal. Clinicians also expressed concern for the prisoner-patients who they believed to be 'stuck between two systems', whose release is solely at the disposal of the Ministry of Justice or whose remaining sentence tariff makes prolonged inpatient stay unfeasible. Clinicians speculated as to the quality of care these individuals receive post-remittal, and highlighted the in-equivalence of post discharge aftercare when compared to community mental health services; a concern which was supported by examples of 'revolving door' cases

Of particular significance was the debate on how best to approach discretionary pathway decisions for prisoner-patients with a short amount of time on their sentence tariff that are therefore close to their earliest release date. There was conflicting opinion on the best route out of secure services for these patients, with some clinicians recommending that discharge from medium secure services is ideal to ensure effective transition into the community and linking with aftercare services. However, other clinicians felt that this would unnecessarily prolong the patient's stay in medium secure services and that remittal to prison is therefore more appropriate to ensure speedy release into the community – an option which was also deemed to be more preferable from the prisoner-patient's perspective. However some clinicians were concerned that

¹³ For example, those sentenced/re-remanded in spite of clinical recommendations, or those subject to hospital treatment orders. This was evident in Study 1a for the patients who were subsequently excluded for the analysis in Study 1b.

this practice is disruptive to an individual's rehabilitation and has potential to damage continuity of care, as referral to community mental health services prior to release from prison is uncertain.

Competing agendas

Clinicians also reported the related economic pressures and external expectations which can impact their clinical autonomy and influence decisions of this type. The context in which prisoner-patients are managed within medium secure care is under pressure from competing agendas and clinicians felt that at times they were expected to compromise prisoner-patients' best interests in order to satisfy commissioning criteria. Clinicians described that there is an inbuilt assumption in the prisoner-patient care pathway that individuals should be treated in the shortest time possible and then returned to prison to resume their prisoner status. Whilst many felt that this was a necessary in order to maintain flow through the pathway, this bed management tactic was criticised by some as putting some prisoner patients at a disadvantage. Post-remittal services were described as underfunded and overstretched, which caused reluctance in some clinicians to remit prisoner-patients. Degree of reluctance was described as mediated by the nature and quality of multi-organisational relationships, particularly between medium secure and prison based mental health services.

Whilst some raised concerns that these relationships may cause conflicts of interest in regards to bed management practices, others explained how the presence of positive relationships with prison colleagues helped to facilitate information exchange and arrangements for care post-remittal. There were examples of successful local discharge planning practices in both the focus group and individual interviews; however this was outweighed by descriptions of arrangements which were not conducted in line with good practice guidance. Both medium security and prison based clinicians expressed concerns in regards to the lack of engagement in the Section 117 discharge planning and aftercare processes from their counterparts. Few made reference to the delivery of post-remittal aftercare via the CPA process, yet those who did highlighted that it is a poorly facilitated process upon prison remittal.

Undesirable patients

Prisoner-patient characteristics and the degree to which an individual is deemed 'appropriate' for the service was a key factor present in discretionary pathway decisions. Prisoner-patient appropriateness was in part determined by how clinicians viewed the role and function of

medium secure services with the forensic mental health system. Culpable prisoner-patients were not considered to be a priority for medium secure services; therefore the pathway and role of secure services for these patients was presented as stabilisation of mental health and remittal to prison. As such, risk reduction and offence related work was considered the responsibility of the prison estate.

Many clinicians felt that prolonged stay in medium secure services was a valuable opportunity and therefore felt that prisoner-patient transfers who choose not to engage in the treatment available or present as high risk towards staff or other patients, required remittal to prison. The degree to which clinicians tolerate this type of behaviour is dependent on the nature of an individual's disorder. Prisoner-patients with a diagnosis of severe mental illness were described as more likely to receive continued treatment in inpatient care, whereas for prisoner-patients with a primary diagnosis of personality disorder, this type of behaviour will likely result in remittal to prison. Many clinicians felt that medium secure services were not an appropriate environment for persons diagnosed with a personality disorder. Few services are available within medium secure services that provide targeted support for patients with personality disorders, and those that do exist were described as having narrow admission criteria. As such it was felt that the boundaries and nature of the prison environment was more appropriate for prisoner-patients with personality disorders, although clinicians were uncertain as to what services are available within the prison estate post-remittal.

Prison based clinicians provided their experience of receiving remittals who medium secure services had considered inappropriate for continued inpatient care, with many feeling that medium security based clinicians viewed the prison estate as a 'safe place'. However, this was considered to be a dangerous practice, as prison mental health services are not equipped to manage patients who are not engaging or present as high risk. Many felt that a referral to the high secure estate would be more appropriate. These clinicians felt strongly that if a prisoner-patient is not deemed suitable for discharge into the community due to current clinical and risk issues, then they should also not be considered suitable for remittal to prison. Likewise these clinicians also described how prison mental health services do not provide the offence related and risk reduction work that medium secure clinicians consider to be the responsibility of the prison estate. It was suggested that some of these patients are ultimately released into the community in the absence of completing this work, many of whom go on to re-offend.

7.5.1 *Conclusions*

This study was conducted with the intention of adding context to the quantitative findings observed in Study 1, and to explore factors which may address the identified areas of outstanding interest (see section 5.9.4). This thematic analysis supports many of the conclusions made in Study 1, in regards to the relevance of individual factors observed to differ significantly across community discharges and prison remittals. In particular, this study has added more understanding into why characteristics such as primary diagnosis of personality disorder, increased risk of future violence and low presence of protective factors are more likely for prison remittals than community discharges. Overall, it appears that prison remittal decisions are not only driven by an individual having completing their necessary treatment, but also due to some prisoner-patients not meeting the remit of the service and lack of treatment options available for high risk prisoner-patients with personality disorder. However, the outlook of prisoner-patients is currently unclear. Many clinicians were concerned about the quality of prison mental health services and continuity of care post prison release. Whilst prison based clinicians provided insight into the outcome of some prisoner remittals, it still remains unclear what targeted services are available for prisoner-patients upon remittal.

7.5.2 *Outstanding research questions*

There has been no previous research investigating the outcomes and treatment available post-remittal for prisoner-patients returning from medium secure services. As such many areas of interest remain outstanding. Most pertinent to this study are the following gaps in knowledge;

- Post-remittal aftercare services were described as limited and not equivalent to those provided by community mental health teams for. It is currently unclear what services and therapeutic interventions prisoner-patients receive upon remittal, and whether these differ across diagnostic groups.
- It is also unclear the extent to which prisoner-patients' legal rights to ongoing aftercare under Section 117 are upheld post-remittal, and whether this care is managed through the CPA process.
- Both medium secure and prison-based clinicians expressed concerns about continuity of care, particularly in regards to referral to community mental health services for prisoner-patients who are subsequently released into the community. Whether remittals remain under the care of prison mental health services prior to release and the extent to which they are referred to community mental health services is currently unknown.

These outstanding questions cannot be addressed through clinician accounts alone; therefore a national one year follow-up study was utilised in Study 3. This design allowed for the collection of data in regards to access to mental health inreach services, continuity of care following prison transfer and release, and prisoner-patient outcome post-remittal.

Chapter 8: Methodology 3

National follow-up study: a population of prisoner-patients remitted to prison from medium secure services

This chapter provides an overview and justification for the methodology used in Study 3. This is the first study both in the United Kingdom and internationally to follow-up patients who are remitted to prison following treatment in secure psychiatric services. Thus, design considerations were loosely informed by previous studies of community discharges from medium secure services. This study was designed as a feasibility study, with the intention of collecting descriptive data on patient access to services and outcomes post-remittal, and also to consider the practicalities of conducting follow-up studies within prisons.

8.1 Study objectives

The objectives of Study 3 were to:

- Describe and explore the follow-up care pathways for prison remittals from medium secure services
- Describe follow-up treatments received and outcome for prison remittals from medium secure services

Quantitative methodology was chosen as being the most appropriate approach to achieve these goals as it allowed for objective measurement of prison remittal follow-up care pathways and outcomes.

8.2 Design considerations

8.2.1 *National one year follow-up of prison remittals*

To conduct this study a national cohort study design with one year follow up of all patients remitted from medium secure services back to prison over a 6 month discharge period was implemented. This follow-up study was designed in conjunction with Study 1, and therefore the follow-up cohort were those patients remitted from the 33 NHS medium secure services between May 2014 and October 2014.

During set up of Study 1, it was anticipated that a follow-up study of patients from this many medium secure services would require site approvals and data transfer from a large number of prison establishments. Guidance for remittal of prisoners from medium secure services now requires that patients should be returned to the prison which is local to the medium secure service (Department of Health, 2011). Therefore a scoping exercise was conducted to establish which prisons would likely be included as follow-up sites (medium secure services were asked to provide details of the prisons to which they usually remit). Through this exercise it became clear that, whilst prisoners are returned to their local prisons, they are often transferred to other prisons afterwards, commonly their referring prison, once a placement has been confirmed. On this basis, the decision was made to apply to the National Offender Management Service (NOMS) for nationwide approval to access all prisons in England & Wales during the 1 year follow-up. (See section 8.6 for approval information). NOMS was provided with a list of 66 prisons for which access requirements were anticipated. This included details of the prisons to which the medium secure services commonly remitted patients, and also prisons which the service had recently received admissions from. At this point, administrators within the NOMS Research and Evaluation Team agreed to notify the 'lead area psychiatrists' that the follow-up study was taking place and that patients within their service might be included.

Obstacles to gaining individual site approvals and accessing data at this number of prisons sites were anticipated. Therefore it was necessary to develop a contingency plan for the follow-up study in the form of a regional follow-up design. The Offender Health Research Network has existing professional relationships with prison establishments across the North West of England region, including with prison staff and mental health professionals. Therefore, if a national follow-up design was to prove unmanageable, the contingency plan was to conduct a regional follow-up study with patients who were remitted to prison from The Edenfield Centre (Greater Manchester), Guild Lodge (Preston) and Scott Clinic (St Helens). However, the national follow-up

approach was successful, and access was obtained at 89% of follow-up sites (see section 8.6.3 for a description of access issues).

8.2.2 Follow-up period

Previous community discharge studies from medium secure studies have ascertained patient outcomes with varying lengths of follow-up (Fazel et al., 2016). Previous researchers have found that a follow-up period of 2-5 years is necessary to access information regarding outcomes such as mortality, readmission and reoffending (See Fazel, et al., 2016 for review of outcome studies). The key justification for lengthy follow-up periods in community discharge studies is to allow for accurate capture of reconviction data and to account for issues such as the lag from official sources such as the Offender Index. This system has a lag as long as 2 years between charges and conviction upload (Coid, Kickley, Khatan, Zhang & Tang, 2007; Maden, Skapinskis, Lewis Scott & Jemieson, 2006). As this study was a feasibility study of follow-up within prisons, reoffending was not an outcome of interest, therefore a follow-up period of this length was not deemed necessary. Additionally, this study was particularly focused on the immediate post-transition period of whether patients had received mental health inreach services following remission. Therefore a shorter follow-up period than those previously used within the literature was deemed sufficient.

A follow-up period in excess of one year was considered also unfeasible. Firstly, this is the first study of its type and therefore the extent of barriers to data collection was unknown. It was unclear how common patient transfer between prisons would be, yet it was anticipated that an unduly long follow-up period may have allowed for multiple prison transfers per patient, and therefore could have resulted in a high attrition rate. Secondly, there also needed to be sufficient time to account for the anticipated follow-up delays to ensure that data could be collected within the doctoral programme. Therefore the follow-up period was set as being for one year between May 2015 and October 2015.

8.2.3 Data collection

As with Study 1, data were extracted from patient medical records from the SystmOne medical record system (See section 8.7 for a description of the medical documents accessed for data extraction). Where data were unclear, for example regarding acceptance and discharge from mental health inreach services, attempts were made to gain clarification from administrators. In

the first few weeks of accessing follow-up data, attempts were also made to conduct interviews with collateral informants to supplement information gathered from medical notes, as in Study 1. However, it was clear that this would not be a feasible means of data collection as it was difficult to find a member of the mental health inreach team who had worked with the patient or had adequate knowledge of the care and treatment they had received. This was commonly due to high staff turnover rates and long-term sickness within the prison establishment, or that the patient had not been treated by the inreach team during follow-up. Therefore collateral informant interviews were not conducted as a means of data collection in the follow-up study.

8.3 Patient sample

There were 96 prisoner-patients remitted to prison from medium secure services across the 6 month baseline period (May 2014 to October 2014). Of these, 7 individuals were lost to follow-up due to clinical note access issues. For 47 patients, a partial follow-up was completed as the patient was released from prison, transferred back to hospital, or due to note access issues (see figure 8.1). The remaining 42 patients remained in prison throughout their one year follow-up period, and the clinical notes of all of these individuals were accessed. Therefore at least some follow-up data were available for 89 patients (93%).

Patients who were readmitted to secure psychiatric services or released from prison back into the community were not followed up beyond their readmission/release date. It would have been impracticable to follow up these patients beyond this point as this would have introduced more hospital and community sites which would have required further approvals. Nevertheless both release from prison and readmission were examined as outcomes in this study. Therefore information regarding to time between remittal and release/readmission was collected, alongside the nature of the environment the prisoner-patient moved on to. Patients who were transferred from their remittal prison to another prison during follow-up were, however, continually followed up beyond transfer, to allow for description of the impact of prison transfer on access to services.

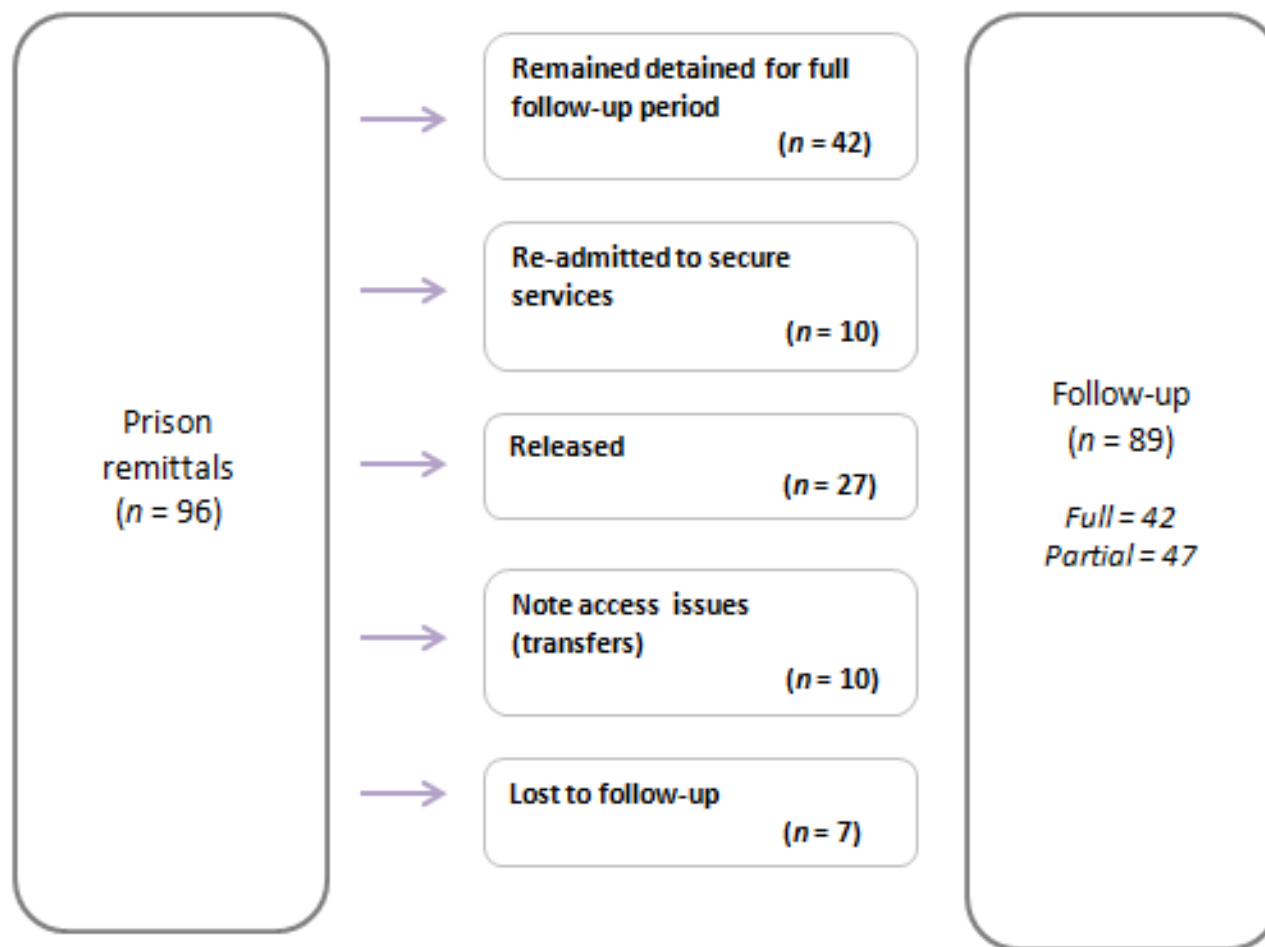


Figure 8.1: Remittal follow-up

8.4 Follow-up sites

Discharge destinations for prison remittals were noted at date of discharge from medium secure services. Letters were sent to prison governors and heads of prison healthcare immediately after patient discharge to notify them of the patient's involvement in the study and to request permission to access their SystmOne medical record at one year of follow-up. Governors and heads of prison healthcare were asked to provide their written approval for the follow up to take place and to provide the contact details of the mental health inreach service provider (NHS trust or private provider) and mental health inreach lead clinician.

The 96 patients were remitted to 48 separate prisons. Approvals were gained and medical notes were obtained for patients at 44 of these prisons. Four prisons could not be accessed; one due to the governor's refusal, two due to the prison MHIRT refusing to transfer the notes, and one due to the patient's notes being unavailable – (the patient had since moved on and their healthcare record was locked to the clinicians and therefore could not be transferred) (see Table 8.1).

Table 8.1 Prison follow-up sites (*n* = 44)

HMP Altcourse	HMP Exeter	HMP Hull	HMP Pentonville
HMP Bedford	HMP Featherstone	HMP Humber	HMP Preston
HMP Belmarsh	HMP Forest Bank	HMP Holme House	HMP Stocken
HMP Birmingham	HMP Gartree	HMP Lancaster Farms	HMP Stoke Heath
HMP Bristol	HMP Glen Parva	HMP Leicester	HMP Swinfen Hall
HMP Buckley Hall	HMP Grendon	HMP Lewes	HMP Thameside
HMP Chelmsford	HMP Hewell	HMP Longlartin	HMP Wandsworth
HMP Doncaster	HMP Highdown	HMP Manchester	HMP Wayland
HMP Dovegate	HMP Hindley	HMP Northumberland	HMP Whitemoor
HMP Durham	HMP Holloway	HMP Norwich	HMP Winchester
HMP Elmley	HMP Holme House	HMP Nottingham	HMP Wormwood scrubs

Patient prison transfers resulted in requiring access to a further 15 prisons. Approvals were gained and medical notes were obtained for patients at 12 of these prisons. Three prisons could not be accessed due to the governor’s refusal (See Table 8.2).

Table 8.2 Follow-up sites added due to patient transfer ($n = 12$)

HMP Bullingdon	HMP Frankland	HMP Highdown	HMP Littlehey
HMP Bure	HMP Full Sutton	HMP Highpoint	HMP Oakwood
HMP Coldingly	HMP Garth	HMP Langdon Grange	HMP Swaleside

As such of the 63 prisons, 56 could be accessed for the purpose of patient follow-up (89%).

8.5 Ethical approvals

National NHS Ethical approval to follow-up prison remittals was granted at the same time as the initial applications described in Section 3.9, subject to the same conditions under to Section 251 NHS Act 2003.

8.5.1 *National Offender Management Service (NOMS)*

Approval to conduct follow-up assessments within prison establishments was sought from The National Offender Management Service and was granted on 25th February 2014, on the basis that the study did not require access to non-health related prisoner records, and that the approval of the prison’s governor was sought prior to accessing prisoner information at each site. Governor’s approval was sought upon the notification of a prisoner-patient remittal to a prison establishment (as described in 8.5).

8.5.2 Prison access and site specific research and development approvals

The prison approval process to conduct the follow-up study involved gaining individual governor approval for each prison. Prisons ran by private security providers (e.g. Serco and G4S) also required approvals from these organisations alongside the governor's approval. Site specific research and development approval from each MHIR healthcare provider was also gained, which included both NHS and private healthcare providers (e.g. Virgin Healthcare, Spectrum Healthcare, Partnerships in Care and Care UK). Governor approval and approval from the Head of Healthcare within each prison healthcare team was required prior to obtaining site specific R&D approval (see figure 8.2). Once this was confirmed, MHIR Team Lead Clinicians could be contacted to arrange data access.

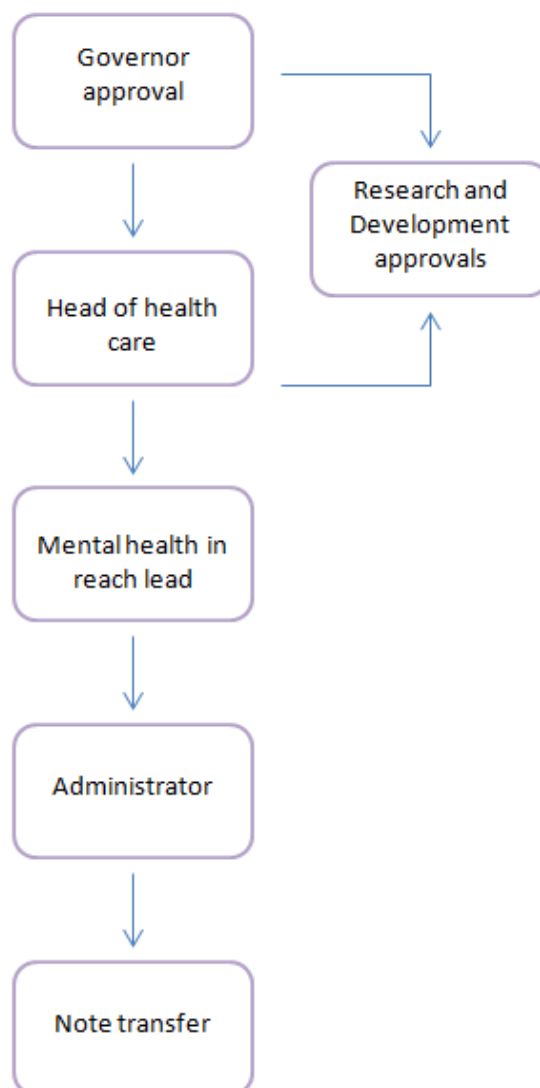


Figure 8.2: follow-up prison approval process

8.5.3 *Issues in gaining approvals*

At many stages of the approval process there were issues which delayed access to the data required to conduct the follow-up. There were three notable instances which caused unexpected delays;

1) Provider disputes

Multiple healthcare providers can provide services in the same prison establishment; therefore the Head of Healthcare and the MHIR team can belong to different healthcare providers. Where this was the case, there were delays in gaining approvals whilst the Governance Teams from each provider established which healthcare provider was the 'data processor' and which was the 'data controller' under s.271 NHS Act. In two cases (see Table 8.1) the Mental Health Inreach Teams refused to transfer the patients' data.

2) Changes to healthcare providers

Between gaining site approvals and requesting data for patients at one year follow-up, the healthcare service within 10 prisons had gone out to tender and providers had subsequently changed. This resulted in new site approvals having to be obtained from these providers.

3) Patient movement within the prison estate

Thirty-eight of the patients were transferred between prisons during their one year follow-up period. Seven of these were transferred twice, and one patient was transferred three times. Where these were prisons for which the study was not already approved, further applications for approvals for these prisons and healthcare providers were required (see Table 8.2).

Due to these delays, an extension of existing national research ethics and CAG approvals was required. A non-substantial minor amendment to protocol was submitted to the National Research Ethics Service on 08/08/2016 to extend the study approvals for a further one year period. This was approved on 19/08/2016 and the project received a revised end date of 30/09/2017. This request was then also approved by CAG on 02/09/2016.

At this stage of the study it was also necessary to receive administrative support from within the Centre of Mental Health and Safety to gain outstanding site approvals. Support from administrative colleagues was provided for a 5 month period between September 2016 and January 2017, resulting in final approvals and data being obtained prior to the revised end date. As such the study was closed in February 2017.

8.6 Materials

8.6.1 Data collection proforma

A data collection proforma was developed to capture the data extracted from participants' medical records. This proforma allowed for efficient collection of a range of variables devised to understand and describe the services accessed and outcome post-remittal from medium secure services, and was structured with 5 distinct subsections:

a) Location at remittal

This section was used to record the name of the prison, and of patients' locations within the prison, at remittal (healthcare wing, first night centre, ordinary location, seclusion, etc.).

b) Mental health inreach services, treatment and access to professionals

This section recorded information regarding MHIR Team referral, assessment, acceptance/declining and discharge, as well as dates for these events. This section was also used to record the equivalent information if the patient had been transferred to another prison during follow-up. Types of professionals involved in the patient's care and the treatment and services received were also documented, as was any evidence that the patient was under the CPA process during follow-up.

c) Management interventions

Instances of healthcare admissions, the use of the ACCT document process and time spent in segregation were documented in this section. Whilst segregation is a prison intervention and is not deployed by healthcare staff, segregated prisoners must be passed as being medically fit following examination by a healthcare professional and they must be regularly observed by healthcare staff. Such information was recorded in and could be extracted from healthcare records. The section also allowed for the recording of any instances of self-harm and attempted suicide as documented by healthcare professionals. This was likely an underestimation of the incidence of self-harm and attempted suicide within this population during follow-up as it relied on the healthcare professional being aware of the event and recording it in the patient's record. However, the data were collected with this caveat in mind as I considered these events to be of considerable interest and importance. It was anticipated that it might not be possible in each instance to distinguish between self-harm and episodes with and without unequivocal evidence of

suicide intent. Therefore I opted to coalesce the two variable groups in the later analysis as a single 'self-harm' group.

d) Secure psychiatric hospital transfer

Referrals, assessments and transfers to inpatient psychiatric services were documented in this section, along with the dates of these events.

e) Prison release into the community

Evidence of liaison with community mental health services and patient location at release into the community was documented in this section.

8.6.2 *Data not extracted*

Discharge studies from medium secure services have previously used instances of violence and recidivism as outcomes of interest (Fazel, et al., 2016). Whilst there was evidence of violent incidents documented in patients' healthcare notes, this information was not extracted for the purpose of this study. Violence is not an event which is routinely recorded by healthcare professionals and therefore episodes that were recorded were likely to be a gross underestimation.

Within prisons 'Adjudications' is the procedure whereby offences against the prison rules alleged to have been committed by prisoners are addressed. Adjudications hearings are conducted and prisoners can be 'charged' and receive a punishment under the local punishment guidelines in relation to the offence committed. A request was made to NOMS to access the CNOMIS system in which adjudications are documented, for the follow-up cohort. It was the intention that this information would provide insight into any criminal behaviour conducted by patients remitted to prison one year post-discharge, which could be compared with the context of recidivism for persons discharged back into the community. Access to this system was however denied on the grounds that informed consent would be required from prisoners to access their non-healthcare prison records.

8.7 Data extraction

The data collection proforma was used to record clinical data extracted from patient SystemOne records. The medical records of each patient were accessed via the mental health inreach team provider. The types of documents accessed for the purpose of data extraction included:

- Daily nursing and clinical staff records of patient observations
- Clinical letters
- CPA documentation

The documents obtained from the SystemOne record were not of the same detail or quality as those accessed from the medium secure services in Study 1. Issues with medical record quality included;

- The discipline of the professionals who recorded patient contact was not always clear, particularly if the clinician was a visiting professional. Where this was the case, attempts were made to clarify these roles with MHIRT administrators.
- Ending of the ACCT document was not recorded in 16 instances; therefore length of ACCT could not be established in these cases.
- Discharge from a healthcare wing was not recorded in 4 instances; therefore the length off admission to the healthcare wing could not be established in these cases.

8.8 Procedure

The study was conducted concurrently at each of the prison sites.

Once the approvals described in Section 8.6 were in place, Mental Health Inreach teams provided an administrative contact to arrange data transfer. Administrators were provided with the patient identifiable information and asked to obtain the patient's medical records for the one year follow-up period. Medical records were transferred to the Centre of Mental Health and Safety either electronically via secure nhs.net email transfer, or hard copies were posted via recorded delivery.

Where patients had been transferred to other prisons during their follow-up period, administrators were asked to provide the details of the transfer prison, including the contact for the transfer prison Mental Health Inreach Team. These patients were then followed-up in the same way at their transfer prison.

Data were then extracted and recorded on the data collection proforma for each patient and subsequently entered into electronic databases held on SPSS version 22. See section 9.3 for description of statistical analysis used.

8.9 Chapter summary

This chapter has provided an overview of the quantitative one year follow-up design and methodology adopted in Study 3. Findings for Study 3 are presented in Chapter 9.

Chapter 9

Results: one year follow-up of prison remittals

This chapter provides an overview of the pathways and outcomes of prisoner-patients who were remitted to prison from medium secure services. The follow-up period was 12 months post-remittal from medium secure services and therefore spanned May 2015 to October 2015. SystemOne clinical notes were accessed from each prison establishment. Key findings are described in text and tables present findings for all included prison remittals, alongside findings stratified by diagnostic groups.

Findings are explored and presented under 5 distinct headings;

- Location at remittal and prison transfers
- Mental health inreach services, treatment and access to professionals
- Management interventions
- Secure psychiatric hospital transfer
- Prison release into the community

9.1 Diagnostic groups

The 89 prison remittals included in the follow-up were coded into 3 distinct diagnostic categories;

- Severe Mental Illness (SMI) ($n = 35$):
 - Schizophrenia, paranoid and other psychotic disorders, bipolar disorder and schizoaffective disorder.

- Personality Disorder ($n = 36$):
 - Including all subtypes of personality disorder.

- Other diagnoses ($n = 18$):
 - Depression, obsessive compulsive disorder, alcohol dependency syndrome, dysthymia, and 'no current diagnosis'.

9.2 Location at remittal and prison transfers

There was insufficient information available to extract detailed transfer process data from both medium security and prison health care records, although location at remittal to prison was available. The majority of remittals were to ordinary wing location within the remittal prison (69%), whereas 18% were to the healthcare wing, and 4% into the segregation unit. Seven remittals were remitted to the ‘first night’ centre within the prison and one to a deportation suite within the prison.

Table 9.1. Location in prison at transfer from medium secure services

Primary diagnosis	N	n (%)				
		Ordinary location	First night centre	Deportation suite	Healthcare wing	Segregation
SMI	35	24 (69)	3 (9)	1 (3)	6 (17)	1 (3)
Personality Disorder	36	24 (67)	3 (8)	-	6 (17)	3 (8)
Other diagnosis	18	13 (72)	1 (6)	-	4 (22)	-
Total	89	61 (69)	7 (8)	1 (1)	16 (18)	4 (4)

Prisoners returning to custody from secure mental health services return to the local prison in that area, unless there are exceptional services to prevent this or they are a Category A prisoner (Department of Health, 2011). As such it is often the case that the local prison to the secure service is not the prisoner-patient’s original referral prison (the prison they were detained in at transfer to medium secure services), and prisoners can be transferred back to their referral prison post-remittal. Inter-prison transfers can also take place throughout a prisoner’s detention for a wide range of reasons (e.g. re-grading of prisoner status, nearing the end of a sentence, prisoner request, etc).

Just under half of remittals ($n = 38$, 43%) were transferred to another prison establishment from their remittal prison during the follow-up period. Ten were lost to follow-up at transfer due to note access issues at their transfer prison (see methodology. Section 8.4); nine were lost following their first prison transfer and one patient was lost at their second prison transfer.

Table 9.2. Frequency of patient transfer

Transfers	<i>n</i> (%)
Same prison	51 (57)
One transfer	30 (34)
Two Transfers	7 (8)
Three Transfers	1 (1)

Just under half (45%) of prison transfers happened within the first three months post-remittal, with the shortest taking place after nine days of remittal.

Table 9.3. Time to first transfer

Time to transfer	<i>n</i> (%)
0 – 3 months	17 (45)
3 – 6 months	11 (29)
6 – 9 months	5 (13)
9 – 12 months	4 (11)
Missing	1 (3)
Minimum	9 days
Maximum	321 days
Mean	115.68
SD	94.38

9.3 Mental Health inreach services, treatment and access to professionals

9.3.1 Access to mental health inreach (MHIR) services at remittal prison

Contact with mental inreach (MHIR) services at remittal prisons was reviewed for each prisoner-patient remitted. There was evidence of a referral to the mental health inreach team for 98% of remittals, 83% of these referrals were recorded as taking place at prison reception screening. The mean interval between remittal and assessment by the MHIR team was 3.1 days (sd = 5.2), with time between remittal and assessment ranging from one day to 31 days.

Of these, (73%) were accepted onto the MHIR caseload, although 20 remittals were deemed inappropriate for the MHIR service and two remittals did not receive an assessment; this included almost a third (31%) of those referred who had a primary diagnosis of personality disorder and five patients with a severe mental illness. Of those accepted, 8 were discharged from the service, five were deemed inappropriate and three were discharged due to non-engagement. Fifty-seven persons remained under MHIR throughout their detention in their remittal prison (until follow-up date or transfer date).

Table 9.4. Access to mental health inreach services at remittal prison

Primary diagnosis	N	n (%)			
		Ref at reception	Ref to inreach	Accepted onto MHIR	Discharged
SMI	35	29 (83)	34 (97)	29 (85)	1 (3)
Personality Disorder	36	30 (83)	35 (97)	24 (67)	3 (13)
Other diagnosis	18	15 (83)	18 (100)	12 (67)	4 (33)
Total	89	74 (83)	87 (98)	65 (73)	8 (9)**

Ref = referral, MHIR = Mental Health Inreach

*20 deemed not appropriate, 2 not assessed ** 5 deemed inappropriate, 3 non-engagement

Prison remittals ($n = 89$)

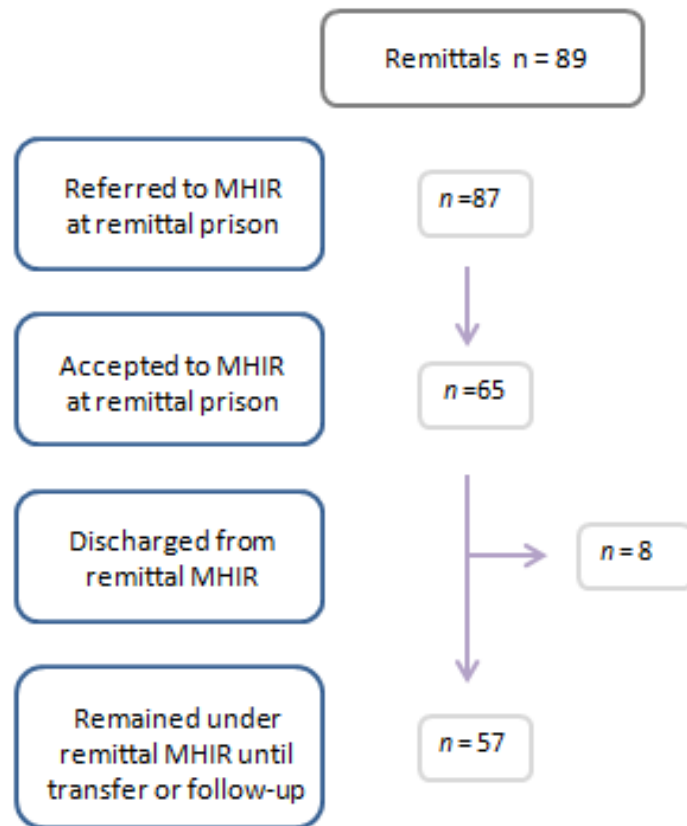


Figure 9.1: Access to MHIR services at remittal prison

9.3.2 Continuity of care - access to mental health inreach services at transfer prison

Thirty-eight (43%) prisoner-patients were transferred to another prison during follow-up. Of these, there was a handover/recorded referral for 12 patients (32%) from remittal prison to transfer prison MHIR services. This included for 4 of the 9 patients who were subsequently lost to follow-up at first prison transfer.

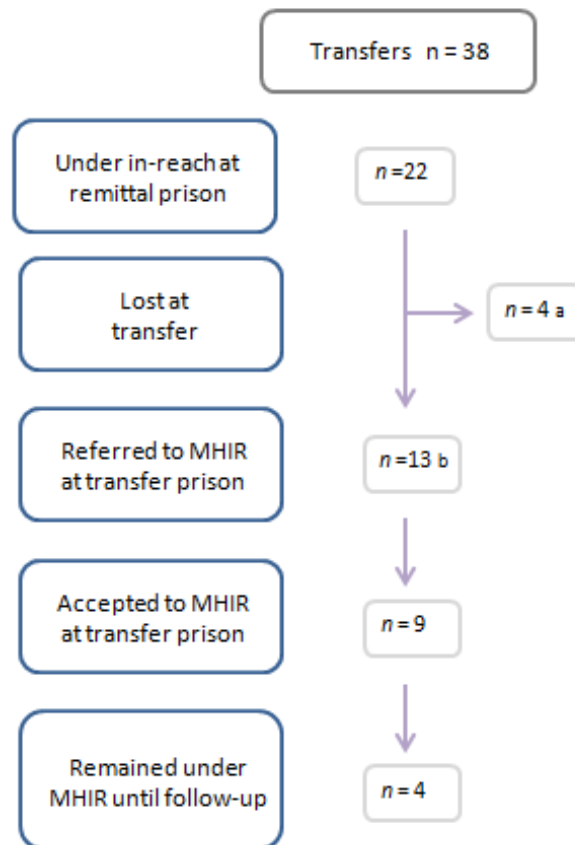
Contact with MHIR services at their remittal prison was recorded for the 29 transferred prisoners. There was evidence of a referral to the mental health inreach team for 21 (72%) patients, of whom 15 (71%) were accepted onto the MHIR caseload. Seven (47%) were discharged from the service due to being deemed inappropriate for the service and 8 remained under MHIR throughout follow-up.

Table 9.5. Access to services at transfer

	<i>N</i>	<i>n (%)</i>
MHIR-MHIR referral	38	12 (32)
Lost at first transfer	38	9 (24)
Referred to inreach	29	21 (72)
Accepted onto MHIR	21	15 (71)
Discharged	15	7 (47)

Figure 9.2 breaks this down further and presents access to MHIR services for those who were engaged in MHIR at their remittal prison at time of prison transfer.

Prison transfers (n = 38)



- a 4 were referred to MHIR by their remittal MHIR team
- b 8 were referred to MHIR by their remittal MHIR team

Figure 9.2: Access to MHIR services following transfer - for those engaged in MHIR at their remittal prison

9.3.3 Summary of access to MHIR services

There was one patient who had not been referred to MHIR services at all during follow-up, and 38 who were either not accepted at their first or subsequent referral (transfer prison) or were discharged from MHIR services during follow-up¹⁴, whereas the remaining 47 were under a MHIR service's caseload at last date of follow-up.

- Twenty-two of those transferred were still under MHIR at time of prison transfer. Four of these were lost to follow-up at transfer. Of the 18 accessed at transfer, 13 were referred to the transfer prison MHIR service and nine were accepted onto the caseload. Five were later discharged from the service due to being deemed inappropriate for the service.
- Four of the patients discharged from the MHIR services at their remittal prison were transferred during follow-up. Two of these were lost to follow-up at transfer. Of the two accessed at transfer, one received a referral to the transfer prison MHIR and was accepted onto the caseload.
- Eleven of the patients not accepted onto MHIR service caseload at their remittal prison were transferred during follow-up. Three were lost to follow-up at transfer. Of the eight accessed at transfer, six received a referral to the transfer prison MHIR. Four of these patients were accepted onto the caseload, yet two were later discharged from the service due to being deemed inappropriate for the service.
- One patient who was not referred to MHIR at their remittal prison was transferred and received a referral to the MHIR at their transfer prison, and was accepted onto the caseload.

(See Appendix R, Figure A1 for full diagrammatical pathway through MHIR services).

¹⁴ There were eight patients who were transferred beyond this point; seven were moved on to one more prison and one was transferred twice more during follow-up. Access to MHIR services beyond the first transfer for these patients is not included here.

9.3.4 *Access to professionals*

Data were extracted on the care and treatment received by patients throughout the follow-up period, including their access to individual professional groups. Just over two thirds of persons remitted were seen by a psychiatrist and 96% saw a mental health nurse at some point during their follow-up period (see Table 8.6 for full breakdown of access to professionals across diagnostic group).

9.3.5 *Access to treatment*

In terms of treatment received, few patients received therapy at follow-up (2%), or were involved in mental health support groups (10%), yet a quarter of persons remitted were enrolled on a substance misuse programme, the majority of whom had a primary diagnosis of personality disorder. Eighty-three percent of patients were prescribed psychiatric medication during follow-up (see Table 8.7 for full breakdown of access to treatment across diagnostic group).

Table 9.6. Access to professionals during follow-up

Primary diagnosis	n	n (%)						
		Psychiatrist	MHN	SW	SuW	OT	Psychologist	Other*
SMI	35	28 (80)	34 (97)	3 (9)	5 (14)	7 (20)	1 (3)	-
Personality Disorder	36	23 (64)	33 (92)	2 (6)	7 (19)	5 (14)	3 (8)	3 (8)
Other diagnosis	18	10 (56)	18 (100)	3 (17)	4 (22)	4 (22)	-	2 (11)
Total	89	61 (69)	85 (96)	8 (9)	16 (18)	16 (18)	4 (4)	5 (6)

MHN = Mental health nurse; SW = social worker; SuW = support worker, OT = Occupational Therapist

* Including Advocates and Support Time and Recovery Workers

Table 9.7. Treatment received during follow-up

Primary diagnosis	N	n (%)				
		Meds	Therapy	SUP	SG	Under CPA
SMI	35	33 (94)	-	4 (11)	4 (11)	8 (23)
Personality Disorder	36	28 (78)	2 (6)	16 (44)	4 (11)	7 (19)
Other diagnosis	18	13 (72)	-	2 (22)	1 (6)	2 (11)
Total	89	74 (83)	2 (2)	22 (25)	9 (10)	17 (19)

SUP = Substance use programme, SG = Support group

The majority of persons remitted were prescribed psychiatric medication at their discharge from medium secure services (86%), but almost half of these patients were documented as stopping their psychiatric medication during follow-up (47%). This included 54% of those with a primary diagnosis of personality disorder and 48% of those with an SMI diagnosis that were prescribed psychotropic medication.

Table 9.8. Patients prescribed medication at discharge

Primary diagnosis	N	n (%)	
		Taking	Stopped
SMI	33	17 (52)	16 (48)
Personality Disorder	28	13 (46)	15 (54)
Other diagnosis	13	9 (69)	4 (31)
Total	74	39 (53)	35 (47)

Thirty-two patients were documented as having stopped taking their prescribed antipsychotic medication. This included 16 patients with a primary diagnosis of SMI and 14 patients with a primary diagnosis of personality disorder. The remaining 3 patients had stopped taking their prescribed antidepressant medication.

Table 9.9. Type of prescribed medication stopped during follow-up

Primary diagnosis	N	n (%)	
		Antidepressant *	Antipsychotic **
SMI	16	-	16 (100)
Personality disorder	15	1 (7)	14 (93)
Other diagnosis	4	2 (50)	2 (50)
Total	35	3 (9)	32 (91)

* Including citalopram, trazodone and sertraline

** Including amisulpride, chlopixol, chlorpromazine, olanzapine, quetiapine and risperidone

Seventeen patients remained under CPA upon remittal to prison (19%), these were predominantly patients with personality disorder or SMI.

Table 9.10. Patients under CPA during follow-up

Primary diagnosis	N	n (%)
		Taking medication
SMI	35	8 (23)
Personality Disorder	36	7 (19)
Other diagnosis	18	2 (11)
Total	89	17 (19)

This group included just 14 of the 78 patients who had the right to aftercare managed through the CPA process (18%), under section 117 of the Mental Health Act (MHA).

Table 9.11. Patients eligible for 117 and CPA (*n* = 89)

Section MHA	N	n	
		Right to aftercare under 117	Under CPA process
<i>Hospital orders</i>			
s. 35	3	-	2
s. 36	1	-	-
s. 37n	1	-	-
s. 38	6	-	1
s. 45a	3	3	-
<i>Prison transfers</i>			
s. 47	64	64	14
s. 48	11	11	-
Total	89	78	17

9.4 Management interventions

Data were extracted on the processes applied to manage the mental health and behaviour of prisoners. This included the opening of an ACCT document, admission to a prison healthcare wing, and being held in segregation. Data were also extracted for any recorded incidents of self-harm and attempted suicide.

9.4.1 Assessment, Care in Custody & Treatment (ACCT)

As part of the National Offender Management Service's (NOMS) suicide prevention strategy, any prisoner identified by a healthcare or prison professional as being at elevated risk of suicide or self-harm must be managed using the ACCT procedures - a prisoner-centred, flexible care plan system¹⁵. There were a total of 61 recorded ACCT documents opened across 44 prison remittals (49%). The majority of remittals managed under ACCT had one ACCT document opened during the follow-up period (n = 31, 70%); however 13 remittals (30%) had 2 or more ACCT documents opened during the follow-up period, 10 of whom were patients with a primary diagnosis of personality disorder.

Table 9.12. Persons remitted under ACCT during follow-up

Primary diagnosis	N	n (%)
		Under ACCT
SMI	35	15 (43)
Personality disorder	36	20 (56)
Other diagnosis	18	9 (50)
Total	89	44 (49)

Table 9.13. Number of ACCTS during follow-up

Primary diagnosis	N	n (%)			
		1	2	3	4
SMI	15	13 (87)	2 (13)	-	-
Personality Disorder	20	10 (50)	7 (35)	2 (10)	1 (5)
Other diagnosis	9	8 (89)	1 (11)	-	-
Total	44	31 (70)	10 (23)	2 (5)	1 (2)

¹⁵ Any member of staff who receives information or observes behaviour indicative of elevated suicide/self-harm risk must open an ACCT. This can include both healthcare staff and prison establishment employees.

Patients were compared across two groups, Personality disorder versus 'SMI and Other diagnosis combined' for whether they were managed under an ACCT document during follow-up. There was no difference for whether an ACCT document was opened across these two diagnostic groups, however patients with a primary diagnosis of personality disorder were four times more likely to have had two or more ACCT documents opened during follow-up than the other groups (50% vs. 12%, $p = .007$).

Table 9.14. Rate ratio comparisons of persons under ACCT during follow-up

	<i>n (%)</i>			χ^2	<i>p</i>	Rate Ratio (95% CI)
	Total	PD (36)	Other (53)			
Under ACCT (44/89)	44 (49)	20 (56)	21 (40)	2.19	.139	1.40 (0.90 - 2.18)
2 + ACCTs during follow-up (vs. 1 ACCT only) (13/44)	13 (29)	10 (50)	3 (12)	7.37	.007	4 (1.27 - 12.58)

Events triggering the use of an ACCT document varied. The two most common events were a patient harming themselves ($n = 23$) or a patient having thoughts of suicide ($n = 23$). Six ACCT documents were opened following the patient exhibiting psychiatric symptoms (10%). ACCT documents opened following attempted suicide ($n = 3$, 5%), refusal of psychiatric medication ($n = 3$, 5%) and not eating ($n = 2$, 3%) were less common. For one patient the event triggering the opening of an ACCT document was unclear.

Table 9.15. Reason for ACCT being opened

Reason for ACCT	<i>n (%)</i>
Self-harm	23 (38)
Thoughts of suicide	23 (38)
Suicide attempt	3 (5)
Psychiatric symptoms	6 (10)
Refusing psych medication	3 (5)
Not eating	2 (3)
Unclear	1 (2)
Total	61 (100)

It was not possible to record the duration of all ACCT management due to inaccurate recording or lack of recording of this process on the patient's SystemOne record ¹⁶. The length of ACCT was recorded for 45/61 of opened ACCTS. The mean length of ACCT was 87.6 days (sd = 113.96); the shortest ACCT document was open for one day and the longest for the whole 1 year follow-up period.

9.4.2 Healthcare wing admission

A third of persons remitted (n = 33, 37%) spent time admitted to a prison healthcare wing for psychiatric assessment/treatment during the follow-up period. It was not possible to document the length of each healthcare wing admission due to inaccurate documentation or lack of documentation on the patient's SystemOne record. The length of health care wing admission was recorded for 29/33 cases. The mean length of healthcare wing admission was 62.5 days (sd = 93.33); the shortest admission was for one day and the longest for the whole follow-up period.

Table 9.16. Healthcare wing admission

Primary diagnosis	N	HCW n (%)
SMI	35	14 (40)
Personality Disorder	36	12 (33)
Other diagnosis	18	7 (39)
Total	89	33 (37)

¹⁶ Perhaps due to ACCT document being opened and closed by prison establishment employees and not healthcare staff in some instances.

9.4.3 Segregation

Nineteen remittals (21%) spent time within segregation for behavioural issues during their follow-up period. The mean length of segregation was 56 days (sd = 93.33); the shortest segregation was for one day and the longest for the whole follow-up period.

Table 9.17. Patients who spent time in segregation

Primary diagnosis	<i>N</i>	<i>n</i> (%)
SMI	35	6 (17)
Personality Disorder	36	10 (28)
Other diagnosis	18	3 (17)
Total	89	19 (21)

9.4.4 Self-harm and attempted suicide

Incidents of self-harm and attempted suicide during follow-up were extracted. These were incidents which were recorded by health care professionals and therefore the degree to which the incidents were considered self-harm or an attempted suicide was based on their individual clinical judgements. Incidents of self-harm were recorded for 20 (22%) of persons remitted and attempted suicide was recorded for 7 (8%) of remittals. A third of those with a primary diagnosis of personality disorder had a recorded incident of self-harm during follow-up, whereas the proportion of those with a SMI or 'other' diagnoses who has recorded incident of self-harm was lower. The most common type of self-harm was cutting (*n* = 15, 75%).

Table 9.18. Self-harm and attempted suicide (*n* = 20)

Primary diagnosis	<i>N</i>	Self-harm	Attempted Suicide	Combined
SMI	35	5 (14)	1 (3)	6 (17)
Personality Disorder	36	12 (33)	5 (14)	17 (47)
Other diagnosis	18	3 (17)	1 (6)	4 (23)

Total	89	20 (22)	7 (8)	27 (30)
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Patients were compared across two groups, personality disorder versus ‘SMI and Other diagnosis combined’ for whether they were recorded as having self-harmed or attempted suicide (combined) document during follow-up. Patient’s with a primary diagnosis of personality disorder were 2.5 times more likely to have a recorded incident of self-harm or attempted suicide during following than did than the other groups (47% vs. 19%, $p = .004$).

Table 8.19. Rate ratio comparisons of recorded incidents of self-harm or attempted suicide combined

	<i>n (%)</i>			χ^2	<i>p</i>	Rate Ratio (95% CI)
	Total	PD (36)	Other (53)			
Self-harm/attempted suicide	27 (30)	17 (47)	10 (19)	8.16	.004	2.50 (1.30 - 4.82)

Types of self-harm and attempted suicide recorded are presented in Table 9.20 below.

Table 9.20 Primary self-harm attempted suicide method

Method	<i>n</i>
Self-harm (<i>n</i> = 20)	
Cutting	15
Head banging	1
Punching self	2
Refusing physical meds	1
Swallowing foreign object	1
Attempted suicide (<i>n</i> = 7)	
Cutting	2
Ligature	2
Overdose	3

9.5 Secure psychiatric services referral and admission

Nineteen remittals (21%) were re-referred to secure psychiatric services during the follow-up period. The average length of time between remittal and re-referral was less than six months ($m = 126.9$ days, $sd = 97.6$), with time between remittal and referral ranging from one day to 273 days.

Table 9.21. Secure services referrals and admissions

Primary diagnosis	<i>N</i>	MSU referral	HSU referral	MSU admission
SMI	35	8 (23)	1 (3)	5 (14)
Personality Disorder	36	5 (14)	3 (8)	5 (14)
Other diagnosis	18	2 (11)	-	-
Total	89	15 (17)	4 (4)	10 (11)

MSU = medium secure services, HSU = high secure services

Nine of those remittals re-referred to secure psychiatric services were not accepted, however 10 of the referrals were re-admitted to medium secure services during the follow-up period; this included five patients with a primary diagnosis of personality disorder and five with an SMI diagnosis. The mean length of time between remittal and re-admission was just over 6 months ($m = 194.40$, $sd = 73.63$), with time between remittal and assessment ranging from 70 day to 316 days.

9.5.1 Discharge circumstances of readmissions at baseline

Baseline data were extracted for patients who were readmitted to medium secure services from prison, to establish how these patients came to be remitted to prison. All 10 patients were remitted to prison either by their Responsible Clinician ($n = 8$) or via court recall with agreement from their Responsible Clinician ($n = 2$). Whilst six of these patients were considered to have completed their treatment within medium secure services (including the two court recalls), three patients were remitted due to management issues (engagement/risk) and one patient was not considered to have an SMI or the symptomatology to require a detention in medium secure services. Over half of these patients had a length of stay in medium secure services of less than six months prior to remittal ($n = 6$).

Table 9.22. Discharge circumstances from MSU for readmissions

Reason for discharge	<i>n</i> (%)
Responsible Clinician	
Treated	4 (40)
No SMI	1 (10)
Not engaging	2 (20)
Risk/management	1 (10)
Court recall	
Sentenced	1 (10)
Re-remanded	1 (10)

Table 9.23. Length of stay in MSU for re-admissions

Length of stay	<i>n</i> (%)
0 - 6 months	6 (60)
6 - 12 months	1 (10)
12 - 18 months	2 (20)
18 - 24 months	-
24 months +	1 (10)

9.6 Prison release

Twenty-seven remittals (30%) were released from prison during the follow-up period. Almost half of the patients with a primary SMI diagnosis were released during the follow-up period ($n = 17$, 49%), representing 63% of those who were released. The mean length of time between remittal and release was under 6 months ($m = 156.92$ days, $sd = 99.86$), with over a third of prison releases taking place within 3 months of remittal to prison (37%). The shortest length of time between remittal and release was one day; the longest was longest 330 days.

Table 9.24 Time from remittal to release ($n = 27$)

Primary diagnosis	N	n (%)				Total
		0-3 months	3-6 months	6-9 months	9-12 months	
SMI	35	6 (17)	4 (11)	4 (11)	3 (9)	17 (49)
Personality Disorder	36	2 (6)	1 (3)	1 (3)	1 (3)	6 (17)
Other	18	2 (11)	1 (6)	-	1 (6)	4 (22)
Total	89	10 (37)	6 (22)	6 (25)	5 (19)	27

9.6.1 Access to mental health inreach services

Of those released from prison, one patient was not referred to MHIR and five were not accepted onto the MHIR caseload at their remittal prison. One patient was discharged from the MHIR team prior to release from prison, and one prior to prison transfer.

Table 9.25. MHIR Referrals at remittal prison

Time to release	N	n (%)			
		Ref at reception	Ref during stay	Accepted onto MHIR	Discharged
0-3 months	10	7 (70)	9 (90)	7 (70)	-
3-6 months	6	5 (83)	6 (100)	5 (83)	-
6-9 months	6	4 (66)	6 (100)	5 (83)	-
9-12 months	5	4 (80)	5 (100)	5 (100)	2 (40)
Total	27	20 (74)	26 (96)	22 (85)	2 (9)

Ref = referral

9.6.2 Prison transfers – access to MHIR services

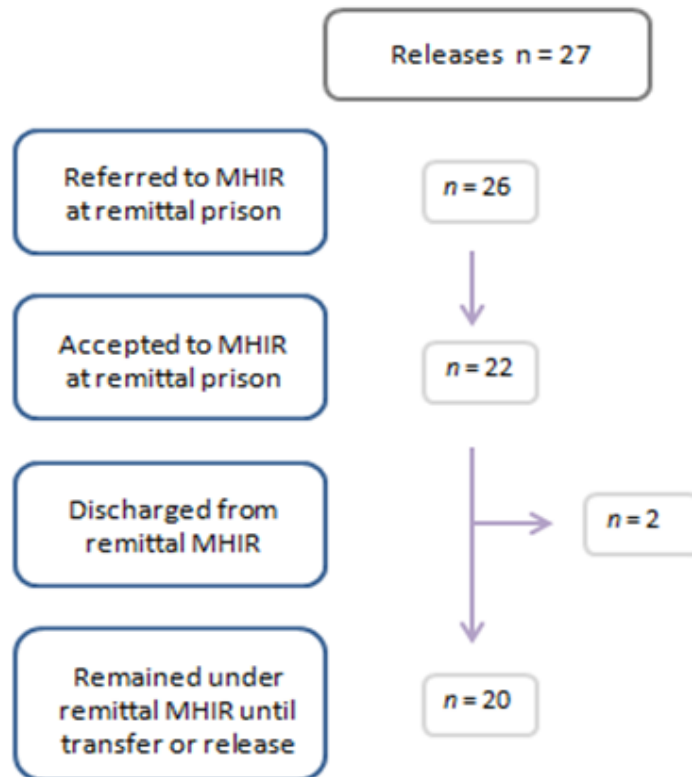
Eight of the patients released into the community were transferred to another prison prior to release. For three of these patients there was a handover from remittal prison to the transfer prison MHIR service. Five of these patients were referred to MHIR services upon transfer, two of whom were accepted yet both were discharged from the service prior to prison release.

Table 9.26. Services at transfer (*n* = 8)

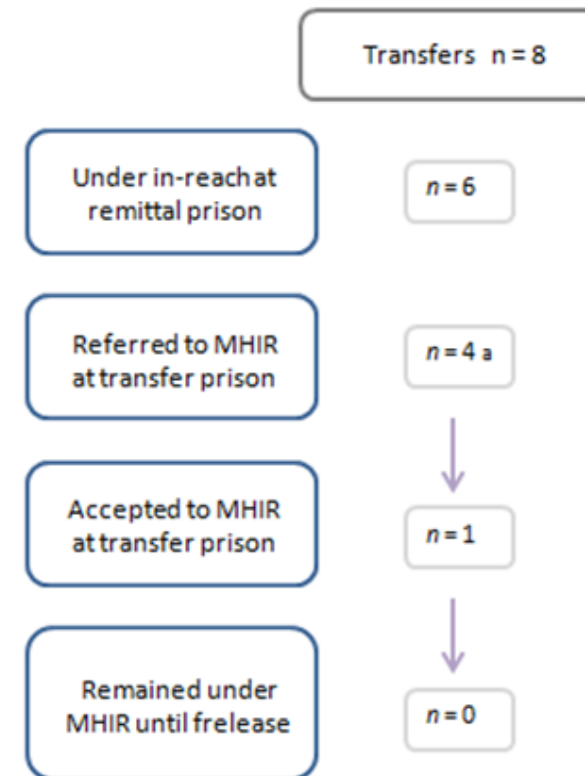
	<i>n</i>	<i>n</i> (%)
MHIR-MHIR referral	8	3 (38)
Referred to inreach	8	5 (63)
Accepted onto MHIR	5	2 (40)
Discharged	2	2 (100)

Figure 9.4 breaks this down further and presents access to MHIR services for those who were engaged in MHIR at their remittal prison at time of prison transfer.

Prison releases (n = 27)



Prison transfers (n = 8)



a 3 were referred to MHIR by their remittal MHIR team

Figure 9.3: Access to MHIR services at remittal prison for released prisoners

Figure 9.4. Access to MHIR services for those who were engaged in MHIR at their remittal prison at time of prison transfer (prison releases)

9.6.3 Summary of access to MHIR services for released prisoners

Over half of the patients released into the community (52%) were not on a MHIR caseload prior to release from prison.

- Of those patients released into the community from prison, one was not referred to MHIR services at all during their stay.
- Of the five patients not accepted onto the MHIR caseload at their remittal prison, one was transferred and received care from their transfer prison MHIR service, yet was later discharged prior to release.
- Six of those on a MHIR caseload at their remittal were transferred, 4 of whom were referred to their transfer prison MHIR service. Just one of these patients was accepted onto the MHIR caseload, yet they were later discharged prior to release.
- As such, none of the 8 patients transferred to other prisons prior to release, were on an MHIR caseload at their transfer prisons at time of release.

(See Appendix S, Figure A2 for full diagrammatical pathway through MHIR services).

9.6.4 Community mental health team referral

None of 13 patients who were not engaged in MHIR services at time of release were referred to a CMHT prior to release from prison. However, there was evidence of a referral to or liaison with a CMHT for all but one of the patients who were engaged with MHIR services prior to release ($n = 13$, 48%). Table 9.27 presents these referrals by diagnosis.

Table 9.27. Evidence of CMHT referral ($n = 27$)

Primary diagnosis	(n)	n referred
SMI	(17)	6
Personality Disorder	(6)	5
Other diagnosis	(4)	2
Total	27	13

Data was extracted on the residence type that these patients were released to. Ten were released either to their own home ($n = 2$) or to a home with relatives ($n = 8$), whereas five were released to probation hostels and three were released with no fixed abode. Four of the patients were deported to their own country and post-release residence was unclear, and for five patients this information was not available.

Table 9.28. Residence at release ($n = 27$)

Release residence	n (%)
Own home	2 (7)
Family	8 (30)
Hostel	5 (19)
NFA	3 (11)
Repatriated	4 (15)
Missing information	5 (19)

9.6.5 Discharge circumstances of prison releases at baseline

Baseline data was extracted for patients who were released into the community from prison, to establish how these patients came to be remitted to prison. All 27 patients were remitted to prison either by their Responsible Clinician ($n = 25$) or via court recall with agreement from their Responsible Clinician ($n = 2$). Whilst 14 of these patients were considered to have completed their treatment within medium secure services (including the two court recalls), nine patients were remitted due to management issues (engagement/risk) and two patients were not considered to have an SMI or the symptomatology to require a detention in medium secure services. Table 9.29 presents these data alongside whether patients received a CMHT referral prior to release.

All but one of those patients considered to be treated prior to remittal were expected to be released from prison soon after remittal; one patient was due for deportation, 8 were close to their earliest release date and two were remitted to complete the work necessary to achieve parole. Over half of these patients had has a length of stay in medium secure services of less than six months ($n = 14$).

Table 9.29. Discharge circumstances from MSU for released prisoners

Discharge circumstances	<i>n</i>	CMHT referral
Responsible Clinician		
Treated	12*	6
No SMI	2	1
Not engaging	6	3
Risk/management	3	1
Court recall		
Sentenced	1	1
Re-remanded	1	1

MSU = Medium secure unit

* 8 were close to their earliest release date and 2 we working for parole

Table 9.30. Length of stay in MSU for released prisoners

Length of stay in MSU	<i>n</i>
0 - 6 months	14
6 - 12 months	6
12 - 18 months	3
18 - 24 months	2
24 months +	2

MSU = Medium secure unit

9.7 Chapter summary

This chapter describes findings from a population of prisoner-patients remitted from medium secure services over a 6 month period. There were 96 prisoner-patients remitted from medium secure services, of which, 89 were included in the descriptive data above.

9.7.1 Access to services

Remittal to prison from medium security is a key transition point in a prisoner-patient's care pathway and a time of elevated risk and vulnerability, which presents challenges in terms of continuity of care between services. The CPA process is designed to support this transition between inpatient and discharge settings. It was therefore anticipated that the majority of remittals would have their aftercare managed through the CPA process to some degree during follow-up, considering their legal right to aftercare under S.117 of the MHA (relevant for 78 remittals, 88%). However, few patients were found to be subject to the CPA process ($n = 17$, 19%) and just 14 of those with the legal right to aftercare had a CPA care plan in place at follow-up (18%). Once triggered the right to aftercare is ongoing and should remain in place regardless of the person's circumstances. Such care should only end when both health and social care services jointly agree that the individual no longer requires aftercare (Richards & Mughal, 2010). This is not observed to be the case in this study.

It was identified, however, that patients were largely referred to mental health inreach services at their remittal prisons, but that not all patients were considered appropriate for inreach caseloads. Likewise some remittals were discharged from an inreach caseload when they were no longer considered appropriate for the service or if they did not engage. It is perhaps not surprising that just under a third of those with a primary diagnosis of personality disorder, who were referred to MHIR at their remittal prison, were not accepted onto the MHIR caseload, considering the sparse services available for personality disorder within prisons. However, seven patients with a primary diagnosis of SMI also did not access MHIR services at their remittal prison (five were not accepted and one was discharged), with one of these patients not receiving a referral to their remittal prison MHIT at all. This appears at odds with the care and treatment expected to be available for prisoners with SMI, considering that MHIR services were designed specifically for those with a SMI diagnoses. As highlighted, remittal to prison is a time of heightened vulnerability therefore it was anticipated that patients with an SMI diagnosis would receive monitoring from the MHIT after discharge from medium secure services, in the same way patients with an SMI diagnosis would

receive CMHT input if they had been discharged into the community from medium secure services.

Tracking of patients to transfer prisons allowed for further investigation into access to MHIR services, particularly with regards to continuity of care. Of those transferred to a second prison, less than a third were handed over by their remittal prison MHIR service, to the transfer prison MHIR service. Of those who were followed up within their transfer prison (n = 29), the majority were referred to the MHIR service (n = 21) and 15 of these were accepted (7 were later discharged). What this data suggests is that transfer between prisons is key time of risk for loss of aftercare due to poor information transfer, particularly for those patients who are engaged in MHIR services prior to transfer.

Five patients who were engaged with MHIR services at time of transfer did not receive a referral to MHIR services at their transfer prisons, and therefore were no longer being monitored by mental healthcare professionals. Likewise, those who did receive a referral to MHIR were not always accepted or could be later discharged. In other cases transfer to a second prison also served as an opportunity for those who were not engaged in MHIR services prior to transfer to be re-assessed for their appropriateness to access inreach services. Nevertheless there remained 39 patients who were not accessing MHIR services at their last follow-up date, one of whom was not referred throughout follow-up.

This is particularly concerning when this data is explored for those who were released into the community from prison during follow-up. Over half of those released into the community were not on a MHIR caseload at time of release (n = 14) and were therefore released with no referral to a CMHT - this included 11 patients with an SMI diagnosis. It is, however, reassuring that almost all patients on a MHIR caseload at time of release were referred to a CMHT prior to release (n = 13).

9.7.2 *Released patients*

Data gathered at baseline allowed for insight into why the patients released into the community from prison during follow-up were originally remitted back to prison from medium secure services. All prison releases were remitted at the request of or with agreement from their Responsible Clinical. For 10 patients it appears that the Responsible Clinical expected quick release into the community would follow remittal, as two patients were remitted with the intention of them completing the work required to achieve parole and eight were remitted following treatment as they were close to their earliest release date. It is unclear why these patients did not remain in medium secure services until the end of their custodial sentence, which

may well have better ensured successful transition into the community and more likely referral to a CMHT (less than half of these were referred). Whilst this is the first study to provide data for the pathways of this group, this may well represent a change in clinical practice – remittal of those to prison who are close to release, to avoid what may be a lengthy transition if released directly from medium secure services into the community.

Of particular concern are the nine released patients who were remitted due to engagement/risk issues (six due to not engaging with treatment/therapy and three due to presenting as too high risk to continue to be detained in the medium secure unit). The quick release of patients who are unwilling to engage and/or are at elevated risk raises public protection issues, as does the relatively short lengths of stay both in medium secure services, and in prison upon remittal for this patient group. The potential for relapse or reoffending in this group may be high, and there is no evidence of the degree to which risk assessment and management is utilised in these cases. This is concerning, particularly in a time of increased media focus on what happens to patients who are released from secure psychiatric services.

9.7.3 *Treatment and management*

Quality of the care and treatment received by patients was not assessed, yet access to mental health professionals and type of treatment received was documented. Whilst the majority of remissions were seen by a mental health nurse at some point during follow-up (n = 85, 96%), just under a third were not reviewed by a psychiatrist during follow-up (n = 28, 31%), and even less received care/treatment from other mental health care professional (psychologists, social workers, etc.). The use of medication for the treatment of psychiatric disorders was commonplace yet alarmingly, almost half of the patients who were prescribed psychotropic medication stopped taking it during the follow-up period (n = 35, 47%), the majority of whom had been prescribed antipsychotic medication (n = 31, 91%).

Almost half of all persons remitted required monitoring under an ACCT document during follow-up, with those with a primary diagnosis of personality disorder being four times more likely to require multiple ACCT interventions. In addition admissions to prison healthcare wings for psychiatric assessment/treatment were required for over a third of the population (n = 33, 37%) and segregation for behavioural issues was utilised for a fifth of remittals (n = 19, 21%). These interventions are likely to have substantial cost implications considering the enhanced observations and monitoring required by both mental healthcare and prison based staff to ensure the safety of these patients. Levels of distress in this population appear high; just under a third of

remittals were recorded as having self-harmed or attempted during follow-up (n = 27, 30%). As these are healthcare recorded instances of self-harm and attempted suicide this is likely an underestimation of the true prevalence for prison remittals, therefore it is concerning that almost half of those with a primary diagnosis of personality disorder were recorded as having self-harmed during follow-up (n = 17, 47%), and that these patients were 2.5 times more like to have this recorded than remittals of those diagnoses.

9.7.4 *Re-admission to secure psychiatric services*

For 19 (21%) patients a re-referral back to secure-psychiatric services was deemed necessary, all of which took place within the first 9 months of remittal. Ten of these patients were re-admitted to medium secure services during the follow-up period (11%); this included patients with both personality disorder and SMI diagnoses. Readmission to inpatient psychiatric services is often used as an indicator of quality of inpatient care and, in this case, may well represent premature discharge from medium secure services and/or lack of coordination with follow-up mental health services - over half of these patients had a length of stay in medium secure services of less than six months and just three were under the CPA process at remittal.

Readmission to secure psychiatric services for prisoner-patients can be disruptive for both the patient's progress through their criminal justice pathway and also for the prison service. Such disruption could perhaps be avoided by ensuring appropriate care and treatment has been received prior to remittal to prison. All of the patients readmitted to medium secure services were originally remitted at the request of or with the agreement of their Responsible Clinician. Whilst most were considered to be treated prior to discharge, one was considered not to have SMI, two were remitted due to not engaging with treatment and two were considered too high risk to remain detained in the service.

Considering the rising cost of health care and the added strain to limited healthcare resources readmission can cause, these findings highlight the importance of providing adequate discharge and transition planning, and targeted follow-up services for this population, to allow the patient to complete their criminal justice pathway and to transition safely into the community upon their eventual release

Chapter 10 Discussion

This thesis has presented a mixed methods study, which has provided insight into the remittal of prisoner-patients from medium secure services. This final chapter summarises and integrates the main findings of the three studies in the context of existing policy and literature. Implications of the research findings alongside considerations and recommendations for clinical practice are discussed. The strengths and limitations of the research are also explored and innovative suggestions for future research are made.

This chapter is presented in four sub-parts:

- Summary of main findings
- Methodological strengths and weaknesses
- Implications for clinical practice and related policy
- Directions for future research

10.1 Overview of main findings

10.1.1 *National prospective cohort study*

This is the first study of its kind to investigate prisoner-patients as a distinct population within medium secure services. In a previous national study of people discharged from medium security, differences were observed in characteristics and risk profile across community discharges and prison remittals (Doyle et al., 2014). However this study included discharges across all admission sources; only just over a half of (53%) of whom were patients admitted to medium secure services from prison. Therefore the magnitude of the observed differences across discharge destination may have been inflated due to the presence of non-forensic patients within the community discharge group. Study 1 entailed the extraction of a large volume of clinical data, some of which was similar to data collected in this previous study. As such, comparisons of findings can be made in relation to index offence, diagnosis, length of stay, and scores on validated violence risk assessments between the two datasets.

Median length of stay was shorter for the prisoner-patient cohort as compared to the full medium security cohort (392 vs. 224 days), as was median stay of the community discharge group (622 vs. 404 days), indicating that prisoners have shorter admissions to medium secure services than do the general medium security population. However, median length of stay was observed as longer for prison remittals in this study compared to the previous investigation (144 days vs. 177 days).

Across both studies patients with a primary diagnosis of schizophrenia were less likely to be remitted to prison, whereas those with a primary diagnosis of personality disorder were over 5 times more likely to be remitted to prison than discharged into the community. Likewise, index offences were rated as significantly more severe for prison remittals across both studies and the same differences across the community discharges and prison remittals were observed for scores across all assessment scales and subscales (prison remittals scored higher on the HCR: 20 v3 and the MSRAG, but lower on the SAPROF), aside from the Historical Subscale on the HCR: 20 v3. There was no difference observed across discharge destination on this scale in the present study, indicating that the two discharge groups had similar histories as regards previous psychosocial adjustment.

A novel aspect of this study was the collection of contextual data regarding patients' criminal and legal status under the Mental Health Act, and the nature of their care pathways through medium secure services, including the circumstances leading to their discharge. These data, together with a more detailed insight into key differences across prison remittals and community discharges, are presented in the following three sections of this chapter.

Results 1a: Prisoner-patient pathways through medium security

This chapter presented a national overview of the criminal, legal and care pathways through medium secure care of 153 prisoner-patients; from transfer into medium secure services from the prison estate, to discharge into the community / remittal to prison. These data were collected to enable exploration of pathways and discharge circumstances for prisoner patients, and the identification of appropriate discharges for inclusion in the comparative analysis (Results 1b). Just over a third of the sample were discharges into the community, all of whom were considered to have completed the necessary treatment required prior to discharge (n = 57, 37%). Remittal to prison following treatment was not a discharge pathway option for the overwhelming majority of these patients (n = 54, 95%) on their date of discharge. Extracted data highlighted that, for many of these patients, their discharge pathways were directed by criminal court decisions to some degree. However, all externally directed community pathway decisions in this study were made with the support of the patient's Responsible Clinician, as were all decisions around suitability and timing of discharge

Likewise the majority of court-led remittals were considered to have completed their required treatment at discharge and were therefore conducted with agreement of the Responsible Clinician. However, there were two patients who still required hospital treatment but, contrary to clinical opinion, were re-remanded to custody following court appearance. As with community discharges, 44 patients were remitted to prison solely under the instruction of their Responsible Clinician once their required treatment was completed¹⁷. Many of these remittals will have returned to prison to resume their prisoner status and continue to serve their custodial sentences. However, 16 of these patients were documented as being close to their earliest release date and/or eligible for parole and were therefore expected to be released into the community promptly following their remittal. It was unclear why this practice was taking place and it was therefore highlighted as an issue of potential concern to be explored further in the consecutive qualitative study (see Theme 2). There were also nine patients who were remitted due to the clinical team not detecting evidence of mental disorder or symptomatology that warranted hospital treatment. All were emergency transfers (s. 47 and s.48) as opposed to court remands for assessments to inform sentencing decisions; therefore these cases could constitute evidence of inappropriate referrals/admissions.

Unique to prison remittals were those patients who were discharged on the grounds that they were not engaging in the required ward-based treatment (n = 17), or because they were

¹⁷ However for 2 patients, prison was not the preferred discharge destination of the responsible clinician (Table 3.6)

considered too high risk to others to remain detained within the service (n = 10). This seemed counter-intuitive and at odds with the purpose of medium secure services. It was unclear how this will be managed post-remittal considering the lack of safeguards to ensure compliance with treatment post-remittal (such as Community Treatment Orders). This is in stark contrast to community discharge circumstances, as not only were all considered treated and ready for community discharge, but over half were discharged liable to hospital recall or with a Mental Health Treatment requirement. This indicated that different factors may be taken into account depending on a prisoner-patients' discharge destination. Therefore this was also highlighted as an issue of interest to be explored further in the consecutive qualitative study (see Theme 2).

Results 1b: Factors associated with discharge destination: all prison-patients irrespective of their diagnosis

This subsection provided a detailed description of the characteristics of 141 prisoner-patients discharged from medium secure services, and the observed key differences between community discharges and prison remittals. Demographic, clinical and criminological characteristics were compared across discharge destination, as were patient ratings on four standardised clinical assessment tools. There were few differences across criminal histories aside from remittals having received significantly more prison sentences historically and having a more severe index offence on average¹⁸. Remittals were also more likely to have committed an index offence categorised as 'Loss of life'. Clinically, however, prison remittals represented a complex and potentially vulnerable subset of patients who were found to be treated for a significantly shorter period of time prior to remittal to prison as compared to community discharges.

For 13 remittals this was their second or subsequent admission to medium secure services during their current custodial sentence, and remittals were also more likely to have had a stay in medium secure services at some point in their clinical history, including prior to their current custodial sentence. These individuals were more likely to have a primary diagnosis of personality disorder and were also more likely to have a history of self-harm – including self-harm episodes in prison during the period just prior to their admission. At this stage of the research there was little contextual information available to explain these differences, including to what extent those characteristics influenced likelihood of remittal from the position of a clinical decision maker. Therefore this was highlighted as an area to be further explored thoroughly in Study 2 (See Theme 3).

¹⁸ As rated by the Severity of Index Offence Scale

Assessment of the presence of dynamic risk factors in the time prior to discharge revealed that prison remittals had elevated risks of serious acquisitive and violent offending as compared to community discharges. These individuals were rated as having had more recent problems with psychological adjustment and were anticipated to have more future issues in this respect post-discharge as indicated by the clinical and risk scales of the HCR-20^{v3}. This was particularly concerning when considered along with the findings that these individuals were also rated as having fewer protective factors against future violence and relapse according to the internal and motivational scales of the SAPROF. Comparison of treatments received during detention were not extracted and coded as standalone variables. However, treatment information was accessed and reviewed to inform ratings of dynamic risk. These ratings indicated that prison remittals were two times more likely to have had recent problems with maintaining stable adjustment, and six times more likely to have had recent problems with compliance or responsiveness to/with intervention, management or supervision response (see Tables 4.12). There was also evidence that prison remittals were 50% more likely to have had partial/definite presence of recent problems with active symptoms of major mental disorder prior to discharge. It was unclear why prison remittals were discharged at a time when they were considered to be high risk of future violence and to require further intervention, especially considering that over a third of these remittals had an SMI diagnosis. It was unclear why prison remittals were discharged at a time where they were considered to be high risk of future violence and to require further intervention¹⁹, especially considering that over a third of these remittals had an SMI diagnosis.

It was anticipated that these differences could be due to the overrepresentation of individuals with personality disorder in the remittal group (38% vs. 8%), and therefore may not be representative of all persons remitted, particularly those with a primary diagnosis of SMI. Therefore Study 1c was conducted to investigate this further.

¹⁹ Participants who were rated as 'High Risk' on the HCR: 20v3 and requiring urgent development of risk and management plans were almost four times more likely to be remitted to prison (32% vs. 8%, $p = .001$).

Results 1c: Factors associated with discharge destination: prisoner-patients diagnosed with a severe mental illness

Individuals discharged with a primary diagnosis of SMI were compared in relation to key explanatory variables and scores on the violence risk assessment tools, according to their discharge destination. Key variables were those found to be associated with discharge destination among all prisoner-patients. However, in general the differences across discharge destination remained largely the same for patients with SMI, particularly regarding patients' presentations at time of discharge, as measured by the dynamic items on the violence risk assessment tools. Given the degree of problems with psychosocial adjustment in the period preceding discharge, prison remittals with SMI represent a potentially vulnerable subgroup, especially when we consider that these patients were also more likely to be documented as harming themselves in prison prior to their current admission.

It was thought that this finding could be explained in part due to the nature of the relationship between the patient's SMI and their offending behaviour. The majority of community discharges with SMI were those who either did not require a custodial sentence due to less severe index offences, or those who had received a hospital treatment order in place of a custodial sentence as their SMI was deemed to contribute to their offence (see Table 5.12 for discharge circumstances). Almost all of the prison remittals with SMI were persons serving custodial sentences for more severe offences who had become unwell during their stay in prison. It was felt that this might indicate that medium secure services provide differing functions for prisoner-patients depending on their legal status, and that different legal and contextual factors are considered when planning for prison remittal as compared to community discharge. This was also highlighted as an area to be further explored in Study 2 (See Theme 3).

10.1.2 Qualitative investigation of clinicians' experiences of managing and discharging prisoner-patients from medium secure services

The chapter provided a thematic analysis of clinicians' experiences of managing and discharging prisoner-patients from medium secure services. Previous research has focussed on the factors that underpin decisions to admit to medium security, and highlighted a range of contextual pressures which can impact admission decisions, including clinicians' gatekeeping responsibilities and maintenance of service throughput (Grounds et al., 2004). Similar contextual factors were found to be external influencers of care pathway and discharge decisions in Study 2. Clinicians described how they were subject to multiple external pressures and felt that, at times, they are expected to compromise prisoner-patients' best interests to satisfy commissioning criteria,

particularly in relation to reducing lengths of stay and returning prisoner-patients to the prison estate. This was further complicated by clinicians expressing reluctance to remit some prisoner-patients due to the nature of the environment and the quality of services available post-remittal.

Reluctance to remit from medium secure services has been briefly described in a previous survey of psychiatrists by the Royal College of Psychiatrists. Its findings indicated that, at times, clinicians felt concerned as to whether patients' needs will be met in prison and whether their patients are likely to relapse upon their return (Royal College of Psychiatrists, 2011). These concerns were shared by the clinicians in the present study, who indicated that there is poor communication and continuity of care between medium secure and prison based services. Of particular concern were clinicians' accounts of the Section 117 discharge planning process. There was a suggestion that although clinicians are aware of the need to plan for and provide targeted aftercare upon remittal, in practice discharge planning for prison remittals is an arbitrary process conducted to satisfy the requirements of the Ministry of Justice. This was highlighted as a key area of interest to be explored further in Study 3, through the collection of data in relation to care received and service access post-remittal.

Clinicians described the nexus between the criminal justice and mental health systems and how court disposal decisions and the nature of particular custodial sentences can restrict the pathways available to individual prisoner-patients. However, of particular significance to the findings in Study 1 were discretionary pathway decisions clinicians make when prisoner-patients are close to their earliest release date. There were conflicting opinions in relation to the practice of remitting prisoners when their release date is imminent, as observed for the 16 patients in Study 1a. Clinicians revealed that this practice takes place with both the individuals' and the services' interests in mind; it is considered to be a quicker route into the community for prisoner-patients, and it also avoids blocking a valuable bed that could otherwise be used for other patients requiring transfer. However, there were also clinicians in the present study who disapproved of this practice, and who highlighted that a discharge from medium secure services back into the community would ensure effective referral to community mental health services.

There was also consensus among medium security clinicians regarding patients who were considered to be within the remit of secure services, and a clear expressed need for clinicians to protect the role of their service as they viewed it. In particular, this study has enhanced our understanding of why characteristics such as primary diagnosis of personality disorder and increased risk of future violence were more likely for prison remittals than community discharges. This largely centred on culpability, in that patients who were considered culpable for their crimes were not considered to be a priority for medium secure services. As such little risk related or

rehabilitative interventions were described as being available for these individuals prior to remittal. Clinicians described how different factors influence remittal decisions as compared to community discharges, as remittals are not expected to evidence a reduction in risk prior to discharge. This in part may account for the shorter length of admissions for prison remittals observed.

This study also explored the finding in Study 1 that 27 remittals occurred as a result of non-engagement or high risk behaviour. There were conflicting opinions across medium security and prison-based clinicians as regards this practice. Many medium security-based clinicians described how a prolonged stay in medium secure services presented a valuable opportunity for a prisoner-patient, and therefore prisoner-patients who choose not to engage in the treatment available, or who presented as high risk towards staff or other patients, required remittal to prison. The degree to which this behaviour is tolerated was described as being dependent on an individual's primary diagnosis; those with an SMI diagnosis were looked upon more favourably, whereas those with a primary diagnosis of personality disorder were not considered to require continued care. However, prison-based clinicians expressed concerns and shared experiences of receiving remittals of this type, and they also highlighted that many are released back into the community without these issues having been addressed in prison. This was also highlighted as a key area of potential concern to be explored in Study 3.

10.1.3 *National one year follow-up of prison remittals*

This chapter presented a national one year follow-up of 89 prisoner-patients remitted to prison from medium secure services. To the author's knowledge, this is the first study of its type both nationally and internationally.

Patients were largely referred to MHIR services upon remittal (n = 87, 98%), yet not all were considered appropriate for treatment (n = 22, 25%), particularly those who had a primary diagnosis of personality disorder (33% of these referrals were not accepted). Few patients were receiving care via the CPA process during the year following their discharge; just 14 patients who had the right to aftercare were subject to the CPA process during follow-up (18%). This seemed to confirm some of the clinicians' concerns outlined in Study 2 as regards the quality of care received post-discharge, and the arbitrary nature of the Section 117 process for those returned to prison. Further discussion is provided on these issues in section 10.3.2. Likewise there was no evidence of offence-related or rehabilitative work being provided by prison mental health services for any of the patients in this cohort, although this may have been conducted via criminal justice agencies. This issue could not be investigated as approvals did not allow access to these data.

Quality of care received was not formally assessed, but the nature of treatment received and access to mental health professionals was documented and found to be limited. Treatment was predominantly prescribed psychotropic medications, adherence to which was poor, and there was little access to professionals other than nurses or psychiatrists. Almost half of patients were managed under the ACCT process during follow-up, and those with a primary diagnosis of personality disorder were four times more likely to be managed under an ACCT document on two or more occasions during follow-up than the other diagnostic groups combined. This highlighted the vulnerability of those with personality disorder who are returned to prison from medium secure services, as did the finding that these individuals were 2.5 times more likely to have a recorded incident of self-harm / attempted suicide during follow up compared with the other diagnostic groups combined. Further discussion on access to care for those with personality disorder is provided in section 10.3.4.

Release from custody was identified as a key transition point for loss of access to mental health care services post-remittal, confirming concerns raised by clinicians in Study 2. Almost a third of remittals (n = 27) were released from custody within one year of remittal and under half of these individuals received a referral to CMHT services prior to release.

A particularly novel aspect of this study was apparent lack of continuity of care for a sizeable proportion of individuals as a result of inter-prison transfer; thirty-eight (43%) patients were transferred to another prison within one year post-remittal. Of these, there was a handover/recorded referral for just 12 patients (32%) from remittal prison to transfer prison MHIR services. This issue is discussed further in section 10.3.2.

10.2 Strengths and limitations

Many of the study's strengths and limitations were addressed in the three methodology chapters when providing justification for the methods adopted. Therefore this section presents reflections on key strengths and limitations upon completion of the research. The mixed methodology approach adopted made it possible to explore the nature of prison remittal both through comparisons between prison remittals and community discharges, and via clinical accounts of the management and remittal of prisoner patients. This allowed for a rich perspective on the process of prison remittal which could not have been achieved through the use of one approach alone.

Successful coordination of data collection in Study 1 relied on a sample size that was manageable for one person. Whilst the study was extensive in terms of number of sites, the baseline period was restricted to six months and this limited the statistical analyses that could be conducted and

the clinical recommendations which have been made. Had this been a regionally-based study with fewer sites, as opposed to the complete national study presented, an increased number of discharges may have been manageable as site initiation and data collection may have been much quicker as extensive travelling across the length and breadth of the country would not have been required. There were many delays to data collection in Study 1 caused by issues in obtaining archived medical notes, although the majority of delays ensued whilst trying to identify an appropriate staff member and convenient time to conduct collateral interviews with ward-based staff. Had there been fewer sites, effective working relationships may have been established sooner at each site, and these delays may not have occurred. However such a design would be representative of a single region only, and not of the national NHS prisoner-patient population. The study conducted was ambitious in its scope and its goals. Nonetheless, it succeeded in capturing a national population of prisoner-patient discharges, and marked differences were observed across community discharges and prison remittals. These findings served as the basis for the topics discussed in relation to Study 2, in which clinicians added context to key differences and provided their experiences of the prisoner-patient care pathway, including their concerns for certain types of individuals post-remittal.

The large number of baseline sites ensured an even larger number of follow-up sites, which went on to further increase as a result of inter-prison transfers. This large undertaking ensured exposure to varied service models across England. Data collection was stalled multiple times due to data access difficulties at individual prisons; however it was the quality of the medical information obtained from SystemOne electronic records in Study 3 that limited successful extraction of data. Clinician recorded accounts of patient contact were not comprehensive and little information was documented in relation to key events such as MHIR assessment and discharge, medications received, opening and closing of ACCT documents, increase/reduction of enhanced observation, and admission to and discharge from healthcare wings. This was a hindrance both in terms of the time it took to screen medical notes for required information and also the limited amount of data that could be extracted. However this task did offer an opportunity for personal insight into how difficult it might be from a clinician's perspective when accessing these records to inform treatment, particularly for those clinicians who receive a MHIR referral for a transferred prisoner who has recently had an admission to medium secure services. Access to these poor quality records shed light on some of the issues highlighted in Study 3. For example, context around how prisoners might be denied aftercare and not be considered suitable for MHIR input, as there is little medical documentation for clinicians to reference when conducting their assessments.

10.3 Clinical implications

Key areas of concern that can be inferred from the study's findings include:

- Criteria for remittal to prison compared to community discharge
- Arrangements for and availability of Section 117 aftercare
- Management of this aftercare through the CPA process upon remittal
- Access to care for prisoner-patients with personality disorder
- Continuity of aftercare following prison transfer
- Continuity of aftercare following prison release

These areas will be addressed across a series of subsections that consider the implications of the study's findings for clinical practice and related policy. Each subsection provides a discrete discussion of an identified area of interest, which may require reconsideration as a result of the central findings within this thesis.

10.3.1 *The role of medium secure services for persons in contact with the criminal justice system*

More mentally disordered offenders are detained in England & Wales than ever before - a trend that has continued over the past decade (National Audit Office, 2017). Transfer from prison to medium secure services have increased by 21% between 2011 and 2014 (Yeung, 2016), with the largest increase observed amongst sentenced prisoners transferred under section 47/49 for treatment. Whilst it is beneficial that more offenders are receiving treatment for their mental health needs, admission of an increasing number of prison transfers will undoubtedly be putting extra strain on the medium secure estate.

Receipt of sentenced prison transfers is just one function of medium secure services. These services operate as part of both the wider mental health and criminal justice systems, and have varied roles and responsibilities towards patients depending on their legal status and purpose of admission; for example, receipt of remand prison transfers for treatment (s. 48/49); receipt of patients remanded to hospitals for pre-sentencing report/treatment (s. 35, s. 36, s.38); admission of patients subject to court directed hospital treatment orders (s.37, s37/41, s.45A); 'step-up' of low secure and general acute mental health patients who require the heightened security conditions of medium security; 'step-down' of high secure mental health patients who require the reduced security conditions of medium security and admission of community patients including those recalled from conditional discharge (37/41) or CTO.

There is wide variation in available resources to manage medium secure services and many different styles of service delivery exist. However, for the majority of admissions, services are required to provide assessment and/or treatment, and rehabilitation/management of the risk that patients pose to others, with the view to reducing reoffending (NHS Commissioning Board, 2013). This involves undertaking clinical and risk interventions followed by safe discharge of patients to lower levels of security, back into the community, or back to prison.

Therefore it was unclear in Study 1b why some individuals discharged from medium secure services were rated as having current problems with issues such as lack of insight into their condition and behaviour (22%), current violent ideation and intent (36%), and evidence of emotional instability (24%). Presence of these factors was found to be more common among prison remittals than community discharges. It was concerning that persons discharged back to prison still had significant psychiatric need and elevated risk of reoffending. Final risk judgements on the HCR: 20 v3 indicated that prison remittals posed an overall higher risk of future violence than did community discharges. Those participants rated as low risk and not in need of special intervention were 47% less likely to be remitted to prison, whereas those participants who were rated as high risk and requiring urgent development of a risk management plan, were almost four times more likely to be remitted to prison. This was an indicator that remittals may not receive the same level of rehabilitation and risk intervention as those who are returned to the community.

This issue was addressed in Study 2, when clinicians described the role and function of medium secure services within the wider forensic mental health system, and those patients who are considered 'appropriate' for rehabilitation. There was a collective assumption that the role of medium secure services in risk reduction was for those patients whose mental health and offending is linked, i.e. those subject to a Hospital Treatment Order as opposed to a custodial sentence, whose transition from medium security will follow a community care pathway. Prison transfers, however, were described as members of the general psychiatric population who are detained in custody. These patients were deemed to be reactively unwell and therefore were not considered to have 'forensic issues'. As such offence-related and risk reduction work was deemed neither necessary nor the responsibility of medium secure services, and it was the consensus that this responsibility lies with the prison estate. However, prison-based clinicians described how these needs are not addressed by the prison estate upon remittal, and that prison mental health services do not have the resources to implement the required risk reduction work prior to release. Clinicians expressed their concern for these individuals and highlighted that they often come back into contact with the criminal justice system due to re-offending and/or re-entering custody.

One clinician suggested that this differential treatment is evidence of an institutional effect within the medium secure estate. Services were described as increasingly 'looking inwards' and setting boundaries to protect their function (as they view it) within the wider forensic mental health system. This could be a fair analysis, given the increase in prison transfers. It may be that services are making best use of the limited resources that they have and, in the absence of further funding, differential treatment of prison transfers is to be expected. However, it is concerning that some patients may be disadvantaged in these instances. Not all prison transfers will require risk intervention, but, for those individuals who do, prison resources for those with mental health diagnoses are sparse, and these persons are less likely than other prisoners to benefit from prison-based rehabilitation (Centre for Mental Health, 2009).

Alternative models of care and increased medium security provision may therefore be required to meet the rehabilitative needs of prison transfers, and to ensure that they receive treatment that is equivalent to those who are discharged into the community. This would involve prolonging the treatment period of prison transfers for these individuals and possibly retaining a proportion of them until they are fit to be discharged via a community mental health pathway (Doyle *et al*, 2014). However, this suggestion is unlikely to receive support considering that the cost of a medium secure bed per year is £176,000 - approximately four times higher than the cost of detaining a prisoner for the same length of time (Centre for Crime and Justice Studies, 2010). Whilst it would be costly to keep prison transfers in medium secure services for longer periods, it is a mistaken belief that this is considerably more expensive than detaining a prisoner with a severe mental health problem in a prison environment (Renshaw, 2010). The estimated cost of a prisoner is around £40 – 45,000, a figure that does not include the costs of caring for a mentally disordered prisoner. Extra costs are inevitably incurred, including intensive care from prison and healthcare staff and extra provisions such as single cell 'suicide watch', enhanced observation via the ACCT process, and extended stays in prison hospital wings and segregation (as evidenced in Study 3). As such, it is estimated that the cost of detaining a prisoner with a severe mental health problem in a prison setting is three times greater than that for the average prisoner, at an estimated annual figure of £130,000. In line with this, it has been estimated that appropriate diversion of offenders to medium secure services would lead to an average (mean) lifetime saving of £600,000 for each prisoner with a severe mental health problem (Renshaw, 2010) - a difference which further highlights the need for appropriate placement and the substantial cost penalty that is incurred when a prisoner is readmitted to medium secure services.

Retaining prisoners with severe mental health problems in medium secure services would not only ensure that they receive appropriate treatment, but it would also reduce the overall size of

the prison population. However, according to the Ministry of Justice, prolonged and thus increased use of medium secure facilities would prove challenging and would only relieve 200 prison places in the short-term (House of Commons Justice Committee, 2010), meaning that provision for the medium secure estate will need to increase substantially if effective rehabilitation of prison transfers is to take place. Nevertheless, the potential medium and long-term benefits and outcomes of an expansion to the medium secure estate warrants further consideration.

10.3.2 *Circumstances of remittal - aftercare and practicalities*

As transfers into medium secure services have increased, so have remittals to prison (Doyle et al., 2014). Remittal is a time of elevated risk and vulnerability that presents challenges to continuity of care between services. Few guidelines for the effective remittal of prisoner-patients from medium secure services exist, although the relevant Prison Service Instructions (Ministry of Justice, 2007) and the Department of Health Good Practice Procedure Guide on transfers and remissions (Department of Health, 2011) are currently under review by NOMS and NHS England (d’Cruz & Skett, 2016). An ongoing independent review of the MHA was also recently commissioned by the Government in October 2017 to explore opportunities for MHA reform. A recent interim report has summarised the review thus far, and has outlined the priority areas that have emerged for further examination. Of particular relevance to this body of research are the priority areas ‘Discharge and aftercare’ and ‘Criminal justice system and Part 3 of the Mental Health Act’ (Mental Health Act Review, 2018). I have submitted a response to the report on the basis of the key findings generated from the present study (see Appendix A). The evidence that I put forward and the suggestions that I made are briefly summarised below. This response represents a key output from my study, and it indicates the potential wider societal impact of my findings.

Discharge and rights to aftercare

The review addressed a need to clarify what aftercare means within the modern health and social care system (p36). This research highlights that this priority area should also give further consideration to entitlement to aftercare for prison remittals and the subsequent responsibilities of secondary mental health services and prison-based mental health services in these instances. Section 117 of the MHA provides a right of aftercare from local authorities and the NHS to people discharged from hospital. It is through the CPA process that aftercare is assessed and delivered.

Both the MHA and best practice protocols stipulate that remittals should be accompanied by a CPA care plan which indicates any ongoing mental health services input that may be required, and also that prison mental health services should 'actively participate in the remission process including attending s117 aftercare meetings and supporting the development of aftercare plans' (Department of Health, 2011).

Both medium security and prison-based clinicians in Study 2 described how these arrangements are not always conducted in line with good practice guidance (see section 7.2.2). Clinicians described difficulties in engaging their counterparts in the s. 117 process, with medium security clinicians describing difficulties when attempting to arrange for members of the prison team to attend the discharge planning meeting prior to transfer. Poor discharge planning practice was particularly evident in the focus group interaction where prison-based clinicians expressed surprise at the handover arrangements described by other attendees. Some described how their handover does not resemble a formal process, but that to satisfy the requirements of the Ministry of Justice, 117 meetings are documented as having taken place. One prison-based clinician described how they had never had communication with the Ministry of Justice regarding the appropriateness of a prison remittal.

Collective experiences suggested that the s. 117 meeting is at times an arbitrary process, the results of which have little impact on patient care post-remittal. Clinicians agreed that this process requires further consideration. Some suggested that having the same NHS provider in both the medium secure services and remittal prison encourages effective discharge planning, although others highlighted the conflicts of interest this arrangement may pose. Nevertheless this research highlights that there is a need to formalise the roles and responsibilities of both medium secure and prison mental health services in the effective remittal of prisoner-patients and the establishment of continued aftercare.

Aftercare entitlement was relevant to those in Study 1 who were detained under Section 47, 48 and 45a and were remitted to prison following treatment. Once triggered the right to aftercare is ongoing and remains in place regardless of the person's circumstances. Such care should only end when both health and social care services jointly agree that the individual no longer requires aftercare (Richards & Mughal, 2010). This was not observed to be the case when these remittals were followed-up in Study 3. Just 18% of those with the legal entitlement to aftercare were having care assessed and delivered through the CPA process following remittal to prison, and whilst prison remittals largely received a referral to prison mental health services (98%), a quarter of referrals were not accepted (26%). Likewise some patients were subsequently discharged as they did not meet the criteria set by prison mental health services.

It was also observed in Study 3 that transfer between prison establishments may result in loss or denial of aftercare. It is current policy for prisoners to be remitted to the prison that is local to the medium secure service, which may not necessarily be their referring prison. Once received at the remittal prison, individuals can be transferred on to their referring prison or to a prison within the appropriate category. At this point effective communication and continuity of care should be central to good practice. Forty-three percent (n = 38) of prison remittals in Study 3 were subject to prison transfer post-remittal. Of those who were engaged with MHIR services at their remittal prison, just over half received a referral from these services to the transfer prison MHIR service (12/22, see Figure 9.2). Just nine of those referred to transfer prison MHIR services were accepted, and five were later discharged. Whilst remittal to the local prison may appear practical, the impact on this policy on aftercare needs to be considered by policymakers with a view to ensuring that this process does not jeopardise access to and quality of care received.²⁰

Criteria for discharge (nature of presentation)

Evidence submitted to the independent review also suggested that reviewers should give further consideration to the criteria applied for prison remittal (as compared to community discharge). Prior to discharge Responsible Clinicians are required to assess the health and social care needs of each individual, and incorporate these needs into a care plan, whilst ensuring that the risk to the patient and others has been assessed. This was not always observed to be the case in Study 1. In some instances prison remittal ensued as a result of patient non-engagement in ward-based treatment (18%), or when an individual was deemed to be too high risk to remain detained in the service (10%). It is unlikely that such circumstances would result in discharge for patients whose pathway is via a community trajectory. Therefore from a public protection perspective, it was particularly concerning that nine of the persons who were released back into the community in Study 3 were those who were remitted due to engagement/risk issues. The potential for relapse or reoffending for these individuals may be high, and there is no evidence of the degree to which risk assessment and management was utilised in these cases.

There appeared to be a split across clinicians in Study 2 as regards the appropriateness of this practice (see section 7.4.2). Some clinicians felt that a prolonged stay in medium secure services represents a valuable opportunity and that, if prisoner-patients chose not to engage in the treatment available or present as high risk, remittal to prison is appropriate. Others, however,

²⁰ Recently an issue picked up by the OPD pathway evaluation. The pilot supports a change from current **remission** arrangements (whereby offenders are remitted to the nearest Local prison). It demonstrates that remission direct to a prison-based OPD service instead is achievable, preferable and more beneficial to the offender.

asserted that these patients should receive a more prolonged period of attempted re-engagement within medium secure services, as they would be afforded if the service was responsible for their eventual release into the community. Another group suggested that the correct response to high risk ward-based behaviour is to make a referral for admission to a high secure hospital. Prison clinicians shared their experiences of receiving remittals of this description, and the negative impact that this may have on prison mental health services, and on the patient's outlook following release from prison. Collectively these findings suggest that thresholds for discharge vary across discharge destinations, and the clinical needs of prison remittals are not considered to the same degree as is the case with individuals who are discharged into the community. Further attention needs to be given to this differential treatment, from both MHA and service policy perspectives.

Preparation for release

The transition from prison to the community is a vulnerable period associated with increased risk of relapse, reoffending, suicide and other causes of death, particularly for those with a diagnosis of SMI (Farrell & Marsden, 2008). Preparation for release from custody represents a challenge for prison mental health services (Dyer and Biddle 2013), and widespread disengagement from mental health services at the point of release from custody has been identified (e.g. Lennox et al., 2012). Failure to connect with appropriate mental health services post release has been linked to elevated mortality risk among recently released prisoners (Binswanger *et al.*, 2007). Therefore it is important that preparation for release includes referral and engagement with CMHTs and other sources of support post-release. As such, it is concerning that for 52% of releases in Study 3 there was no evidence of referral to a CMHT service, even though the majority of whom had a diagnosis of SMI (see section 9.6.4). This research did not extend to follow-up beyond release from custody, but did capture the discharge circumstances for these individuals prior to remittal. These are further discussed in section 10.3.4.

Remittal delays

The reviewers plan to further consider how to streamline and speed up the process of prison remittal from medium secure services. Lengthy remittal delays were not observed in Study 1; however clinicians in Study 2 described how poor communication can cause these delays. Clinicians stressed the importance of maintaining positive relationships and communication with individual prison governors and management teams. Poor communication was described as hindering clinical remittal decisions, with clinicians describing instances of prisons refusing to

accept the inward transfer of prisoner-patients. Clinicians felt that there is a lack of understanding from the prison estate as to the circumstances prompting remittal and its purpose. Many described instances where prisons had assumed that a prisoner-patient's remittal was due to a management issue within medium secure services, as opposed to treatment completion. However, some prison-based clinicians also noted that they too are not always fully aware of why a patient has returned to their care. This serves to support the need for further development of remittal guidelines to ensure that there is a shared understanding of the remittal process across the medium secure and prison estates, alongside clarification of responsibilities of both parties in Section 117 aftercare arrangements.

Reluctance to remit (poor services)

The reviewers also suggest that there is clinical reluctance to recommend the remittal of some offenders due to the negative impact of the prison environment (7.16, p43). We anticipate that this priority area should also give further consideration to the improvements to prison mental health services that are required. Data from Study 2 highlights that some medium security based clinicians have concerns about remittal to prison which included: patient vulnerability when transferring from a therapeutic to a punitive environment; inadequate aftercare services (these were described as underfunded and overstretched); and poor continuity of aftercare post release, all of which may result in 'revolving door patients'. Data from Study 3 highlights that services are limited and treatments are predominantly restricted to prescribed medications, adherence to which is poor. Contact with mental health professionals is predominantly with RNMA's, yet two thirds of remittals had access to a psychiatrist at some point during the one year follow-up period. Contact with other professionals (e.g. social workers, occupational therapists, and psychologists etc.) was found to be uncommon.

Patients being cared for in the criminal justice system should have equivalence in terms of outcomes, rights and safeguards with civil patients. This is not observed to be the case across these studies, both in terms of the described criteria for discharge and clinicians' descriptions of services available upon remittal and discharge back into the community²¹. According to the principle of equivalence of care, prisoners are entitled to the same level of healthcare as that provided to the general population and should be treated by services that are of the equivalent standard (Till, Forrester & Exworthy, 2014). Several authors have argued that applying the

²¹ However, in prisons there are clearly environmental, historical and cultural factors to be taken into account, which mean that aspects of healthcare might look different to those in the wider community; making effective to CMHT's difficult.

principle of equivalence to a prison environment is flawed from the outset, and that a change in emphasis in the application of this principle is needed (Exworthy et al., 2011; Forester et al., 2013; Niveau, 2007). Lines (2006) suggested that the emphasis should not be on the equivalence of healthcare standards, but on the equivalence of objectives and outcomes, in that the level of psychiatric morbidity in prisons requires greater levels of clinical interventions to achieve similar levels of success as for CMHTs (Forrester *et al.*, 2013). To achieve this goal, it has been estimated that spending on prison mental health services would need to triple (Brooker, 2008).

10.3.3 *Re-thinking the treatment of prisoners who require inpatient mental health services*

Enforced treatment in prison

Delayed treatment for prisoners with severe mental illnesses whilst awaiting transfer to secure psychiatric services can result in deteriorating mental state and may be associated with increased risk to the individual and to others (Marshall et al., 2005). Lengthy transfer delays are well documented and continue to be a cause for concern for forensic clinicians. It has been almost 10 years since Lord Bradley made the 14 day transfer recommendation (Bradley, 2009) and yet little effective change has occurred (National Audit Office, 2017). Key contributing factors are attributed to responsibilities that lie with hospital services; for example, delays in organising gatekeeping assessments, acceptance/rejection decisions, and in identification of available beds (Sharpe, Vollm, Akhtar, Puri & Bickle, 2016). In response to these delays, forensic clinicians have called for development of a policy which would allow for more extensive treatment of mentally unwell prisoners who lack capacity, whilst arrangements are made for further transfer.

Prior to the 2005 introduction of the Mental Capacity Act (MCA), such individuals could receive compulsory treatment only in the case of emergencies under common law (see; Doy, Burroughs & Scott, 2005; Earthrowl, O'Grady & Birmingham, 2003). It was felt that policy development in this area could reduce periods of unmedicated psychosis in individuals and could help target problem areas, particularly in relation to suicidal behaviour (Home Office, 1990; Home Office, 1991; Towl, Snow & McHugh 2000). This practice was not used as an alternative to appropriate assessment under existing process in the MHA, but to provide care in the interim between assessment and admission (Earthrowl, O'Grady & Birmingham, 2003).

Prison clinicians now have access to powers under the The MCA, which provides guidelines for making health and social care decisions about healthcare for individuals who lack capacity. The Act applies to all persons above the age of 16 and is being used in practice as a legal framework for non-consensual treatment of acutely mentally unwell prisoners (Davis & Diamond, 2012). The

MCA, however, is not intended for those who are severely mentally unwell; rather this is the scope of the MHA in the transfer of these individuals under section 47 and 48. Therefore the MCA appears to be applied uniquely to prisoners in such circumstances. It still remains unclear whether this is legal (Wilson, 2010) and future consideration of the interface between the MHA and the MCA needs to take place. Whilst scope for the application of the MCA appears significant, Wilson (2010) argues that the use of the Act during transfer delays is a practice that continues to collude with a system that routinely fails to admit those in need. Applying the MCA to patients for whom the MHA applies may be to their detriment as there is risk that they may no longer reach the threshold for treatment and transfer to external secondary services following stabilisation. As such we should continue to strive towards improving the transfer system, whereby admissions are coordinated with the same urgency as hospital admissions for severe physical healthcare needs.

Other experts have argued that perhaps coverage of the MHA should be expanded to include the prison estate (for example; Doyle, et al. 2014). This would involve extending some compulsory treatment powers outlined in the MHA for prisoners requiring emergency treatment, and therefore may be useful for non-compliant psychotic prisoners who require re-establishment of antipsychotic medications. However, there are ethical implications for implementing this practice. It is well established that the prison environment itself is sub-therapeutic (Nurse, Woodcock & Ormsby, 2003), and there remain conflicting priorities between security and healthcare; for example, inappropriate practices of placing seriously mentally ill prisoners in special cells or segregations units, and the excessive use of control and constrain measures, remain abundant within the prison system (Scott & Codd, 2011). There is risk of incorrect use of the MHA, with the powers it yields being used as another means of control, rather than as a method of care and treatment. This may raise Human Rights concerns (in relation to Article 3 of the European Convention of Human Rights (as enacted in the UK Human Rights Act 1998) and it may not constitute the least restrictive option as outlined in the MHA. As it stands, prison inreach services remain inadequately funded and do not have the resources to carry out compulsory treatment safely. Provision would need to increase substantially, and a more therapeutic approach will need to be adopted, if this is to be considered.

Prison hospitals

There has been recent debate amongst forensic academics and clinicians which has reignited the contentious topic of designated 'prison hospitals' (Forrester, 2018) as are present across areas of Europe; see Dressing & Salize (2009) for a review of 24 western European countries. Under these terms, compulsory treatment in prisons would extend beyond emergencies to prisoners who may

require a longer period of stabilisation in secondary mental health care, who would be treated in prison wings with designated hospital status under the MHA. This concept was initially introduced in the government's consultation document on its draft Mental Health Bill (2002). It did not set out what such conditions should be, but the parallel drawn between the use of compulsion in the community and in prison, and the specific mention of further inreach service development, gave a broad hint at some sort of "wing-based" service (Kinton, 2002). The Mental Health Act Commission responded to this and outlined that if this was to become practice;

'Such units should, in the Commission's view, be equivalent facilities to in-patient units outside of prison. They should be separate from the normal residential accommodation, staffed at all times with NHS professionals and able to provide the necessary treatment under the same quality-assurance arrangements (such as professional regulation and inspection of services) as exist elsewhere in the NHS. We would also expect the same safeguards to be available to prisoner-patients as would be available to patients subject to compulsion outside prison, such as the oversight of a monitoring body, access to advocacy, ability to appeal against compulsion to a tribunal and to have tribunal oversight and safeguards applied to the treatment itself.

Even if this infrastructure was in place, there should still be a requirement that transfer to an outside hospital should be considered if that would be in the prisoner-patient's best interests'.

(Kinton, 2002, pp 307)

There has been little further development of this initiative over recent years and it remains unclear to what extent this could be implemented in the UK system. However findings from this currently body of research provide a platform that can encourage further debate on the best way to care for and treat prisoners who require secondary mental health service.

An admission to medium secure services for a period of 18 months to 2 years is considered optimal (Bradley, 2009), and an admission of less than one year has been described as being unlikely to produce any substantial therapeutic benefit (Alexander et al., 2006; Halstead et al., 2001), particularly for those patients requiring admission for reasons other than medication re-stabilization (for example; therapeutic interventions). It was observed in Study 1b that less than half of prison remittals had an admission to medium secure services of more than 6 months'

duration. Likewise, it was observed in Study 3 that half of all persons released back into the community within one year post-discharge were those who had a length of stay less than 6 months. Whilst some of these remittals may have been entirely appropriate, particularly for those individuals not deemed to require long-term treatment, or those without a psychiatric diagnosis, there is concern that for some patients, any potential benefits of their admission may be lost upon return to prison or following release into the community. If it has now become standard practice, particularly for those patients who are close to their earliest release date, we need to question whether the benefits of a short admission outweigh the unsettlement caused by imposing multiple transitions on an individual's mental health and criminal justice pathway.

There also needs to be thoughtful consideration as to what is the most appropriate pathway into the community for these individuals. Study 2 shed light on this debate and has highlighted disagreements regarding how best to co-ordinate transition into the community for these individuals. Whilst some clinicians believed that a discharge from medium secure services directly into the community was in the patient's best interests, others highlighted that this may cause some prisoners to remain detained beyond their release date. Additionally, remittal to prison was described as being more advantageous for individuals in terms of accessing the relevant offender manager and probation services who can influence community residency and linkage with community mental health services.

For prisoners who require only a short period of admission, and for those who are close to their earliest release date, the required care and interventions could perhaps be provided in a purpose-designed prison hospital wing similar to those that are described above. This could potentially limit the disruption caused by external admission and remittal, and could secure effective transition into the community post-treatment. This service could be part of a 'combination approach' to inpatient services for prisoners; where those receiving hospital disposal at court are admitted to the medium secure estate, and those who are remanded in custody or serving custodial sentences are treated within the new facility as informal patients. This would be a less restrictive option for these prisoners and would mimic general psychiatric practice (Boast, 2015). Such an approach could make meaningful use of the current hybrid order that is in place (section 45A, MHA) for newly sentenced offenders who require compulsory treatment prior to incarceration, and for serving prisoners there could be a 'step up' feature to medium secure services for those who cannot be treated informally within the prison hospital. This could result in stabilisation of individuals within the prison estate and perhaps fewer applications for treatment in external secondary care, which may help to speed up the transfer of those who require compulsory treatment. This suggestion is currently underdeveloped and needs to integrate the

issues highlighted in section 10.3.1 (e.g. rehabilitative and risk reduction responsibilities). Nonetheless, it certainly warrants further consideration from a policy, clinical and legal perspective (Doyle, Coid & Shaw 2015).

10.3.4 *Targeted support and specified care pathway for personality disorder*

There is increasing reluctance from medium secure services to accept patients whose primary treatment requirement is for personality disorder (Grounds et al. 2004). In Study 2 the majority of clinicians described how the presence of a personality disorder was a key characteristic in determining a prisoner-patient's discharge destination from medium secure services (section 7.4.3). There was consensus amongst interviewees that medium secure services are not an appropriate environment for the treatment of personality disorder and that the bounded nature of the prison environment was more advantageous for these individuals. However, a degree of reluctance was evident from both the medium secure and prison services in taking the responsibility of treating these individuals.

If secure and prison based mental health services are to continue to function under the current nexus then consideration should be given to the function and further development of targeted resources for prisoners with personality disorder diagnoses. Provision for this group is sparse and initiatives such as the Dangerous and Severe Personality Disorder (DSPD) pilot programme have failed to succeed (see Tyer et al., (2010) for a review of the DSPD programme).²² Current provision is provided through the new Offender Personality Disorder (OPD) pathway - a joint commissioned initiative between mental health services and the criminal justice system in 2011, using recycled resources intended for the DSPD programme; see National Offender Management Service & NHS England (2015)²³. Criteria for pathway enrolment include individuals who: a) are considered to present as a high likelihood of violent or sexual offence repetition AND as presenting a high or very high risk of serious harm to others; b) are likely to have severe personality disorder²⁴; c) there is clinically justifiable link between their personality disorder and risk; and d) the case is

²² The Dangerous and Severe Personality Disorder (DSPD) programme was introduced in 2003 and aimed to reduce the risk posed by enrolled individuals through individualised treatment plans which targeted criminogenic factors and mental health need. This was established in 2 high secure hospitals (Broadmoor and Rampton) and 2 high secure prisons (HMP Frankland and HMP Whitemoor) but later decommissioned.

²³ The OPD pathway is a jointly commissioned initiative that aims to provide a pathway of psychologically informed services for offenders who have a severe personality disorder and who pose a high risk of harm to others, or a high risk of reoffending in a harmful way (National Offender Management Service & NHS England, 2015).

²⁴ 'Severe' is a political and not clinical term and is 'intended to indicate the most complex cases, with the most significant levels of dysfunction, with cause the greatest challenges for staff and services (National Offender Management Service & NHS England, 2011)

managed by the National Probation Service. The OPD programme is a regionally commissioned service (London, South, Midlands and East, and North) which has identified over 30,000 offenders who are 'in scope'; although just a fraction of all treatment places are commissioned nationally. Three medium secure services have commissioned OPD beds for prisoner-patient transfer and the pathway post-treatment is remittal to a prison based OPD service.

Clinicians in Study 2 had varied exposure to the OPD pathway. Some expressed their concern that these services operate to tight admission criteria and that it is notoriously difficult to negotiate admission. Likewise, clinicians who worked within a unit with OPD provision described how prisoner-patients were required to demonstrate their drive and ability to engage in the pathway before enrolment is considered. Study 1 included all three medium secure services with OPD provision, and discharges from personality disorder treatment wards were observed. However there was no evidence that remittals were enrolled onto an OPD pathway, and all were remitted to the prison local to the MSU (as opposed to a prison within the OPD pathway).

Over a third of remittals had a primary diagnosis of personality disorder and, whilst there was no evidence of acceptance onto the OPD pathway, three were remitted with the recommendation of transfer to a Psychologically Informed Planned Environment (PIPE)²⁵ post-remittal. However, in Study 3 it was observed that these patients remained within the ordinary prison regime throughout the one year follow-up period. Indeed none of the remittals with a primary diagnosis of personality disorder were found to be receiving targeted intervention for their disorder at remittal. Whilst all but one of these individuals were referred to mental health inreach teams, a third were not accepted on the grounds that they were not considered to be appropriate for the service.

Clinicians in Study 2 expressed their concern for the outlook of remittals with a primary diagnosis of personality disorder. The lack of personality disorder interventions outside of the OPD pathway was highlighted and clinicians expressed their frustrations when recommendations for appropriate interventions are made yet services are not received; for example, further work in a PIPE (P5, section 7.4.3). Presentation of this data at forensic mental health conferences has yielded similar concerns raised by both academic and clinical colleagues. Many expressed that more clarity is required around the OPD pathway, particularly with in relation to acceptance criteria. Prison psychiatry colleagues also provided examples of remitted personality disordered prisoners on their caseloads for whom there were no available interventions – some of these

²⁵ PIPE's are designed to support transition and personal development at significant stages of an offender's pathway.

patients were due for release into the community and/or were considered to pose a risk to themselves and to others.

Beyond forensic psychiatry there has recently been a call for a more comprehensive examination of services for personality disorder. A national study of perpetrators of homicide and people who die by suicide who have personality disorder revealed suboptimal provision of interventions and appropriate care in the period prior to incident (National Confidential Inquiry into Suicide and Homicide, 2018). This is particularly poignant when we consider the characteristics of remittals with the individuals investigated in this study. In particular, there was evidence of vulnerability for personality disorder in Study 3. Over half of those prescribed psychiatric medications were documented as having stopped taking these within one year post remittal, and for all but one person this was prescribed antipsychotic medication (see section 9.3.5). Over half were also managed under the ACCT process and these individuals were 4 times more likely to have been managed under ACCT on two or more occasions during follow-up than remittals with other diagnoses (see section 9.4.1). The majority of documented instances of self-harm/attempted suicide during follow-up were by remittals with personality disorder. Self-harm/attempted suicide was documented for 47% of personality disordered remittals, and such incidents were 2.5 times more likely for these individuals than remittals with other diagnoses (see section 9.4.4).

Collectively, the findings from this body of research presented in this thesis, alongside feedback received from external colleagues, highlights that prisoner-patients with a primary diagnosis of personality disorder are disadvantaged at all stages of their secondary mental health care pathway. Provision both within the medium secure estate and prison mental health services is lacking, and the services which do exist do not appear to be tailored towards these individuals according to what was observed in this study. Consideration needs to be given to the clinical needs and interventions that may benefit these individuals. For many prisoner-patients with personality disorder, an admission to in-patient care is unlikely to be effective and has the potential to be counterproductive (Paris, 2004). However, the current evidence-base for effective treatment of personality disorders in general is insufficient (Bateman, Gunderson & Mulder, 2015)²⁶. At the very basic level, NICE guidance recommends that assessing personality disordered individuals' risk of harm to themselves or to other people should take place as part of a full assessment of patients' needs. This should result in a risk management plan developed in collaboration with the patient, to be managed by a multidisciplinary team (NICE, 2003; 2009).

²⁶ Nevertheless there has been recent a five-fold increase of personality disorder services in England (Dale, Sethi, Stanton et al., (2017)

10.4 Directions for future research

Remittal to prison from medium secure services is a relatively unexplored area. The trio of studies conducted can act as a starting point to influence the direction of future research in this area, both through the analysis of data that was collected but not presented for the purpose of this thesis, and the collection of new data to build upon these findings. Suggestions for future research are presented below.

10.4.1 Further work with available data

Study 2 yielded significantly more data than it was possible to analyse within the available time constraints of the doctoral programme. There are several possible avenues for future work using these data, and through the collection of supplementary data. This research focussed predominantly on remittal to prison although there was much discussion across the interviews and focus groups with in relation to managing community discharge for prisoner-patients. This is a rich and interesting area that is outside the scope of this thesis, covering issues such as: thresholds for acceptance to lower levels of security, general adult CMHTs not accepting former prisoners, forensic CMHTs not accepting 'reactively unwell' prisoners, etc. It is my intention to reanalyse those data for the purpose of publication in a peer reviewed-received journal.

10.4.2 Suggestions for further research

If services are to develop and take on board suggestions outlined in this thesis, then it would be important to explore prisoner-patient accounts of transfer, treatment and remittal from medium secure services. The accounts presented in this thesis provide a good clinical overview of the prisoner-patient experience and reference is made in Study 2 as to how clinicians perceive prisoners to feel in relation to prolonged stay, their status as a patient/prisoner, and access to community discharge/remittal. However, first-hand accounts from individuals subjected to these care pathways would allow for greater insight into the impact of some of the concerns raised in the discussions above. This would be particularly useful regarding the issues highlighted for persons subjected to IPP sentences (see Section 7.3.3). There is a growing body of support for the recategorisation and release of the estimated 3000 prisoners who are post-tariff yet remain subject to these sentencing conditions. Study 1 identified 25 individuals subject to IPP sentencing within the sample, and IPP prisoners represented just under a quarter of prison remittals (24%). There is very little reference to medium security admissions for IPP prisoners within the literature

to date, and this may therefore represent an avenue for future larger studies on access to care for IPP prisoners.

At the design phase of study the need for international comparisons was recognised, yet this was considered too broad a topic to contain within a doctoral thesis. However from presentations at conferences to international audiences it appears that the issues raised in this thesis are also experienced internationally. Regardless of the legislative and system nexus differences, clinician feedback was that the management of offenders requiring secondary mental health services and the process of remittal are also considered to be problematic in their respective countries. In light of this it might be useful for a scoping exercise to be conducted that collates evidence from key countries with regarding optimal versus suboptimal practice (for example North America and European countries). There are recent articles in the literature that compare the mental health and criminal justice systems across other western European countries (Dressing & Salize, 2009). However, as with the UK literature, there is little international literature on the prison remittal pathway and the role of secure services for these individuals. Such an exercise, along with the data and discussion provided in this thesis, could collectively influence the development of renewed Good Practice Guidelines for effective transfer, treatment and remittal of prisoners requiring mental health services.

10.5 Chapter summary

This chapter has provided a discussion of the main findings from the three studies presented in this thesis alongside integration of these findings when considering the implications of this research for future clinical practice. Strengths were briefly discussed and suggestions for future research were made, alongside indications of future work to be completed with the data that were not presented in this thesis.

Evidence on the needs of prisoners requiring inpatient psychiatric care is improving and, through the data presented in this thesis, arguments for how best to respond to these needs can be further developed. It is hoped that this research will act as a platform for further development and consideration as to how best to manage prisoners who require secondary mental health care and the extent to which the medium secure estate can provide a proactive role in the care and rehabilitation of these individuals.

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Appendices

Appendix A: Submission to 'Independent Review of the Mental Health Act: Interim Report'



Centre for Mental Health
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Manchester M13 9PT

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18th May 2018

Submission to 'Independent Review of the Mental Health Act: Interim Report'

On behalf of the Offender Health Research Network

Executive summary

- Remittal to prison from secure mental health services is a key transition point in a patients care pathway which presents challenges to continuity of care between services. This is a time of elevated risk and vulnerability. The Care Programme Approach (CPA) is designed to support the transition between inpatient and discharge settings for patients who are entitled to aftercare under Section 117 of the Mental Health Act (MHA).
- Current areas of concern include:
 - Criteria for remittal to prison compared to community discharge
 - Arrangements for and availability of Section 117 aftercare
 - Management of this aftercare through the CPA process upon remittal
 - Continuity of aftercare following prison transfer
 - Continuity of aftercare following prison release

Introduction

1. The Offender Health Research Network (OHRN) is a multi-disciplinary network of academics and clinicians, based at the University of Manchester. Our portfolio of research focuses on: the health and social care needs of people in contact with the criminal justice system, screening and identification of health needs and risks, pathways of care in the criminal justice system; and implementing and evaluating novel health services and initiatives to improve the health of offenders.
2. Our project 'a comparative study of people transferred from prison to hospital under the mental health act: pathways and outcomes' holds a national dataset of all prisoner-patients remitted to prison from 33 NHS medium secure services over a 6 month period. This project utilises mixed methodology and includes a one year follow-up of prison remittals, alongside a qualitative individual interview and focus group study with forensic clinicians, exploring their experiences of treating transferred prisoners and remitting to prison. Study findings and their relevance to the current independent review are summarised below.



Summary of relevant study findings

3. The authors address a need to clarify 'what aftercare means within the modern health and social care system' (7.12, p36). We anticipate that this priority area should also give further consideration to entitlement of aftercare for prison remittals and the subsequent responsibilities of secondary mental health services and prison-based mental health services in these instances.
4. Section 117 of the MHA provides a right of aftercare from local authorities and the NHS to people discharged from hospital. This entitlement is relevant to those detained under Section 47, 48 and 45a who are remitted to prison following treatment. It is through the CPA process that aftercare is assessed and delivered. Once triggered the right to aftercare is ongoing and remains in place regardless of the persons circumstances. Such care should only end when both health and social care services jointly agree that the individual no longer requires aftercare. This is not observed to be the case in our study.
5. Our data highlights that just 18% of those with the legal entitlement to aftercare were having care assessed and delivered through the CPA process following-remittal to prison. Whilst prison remittals largely received a referral to prison mental health services (98%), a quarter of referrals were not accepted (26%). Likewise some patients were subsequently discharged as they did not to fit the criteria set by prison mental health services.
6. We also observed that that transfer between prison establishments is a key opportunity for loss of aftercare. Forty-three percent of prison remittals were subject to prison transfer post-remittal, under a third of whom received a referral from their remittal prison mental health services to the transfer prison services. Patients involved in the criminal justice system should have equivalence in terms of outcomes, rights and safeguards with civil patients. This is not observed to be the case in our study.
7. The authors plan to further consider how to streamline and speed up process of prison remittal, yet also suggest that there is clinical reluctance to recommend the remittal of offenders back to prison due to the negative impact of the prison environment (7.16, p43). We anticipate that this priority area should also give further consideration to the criteria applied for prison remittal (as compared to community discharge) and the improvements to prison mental health services that are required.
8. Prior to discharge responsible clinicians are required to assess the health and social care needs of an individual, and incorporate these needs into a care plan, whilst ensuring that the risk to the patient and others has been assessed. This was not always observed to be the case in our study. We observed circumstances where prison remittal was a result of patient non-engagement in ward based treatment (18%), or of being considered too high risk to remain detained in the service (10%). It is unlikely that such circumstances would result in discharge into the community. Qualitative findings also highlight inconsistencies in how secure services view their role in regards to the criminal justice system and Part 3 of the Mental Health Act.

9. In line with the authors' suggestions, our qualitative data highlights that some medium security based clinicians have concerns about remittal to prison which included: patient vulnerability when transferring from a therapeutic to a punitive environment; inadequate aftercare services (these were described as underfunded and overstretched); and poor continuity of aftercare post release (our quantitative data found that 52% of those released from prison during follow-up were not referred to community mental health services prior to release).

We welcome further detailed dialogue in regards to our research findings and anticipated clinical implications.

Sarah Leonard

Doctoral Researcher

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Professor Jennifer Shaw

*Professor of forensic Psychiatry and Centre Lead for the Centre of
Mental Health and Safety*

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Appendix B: Research Ethics Committee approval

1



NRES Committee North West - Preston

HRA NRES Centre - Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3QZ

Tel: 0161 625 7818
Fax: 0161 625 7299

31 January 2014

Professor Jenny Shaw
Assistant Director, Centre for Suicide Prevention
University of Manchester
Centre for Suicide Prevention
University Place, UoM
Oxford Road
M13 9PL

Dear Professor Shaw

Study title: The validation of new risk assessment instruments for use with patients discharged from medium secure services (VoRAMSS)
REC reference: 09/H1016/126
Amendment number: 6
Amendment date: 16 January 2014
IRAS project ID: 28180

More detailed follow up of participants

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
baseline data collection sheet	2	16 January 2014
Protocol	5	16 January 2014
Investigator CV	Leonard	16 January 2014
Covering Letter		16 January 2014

Follow up data collection sheet	2	16 January 2014
Notice of Substantial Amendment (non-CTIMPs)	6	16 January 2014

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

09/H1016/126:	Please quote this number on all correspondence
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Yours sincerely



Dr Patricia Wilkinson
Chair

E-mail: nrescommittee.northwest-preston@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Beverley Lowe, Lancashire Care NHS Foundation Trust
Lynne Macrae*



Professor Jenny Shaw
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04 April 2014

Dear Professor Shaw

Study title: Validation of risk assessments for patients from MSS (VoRAMSS)
CAG reference: ECC 6-06(b)/2009
IRAS Project ID: 28180/70422/4/770
REC number: 09/H1016/126

Thank you for your research application, submitted for approval under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 to process patient identifiable information without consent. Approved applications enable the data controller to provide specified information to the applicant for the purposes of the relevant activity, without being in breach of the common law duty of confidentiality, although other relevant legislative provisions will still be applicable.

Please note that research applications covering data generated within England and Wales require an approval decision to be made by the Secretary of State for Health, following a recommendation from the Health Research Authority.

The role of the Confidentiality Advisory Group (CAG) is to review applications submitted under these Regulations and to provide advice to the Health Research Authority to inform the recommendation to the Secretary of State on whether an application should be approved, and if so, any relevant conditions. This application was considered via proportionate review under criteria 8, amendments to approved applications.

Secretary of State for Health approval decision

The Secretary of State for Health, having considered the recommendation from the Health Research Authority as set out below, has determined the following:

1. The amendment is approved, subject to compliance with the standard and specific conditions of approval.

Context

This research application from the University of Manchester set out a prospective study that aimed to validate and assess the reliability and utility of recently developed risk assessment instruments in a group of 560 patients across 38 medium secure units in England and Wales with a diagnosis of Schizophrenia. A recommendation for class 1, 2, 4, 5 and 6 support was sought in order for the research group to access patient medical notes at 6 and 12 months to link with information on the Police National Computer. Identifiers requested were name and date of birth.

Amendment request

An amendment request was received on 15 November 2013 seeking an extension of support under the Regulations until September 2016, on the grounds that the original study had identified a higher number of discharged patients returning to prison than had been expected. There was therefore an interest in finding out why this might be through evaluating the factors influencing the decision to return to prison rather than choosing a health or social care pathway and identifying what healthcare those discharged to prison received while in prison and following release. This would involve a more detailed follow-up of those already discharged to prison and identification of new discharges from medium secure psychiatric facilities, including consideration of additional discharges in order to generate an accurate picture of why more people than expected were transferred back to prison and what happened to them. A refreshed version of the study protocol was supplied to support the amendment.

Confidentiality Advisory Group advice

The amendment request was forwarded to the Chair who was supportive of the request on the grounds that the findings of the study could not have been expected at the time of the initial application, and agreed that there was a clear public interest in following up the initial findings. It is a requirement of the Regulations that an application cannot be inconsistent with the principles of the Data Protection Act 1998 (DPA). The first principle of the DPA requires that reasonable efforts are made to inform data subjects of the use of their data. The Chair recommended that the applicant ensure that information in relation to the study was made available in line with the requirements of the first principle of the Data Protection Act 1998.

Health Research Authority recommendation

Following advice from the CAG, the Health Research Authority agreed to recommend *provisional* support to the Secretary of State for Health, in line with the conditions and clarifications highlighted by the CAG.

Specific conditions of support

1. Confirmation of suitable security arrangements via IG Toolkit submission. Confirmed 25 March 2014.
2. Confirmation of a favourable opinion from a Research Ethics Committee. Confirmed 31 January 2014.
3. Please ensure that fair processing information is made available in line with the requirements of the Data Protection Act 1998.

As the above conditions have been accepted and/or met this confirms final approval for this amendment.

Reviewed documents

The documents reviewed by the Chair were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Refreshed protocol	5	07/11/2013

Please do not hesitate to contact me if you have any queries following this letter. I would be grateful if you could quote the above reference number in all future correspondence.

Yours sincerely

Claire Edgeworth
Deputy Confidentiality Advice Manager

Email: HRA.CAG@nhs.net

Enclosures: Standard conditions of approval

Appendix D: National Offender Management Service approval



**National Offender
Management Service**

Dr Michael Doyle
The University of Manchester and Greater
Manchester West NHS Trust
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National Offender Management Service
National Research Committee
Email: National.Research@noms.qsi.gov.uk

09 May 2014

APPROVAL OF MODIFICATIONS – NOMS RESEARCH

Ref: 64-11

Title: The validation of new risk assessment instruments for use with patients discharged from medium secure services (VoRAMSS)

Dear Mike,

NRC Approval of Amendments to 64-11 (Jenny Shaw: The validation of new risk assessment instruments for use with patients discharged from medium secure services (VoRAMSS))

Further to your emails requesting amendments, this letter is to notify that the NRC has approved the request to extend NRC approval for 64-11 for a further 32 months until September 2016 on that basis that no access to prison (non-health) records is required.

Yours sincerely,
National Research Committee

Appendix E: Baseline data collection proforma

Data Collection Sheet - The validation of new risk assessment instruments for use with patients discharged from Medium Secure Services – VoRAMSS

Patient Demographic Details

RESEARCH ID: _____

Unit/Site: _____

Sample group

Community discharge Prison discharge

Gender

Male Female

Ethnicity

White

- A British
- B Irish
- C Any other White background

Mixed

- D White and Black Caribbean
- E White and Black African
- F White and Asian
- G Any other mixed background

Asian or Asian British

- H Indian
- I Pakistani
- J Bangladeshi
- K Any other Asian background

Black or Black British

- L Caribbean
- M African
- N Any other Black background

Other Ethnic Groups

- O Chinese
- P Any other ethnic group
- Q Not stated

Marital Status _____

Age at discharge: _____ (if appropriate)

Age at admission: _____

Legal status

Remand Sentenced

Section of MHA (1983) at admission _____

Restrictions Yes No

Please state _____

Section of MHA (1983) at discharge _____

Restrictions Yes No

Please state _____

Discharge circumstances (if appropriate)

Responsible clinician MHRT Recalled by courts

Details: _____

Index Offence

Yes No

If yes was it;

Violent Property Sexual Other

Official offence title _____

Severity of Index offence

Rating	Category	Offence
0	No offence	
1	Non-violent	Drug offences, fraud, prostitution, curfew violation, disorderly conduct, trespassing, begging, failure to provide for spouse
2	Ambiguous Violence	Escape, driving offences, theft, possession of weapons, possession of stolen property, violation of probation/parole
3	Property Crimes	Vandalism, burglary, car theft, taking car without consent, malicious mischief
4	Threats to persons	Indecent exposure, robbery, lewd and lascivious, exhibiting a deadly weapon, intimidating a witness
5	Attacks on persons	Car jacking, assault, rape, incest, child molest, forced oral copulation, kidnap, resisting arrest, arson, battery, false imprisonment's, spousal abuse
6	Loss of life	Murder, manslaughter
7	Loss of life /extreme violence	Homicide with special circumstances: serial murder, torture, serial rape, rape with torture

Age at index offence _____

Length of sentence _____

Length of sentence served prior to admission _____

Length of sentence pending upon discharge (to prison) _____ (if appropriate)

Number of previous prison sentences _____

Number of previous convictions _____

Number of previous violent offences _____

Severity of previous offences (scored as above) _____

Age at first conviction _____

Convictions prior to age of 18

Yes No

Current Diagnosis

Schizophrenia

Other Diagnosis

Schizo-affective Mania/bi-polar disorder Anxiety Disorder

Personality Disorder Please state type _____

Substance Use Depression Drug Induced Psychoses

Organic Disorder Please state _____

Other Please state _____

Secondary diagnosis _____

History of conduct disorder

Yes No

Age at first contact with psychiatric services _____

Second or subsequent admission to MSU during current sentence

Yes No

If yes, state number of admissions and lengths of stay (during current prison sentence)

Number of previous hospital orders made by the courts _____

Number of previous hospital admissions (including non-forensic) _____

History of self harm / attempted suicide

Yes No

Details: _____

Evidence in prison prior to admission

Yes No

Details: _____

Date of current admission - _____

Date of current discharge - (if appropriate) _____

Length of stay as inpatient (days) - _____

Psychiatric medication @ discharge:

Psychiatric medication if still detained

Name of link person:

Name of care-coordinator:

Responsible clinician:

Other contacts:

- 1.
- 2.
- 3.
- 4.

Level of security of place patient discharged from at actual time point of discharge :

Level of security of place patient discharged to:

Prison category discharged to _____

Name of prison:

Prison category admitted from _____

Name of prison:

Discharged to same prison

Yes No

Discharge address:

Section 117 (MHA) meeting

Roles of professionals present (list): _____

Patient present at S117 meeting

Yes No

Level of support/services planned _____

MEASURES

Scoring for the acquisitive and serious offending recidivism scales on the Medium Secure Recidivism Assessment Guide (MSRAG)

Items	Score
Acquisitive recidivism	
Number of prior offences	
0-4	-1
5-12	0
>13	+1
Any prior custodial sentences	
Yes	+1
No	-1
Acquisitive index offence*	
Yes	+1
No	0
Age at index offence	
≤24	+1
25-35	0
≥36	-1
Subject to a s.37/41 restricted order	
Yes	-1
No	+1
Admitted to MSU from a high secure hospital	
Yes	-1
No	+1
Serious offending recidivism	
Number of prior custody sentences	
0	-1
1-2	0
>2	+1
Number of prior serious offences*	
0	-1
1	0
≥2	+1
Acquisitive index offence*	
Yes	+1
No	-1
Age at index offence	
≤24	+1
25-35	0
≥36	-1
Subjected to a s.37/41 restricted hospital order	
Yes	-1
No	+1
Admitted to MSU from a high secure hospital	
Yes	-1
No	+1

Total Score =

+ 5 to total score = (final score 0-11)

*Acquisitive – theft, stealing, burglary, fraud

Serious - actual/threatened violence against the person, sexual offences, aggravated burglary, abduction, arson or weapons offences.

Structured Assessment of Protective Factors (SAPROF).

		Evidence	0/ 1/ 2
	Internal		
1	Above average intelligence		
2	Secure attachment in childhood		
3	Empathic		
4	Effective coping skills		
5	Self control		
	Motivational		
6	Stable work situation		
7	Structures leisure activities		
8	Stable financial management		
9	Motivation for treatment		
10	Positive attitude towards authority		
11	Positive life goals		
12	Motivated to use medication effectively		
	External		
13	Prosocial & supportive network		
14	Stable intimate relationship		
15	Professional care available		
16	Professionally supervised living situation		
17	External control present		

Total Score =

HCR-20 Coding Sheet

	HISTORICAL ITEMS EVIDENCE	0, 1, 2, X
H1. Previous violence A – Serious Problems with Violence as a Child, 1. B - Serious Problems with Violence as a Child, 11. C - Serious Problems with Violence as a Child or Adolescent. D - Serious Problems with Violence as an Adolescent. E - Serious Problems with Violence as an Adolescent or Adult. F - Serious Problems with Violence as an Adult.		
H2. Serious problems with other antisocial behaviour. A - Serious Problems with Other Antisocial Behaviour as a Child, 1. B - Serious Problems with Other Antisocial Behaviour as a Child, 11. C - Serious Problems with Other Antisocial Behaviour as a Child or Adolescent. D - Serious Problems with Other Antisocial Behaviour as an Adolescent. E - Serious Problems with Other Antisocial Behaviour as an Adolescent or Adult. F - Serious Problems with Other Antisocial Behaviour as an Adult.		
H3. Problems with Personal Relationships. A – Problems with Intimate Relationships. B – Problems with Other		



Relationships.		
H4. Problems with Employment.		
H5. Problems with Substance Use.		
H6. Major mental illness A – Psychotic Disorders. B – Major Mood Disorders. C – Disorders Primarily Affecting Intellect, Executive Functioning, or Social/ Interpersonal Functioning.		
H7. Personality Disorder.		
H8. Victimization and Traumatic Experiences. A – Victimization/ Trauma. B – Poor Parenting/ Caregiving.		
H9. Procriminal Attitudes.		
H10. Problems with Non-Compliance.		
H10 Total		

CLINICAL ITEMS		
C1. Problems with insight A - Problems with insight into Mental Disorder. B - Problems with insight into Violence Proneness and Risk Factors. C - Problems with insight into Need for Treatment.		
C2. Procriminal and Violent Attitudes and Ideation. A – Procriminal Attitudes. B – Violent Ideation or Intent.		
C3. Current Symptoms of Major Mental Illness. A – Current Symptoms of Psychotic Disorders (with episodes of acute positive symptoms, agitation, paranoia, or distress. B - Current Symptoms of Major Mood Disorders (characterized by		

manic episodes or major depression with psychotic episodes or suicidality). C – Current Symptoms of Disorders Primarily Affecting Intellect, Executive Functioning, or Social/ Interpersonal Functioning.		
C4. Instability		
C5. Problems with Compliance or Responsiveness. A – Problems with Compliance. B – Problems with Responsiveness.		
Clinical Total		
RISK MANAGEMENT ITEMS		
	IN	OUT
R1. Inadequate plans regarding Professional Services.		
R2. Inadequate plans regarding Living Situation.		
R3. Inadequate plans regarding Personal support.		
R4. Potential Problems with Treatment Compliance or Response. A – Problems with compliance. B – Problems with responsiveness.		
R5. Potential Problems with Stress and Coping.		
Risk Management Total		
Overall Total		



PCL:SV

INTERPERSONAL SUB-SCALE OF PCL:SV

	EVIDENCE	Score 0, 1, 2, X
1. Superficial		
2. Grandiose		
3. Deceitful		
4. Lacks remorse		
5. Lacks empathy		
6. Doesn't accept responsibility		
<i>Total - INTERPERSONAL SUBSCALE</i>		
	EVIDENCE	Score 0, 1, 2, x
7. Impulsive		
8. Poor behaviour controls		
9. Lacks goals		
10. Irresponsible		
11. Adolescent antisocial behaviour		

12. Adult antisocial behaviour		
<i>Total - SD SCALE</i>		
<i>Total on PCL:SV</i>		

Appendix F: Staff information sheet (Study 1)



The University of Manchester

The validation of new risk assessment instruments for use with patients discharged from medium secure services (VoRAMSS)

INFORMATION SHEET

Staff

Introduction

The VoRAMSS study is a project that examines the validity, reliability and practical utility of violence risk assessment tools for use in mental health services.

As part of the study, these tools are used to collect data about patients when they are discharged from the unit. Patients are then followed-up 12 months later. In the previous branch of the VoRAMSS study, we identified a higher number of patients returning to prison than had been expected. Almost 90% of these patients had originally been admitted to medium secure services from prison.

We are therefore now identifying new patients who are admitted to medium secure services from prison and conducting assessments when they are discharged, in the view to follow them up 12 months later. This will help us to achieve standardisation of our sample and to ensure that it is representative of the current admission and discharge trends in medium secure services.

What is the purpose of this study?

The protection of the public from violent and high-risk individuals is increasingly expected from healthcare professionals. This puts a burden on healthcare services and specialist mental health services to reduce risk. A relatively small yet significant number of incidents in the community involving people with mental illness have received considerable media attention and this has left an impression of the potential dangerousness to the public from individuals who have various forms of mental disorder. The risk of violence risk is highest in the community where it is more difficult to manage. Therefore, any new developments in risk assessments that focus on the community need to be tested.

Although research validating risk tools for those patients admitted to and discharged from medium secure services is extensive, less attention has been given to the application of these tools to, and the direct study of, those patients discharged to settings other than the community. In particular, studies which address patients who are discharged back to prison are few in comparison to the discharge to community literature. To date, investigation into the discharge pathways from medium secure services and comparison of patient outcomes has not been undertaken, with regards to risk assessment, assessment of projective factors, mental health outcome and the evaluation of post-discharge services for

1

this cohort. This research, therefore, will provide new insight into the outcomes of those patients discharged back to prison as compared to the community, whilst also assessing the practical utility of risk instruments and assessment of protective factors in these environments.

Previous risk assessment research has suffered from methodological problems, which have threatened the validity and reliability of the findings. To overcome these issues the VoRAMSS study adopts a "confidential inquiry" approach, this means that we will not be gaining consent or informing patients about this study.

The sample will include all patients released from all 33 Medium Secure Services in England and Wales over a 6 month period. These patients will have originally been admitted to medium secure services from prison.

Why have I been invited?

You have been invited to take part in this study because you cared for one of the patients released from the Medium Secure Services during their stay. To help us complete some of the risk assessments we need to interview staff to provide collateral information.

What will I have to do if I take part?

If you agree to take part in the study, I will interview you about a patient you have been working with. I will ask about their behaviour and any incidents they have been involved in. This information is used to help me score the Positive and Negative Syndrome Scale [PANSS], the Historical Clinical and Risk Management 20 items scale [HCR-20], the Structured Assessment of Protective Factors for violence risk [SAPROF] and the MacArthur Community Violence Instrument [MCVI]. You will need to allocate 30 minutes of your time for the telephone interview. Please note that we will not be gaining consent from or informing patients about this study.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part you do not have to give a reason and no pressure will be put on you to try and change your mind. You can change your mind about taking part at any time. If you decide not to take part, or withdraw at any stage, your professional role or prospects within this role will not be affected.

If I agree to take part what happens to the information?

All the information you give us will be confidential and used for the purposes of this study only. The information will be used in a way that will not allow you to be identified individually.

What will happen to the results of the research study?

2

It is hoped that the results of the study will be used to improve the assessment and management of risk for patients discharged from Medium Secure Services. Each of the 34 Medium Secure Services will be provided with a summary of the final report.

What if there is a problem?

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Coordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.

Harm

In the event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against The University of Manchester but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Who is organising and funding the research?

This study is funded by and is being carried out by the University of Manchester.

Who has reviewed the study?

The study has been reviewed by an NHS Ethics Committee, the Health Research Authority Confidentiality Advisory Group and local Trust Research Governance department.

Further information and contact details

If you have any concerns or other questions about this evaluation please contact Sarah Leonard (PhD researcher):
Email sarah.leonard-2@posgrad.manchester.ac.uk Telephone: 0161 306 8010

What do I do now?

Think about the information on this sheet and ask me about anything that you are not sure about. If you agree to take part, we will go ahead.

THANK YOU FOR READING THIS

Appendix G: Staff consent form (Study 1)



The University of Manchester

The validation of new risk assessment instruments for use with patients discharged from medium secure services (VoRAMSS)

CONSENT FORM

Name _____

Please initial in each box

1. I confirm that I have read and understood the attached information sheet and have had the opportunity to ask questions.
2. I understand that I can withdraw from the study at any time without having to give any reasons and that my professional role or prospects within this role will not be affected.
3. I understand that relevant sections of my data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research.
4. I give permission for these individuals to have access to this data.
5. I hereby give consent to be involved in this research project.

Name of Participant

Signature of Participant

Date

Name of Researcher

Signature of Researcher

Date

Appendix H: Baseline interview guide

Collateral Baseline Interview

Date of Telephone Interview:

Supporting Information

Collateral Code:

Location:

Patient Discharge Date:

Sample group

Community discharge Prison discharge

Name of person doing interview with:

- **Position**
- **Contact Phone number**

Introduction

Thank you for agreeing to talk to me over the telephone [**Reintroduce study**]

This research study is solely for research purposes. I am interviewing you today to ask about how [Patient] has been during their stay. I will not share anything that you say with [Patient].

The interview should take no longer than 30 minutes and it covers a variety of topics. I realise some of the questions I ask are difficult to answer and sometimes you won't even know the answer. That's OK. Please just answer as best and as honestly as you can. If you have any questions at any time feel free to interrupt.

All information you provide will be strictly confidential. Your name will be removed so you will not be identified. Any information relating to [Patient] will have his/her name removed so they cannot be identified. No information can be released from the study except when this is absolutely necessary to protect [Patient] or others from imminent harm.

Before I begin is there anything you would like to ask?

SECTION 1 – GENERAL INFORMATION

1.1 What is your relationship to [participant]?

1.2 How long have you known [participant]?

1.3 How often have you seen or had contact with [Patient]?

Name of care-coordinator upon discharge –

Responsible clinician –

Other contacts:

What type of place has the participant been discharged to?

Discharge address: _____

Contact telephone numbers:

SECTION 2 - PROTECTIVE FACTORS

<i>DESCRIPTION</i>	<i>EVIDENCE</i>	<i>SCORE</i>
<p>1 Does the patient have above average intelligence/average intelligence or below average intelligence?</p> <p><i>Would you say their above average?</i></p>		
<p>2 Was secure attachment in childhood present/ partially present or not present?</p> <p><i>Attachment with one pro-social adult who is a good influence?</i></p>		
<p>Answer subsequent questions based on knowledge of patient over the past 6 months.</p> <p>clearly present = 2, partially present = 1 not present = 0</p>		
<p>3 Empathy?</p> <p><i>With others/potential victims?</i></p> <p><i>Considers how their behaviour will impact others?</i></p> <p><i>Seems to care about others?</i></p>		
<p>4 Effective coping skills?</p> <p><i>Do they act in a problem solving manner?</i></p>		
<p>5 Self control?</p> <p><i>Self-discipline/perseverance/ability to remain calm?</i></p>		
<p>Motivational</p>		
<p>6 Stable and suitable work situation?</p>		

7	Structures leisure activities?		
8	Steady income and sound financial management?		
	<i>Do they impulsively spend?</i>		
	<i>Able to save?</i>		
9	Motivation for treatment?		
	<i>You said they are taking meds – would you say they are motivated to take these?</i>		
	<i>Do they realise the treatment is necessary? Are they motivated to change their behaviour and be open and co-operative?</i>		
10	Positive attitude towards authority?		
	<i>Is individual able to stick to agreements/ rules?</i>		
11	Positive life goals?		
	<i>What goals do they have? What effort do they put in? How positive are the goals?</i>		
12	Motivated to use medication effectively?		
<p>External</p>			
13	Pro-sodal & supportive network?		
	<i>(this question is not referring to intimate relationships).</i>		
	<i>Family and friends? Good influence? A role model?</i>		

14	Stable intimate relationship?		
PROSPECTIVE ITEMS			
15	Professional care? <i>Contact with other professionals? How often?</i>		
16	Professionally supervised living situation?		
17	External controls clearly present <i>(i.e. permanent clinical control), partially present (e.g. supervision is carried out by the probation service and/or by an outpatient/ community facility), not present (e.g. no supervision)?</i> <i>CTO / section / depot injection / probation order / involvement of teams.</i>		

SECTION 3 - RISK FACTORS

Answer subsequent questions based on knowledge of patient **over the past 6 months**, for each item state if it is **clearly present, partially present or not present?** If clearly present then I will ask if it is **extreme**

CLINICAL ITEMS		
DESCRIPTION	EVIDENCE	CODE <i>clearly present = 2, partially present = 1 not present = 0</i>
C1 Lack of insight Problems of insight into having a mental disorder? Problems of insight into violence proneness & risk factors? Problems of insight into need for treatment?		
C2 Pro criminal & violent attitudes & ideation Pro-criminal attitudes? <i>Minimising / justifying offending</i> Violent ideation or intent?		
C3 Active symptoms of mental illness Current symptoms of psychotic disorders? Current symptoms of major mood disorders? Current symptoms of disorders primarily affecting intellect/ executive functioning/ social functioning?		
C4 Instability Signs of impulsivity (fluctuations in mood/general demeanor or inability to remain composed and directed when under pressure to act)?		

C5	Problems with compliance or response Problems with compliance? Problems with responsiveness?		
RISK MANAGEMENT ITEMS			
	DESCRIPTION	EVIDENCE	CODE <i>clearly present = 2, partially present = 1 not present = 0</i>
R1	Inadequate plans regarding professional services <i>Will the same level of contact continue? Are they engaging in appropriate services?</i>		
R2	Inadequate plans regarding living situation <i>Risk factors / destabilizers (people / substances / gambling) Future – e.g. move to independent living / off section or CTO</i>		
R3	Inadequate plans regarding personal support <i>Support network has insight? Links to care team? Quality of support and subjects interpretation of it?</i>		
R4	Potential problems with treatment compliance or response	<i>Consider responses so far re: engagement/medication</i>	

R5	Potential problems with stress and coping <i>Effective coping skills shown? Destabilizers?</i>		
-----------	--	--	--

PCL:SV

For this section we are considering psychopathy and aspects of a person's personality. For this section there is no specific time period to focus on as personality is a stable construct and should remain the same. It is important, however, to exclude any psychotic symptoms in answering these questions, as the focus is on personality traits. e.g. We will be asking about grandiosity and some people are grandiose or have grandiose delusions when they are psychotic but this type of grandiosity should not be included here.

Superficial

1. Would you describe their interactions with others as shallow or insincere?
2. Do they tell stories that portray them in a good light?
3. Do they make unlikely excuses for their behaviour?
4. Have they repeatedly changed their account if challenged by a contradictory fact?

Score overall: 0 1 2

Grandiose

5. Do they have an inflated view of themselves?
6. Are they self-assured and opinionated?
7. Do they attribute their hospitalisation or imprisonment to external forces, e.g. bad luck or the system?
8. Do they seem unconcerned about the future?

Score overall: 0 1 2

Deceitful

9. Do they seem to enjoy lying to or misleading others to benefit themselves?
10. Are they a confident liar, seeming very calm even when challenged with facts?

Score overall: 0 1 2

Lacks Remorse

11. Do they seem to lack guilt or have no conscience regarding their harmful behaviour?
12. Do they express regret for such a behaviour but seem insincere?
13. Do they focus on the suffering caused to them more than on any harm caused to others?
14. Do they display little emotion at all about any harm they may have caused to others?

Score overall: 0 1 2

Lacks Empathy

- 15. Are they able to understand the impact of their actions on others' emotions?
- 16. Have they demonstrated compassion towards others?
- 17. Do their emotional expressions to others seem shallow or insincere?

Score overall: 0 1 2

Doesn't Accept Responsibility

- 18. Do they blame others for their harmful behaviour?
- 19. Have they tried to trivialise or play-down the consequences of their harmful behaviour?
- 20. Do they deny their harmful behaviour/past offending altogether?

Score overall: 0 1 2

Impulsive

- 21. Do they often act without thinking ahead about the possible consequences?
- 22. Are they easily bored or do they have a short attention span?
- 23. Have they lacked stability in relationships, employment and accommodation?

Score overall: 0 1 2

Poor Behavioural Controls

- 24. Are they easily angered or frustrated?
- 25. Do they have sudden and unprovoked outbursts of verbal and/or physical abuse to others?

Score overall: 0 1 2

Lacks Goals

- 26. Do they seem to live "day-to-day", not really making long-term plans for the future?
- 27. Do they have unrealistic goals and plans?
- 28. Have they happily relied excessively on others or social assistance for financial support?

Score overall: 0 1 2

Irresponsible

- 29. Are they a reckless or careless individual who frequently puts others at risk?
- 30. Have they been unreliable as a parent, partner or at work as an employee?
- 31. Have they been reckless with money – e.g. had lots of debts or not paid bills?

Score overall: 0 1 2

Adolescent Antisocial Behaviour?

- 32. Were they frequently in trouble with the law as a youth?
- 33. Did they have serious conduct problems at home, in school or in the community?

Score overall: 0 1 2

Adult Antisocial Behaviour

- 34. Do they frequently violate rules and regulations?
- 35. Have they had lots of criminal charges or convictions as an adult?
- 36. Do they persistently behave inappropriately or in a way that causes annoyance and disapproval in others?

Score overall: 0 1 2

Any other comments: Is there anything else we should know in order to rate this person's future violence risk as accurately as possible?

Thank you for your time and patience

Appendix I: Link person professional role

Table A1. Link person professional role

NHS Trust	Medium secure unit	Link Person role
Abertawe Bro Morgannwg University NHS Trust	Caswell Clinic	Clinical Studies Manager
Avon and Wiltshire Mental Health Partnership NHS Trust	Fromeside Clinic	Medical Records Coordinator
Barnet, Enfield & Haringey Mental Health NHS Trust	Camlet Lodge	Administration Team Leader
Besti Cadwaladr University Health Board	Ty Llywelyn	Medical Secretary
Birmingham and Solihull Mental Health NHS Foundation Trust	Ardenleigh	Clinical Studies Officer
	Reaside Clinic	Clinical Studies Officer
	The Tamerind Centre	Clinical Studies Officer
Devon Partnership NHS Trust	Butler Clinic	Business Support
East London Foundation NHS Trust	John Howard Centre	Medical Records Assistant
Greater Manchester West Mental Health NHS Foundation Trust	The Edenfield Centre	Performance Manager
Humber Mental Health Teaching NHS Trust	The Humber Centre	Medical Secretary
	Green Trees	Medical Secretary
Kent and Medway NHS and Social Care Partnership Trust	Trevor Gibbens Unit	Assistant Psychologist
Lancashire Care NHS Trust	Guild Lodge	Flow and Capacity Manager
Mersey Care NHS Trust	Scott Clinic	Nurse Consultant
Norfolk and Suffolk Foundation Trust	Norvic Clinic	Consultant Psychiatrist
Northumberland Tyne & Wear NHS Trust	Bamburgh/Oswin Clinic	Medical Secretary
Nottinghamshire Healthcare Trust	Arnold Lodge	Mental Health Law Administrator

	Wathwood Hospital RSU	Clinical Nurse Specialist
Oxford Health NHS Foundation Trust	Oxford Clinic	Senior Clinical Research Fellow
	Marlborough Clinic	Senior Clinical Research Fellow
Oxleas NHS Foundation Trust	Bracton Centre	Clinical Studies Officer
South Essex Partnership University NHS Foundation Trust	Brockfield House	Clinical Nurse Specialist
South London and Maudsley NHS Foundation Trust	Bridge House	Clinical Studies Officer
	River House	Clinical Studies Officer
South Staffordshire and Shropshire Healthcare NHS Trust	The Hatherton Centre	Administration Manager
South West London and St George's Mental Health NHS Trust	Shaftesbury Clinic	Clinical Studies officer
South West Yorkshire Mental Health NHS Trust	Newton Lodge	Clinical Studies officer
Southern Health NHS Foundation Trust	Ravenswood House	Performance Lead
Sussex Partnership NHS Foundation Trust	The Hellingly Centre	Administration Team Coordinator
Tees Esk and Wear Valleys NHS Trust	Roseberry Park	Consultant Forensic Psychiatric
West London Mental Health NHS Trust	Orchard	Referral Administrator
	Three Bridges	Referral Administrator

Appendix J: Staff information sheet (Study 2a)

The University of Manchester

The validation of new risk assessment instruments for use with patients discharged from medium secure services (VoRAMSS)

INFORMATION SHEET

Staff

Introduction

The VoRAMSS study is a project that examines the validity, reliability and practical utility of violence risk assessment tools for use in mental health services, whilst also investigating the clinical pathways in and out of medium secure care.

As part of the study, we wish to conduct qualitative interviews with clinicians who are involved in the decision making and transfer of prisoner-patients from medium secure services.

What is the purpose of this study?

Discharge from medium secure services represents a significant event for patients in their care pathway. Understanding the clinical contexts and circumstances influencing who leaves medium secure services, what factors influence discharge destination and what happens to patients once they move on is important to ensure that the needs of patients are met post-discharge.

Whilst research involving the follow-up of patients discharged from medium secure services is quite extensive, less attention has been given to the follow-up and direct study of those patients discharged to settings other than the community, particularly those prisoner-patients who are remitted back to prison.

Preliminary findings from the main VoRAMSS project have identified some key differences between specific subgroups of prisoner-patients at time of discharge. Of particular interest are the differences between those prisoner-patients remitted back to prison and those discharged into the community. For example, those remitted back to prison had a significantly shorter length of stay than the community discharges.

In this context, the current project seeks to better understand these apparent differences by drawing on the experiences of clinicians who make decisions and arrangements for the discharge/transfer of prisoner-patients, in particular, experiences of remitting patients back to prison from medium secure services.

It is the hope that this research will add substantially to the project initial findings and help to embed the observational data in clinical context, whilst also bringing to light experience of the hospital-prison care pathway from the clinical team perspective.

* For the purpose of this study, a prisoner-patient is defined as a patient admitted to medium secure services directly from prison.

Why have I been invited?

You have been invited to take part in this study because you have been involved in the care and management of prisoner-patients discharged from medium secure services.

What will I have to do if I take part?

If you agree to take part in the study, I will interview you about your experiences of managing the transfer of prisoner-patients back to prison or into the community. Prior to the meeting you will be given the opportunity to discuss the nature of the project, this information sheet and your role in the project. If you are happy to continue to participate you will be asked to sign a consent form.

Interviews will take place in person, in a venue convenient for you. The interviews will follow a loose interview schedule to support the flow of the interview but will not be relied upon extensively, and will be audio-recorded to aid future analysis.

Audio recording can be stopped at any time and words deleted or replaced. Audio recordings will be transcribed in such a way that individual participants become anonymous. Quotations from these meetings may be presented, anonymously, in publications relating to the project.

You will need to allocate 40-50 minutes of your time for the interview.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part you do not have to give a reason and no pressure will be put on you to try and change your mind. You can change your mind about taking part at any time. If you decide not to take part, or withdraw at any stage, your professional role or prospects within this role will not be affected.

If I agree to take part what happens to the information?

All the information you give us will be confidential and used for the purposes of this study only. The information will be used in a way that will not allow you to be identified individually.

What will happen to the results of the research study?

It is hoped that the results of the study will be used to improve the assessment and management of risk for patients discharged from Medium Secure Services. Each of the 33 Medium Secure Services will be provided with a summary of the final report.

What if there is a problem?

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Coordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.

Harm

In the event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against The University of Manchester but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Who is organising and funding the research?

This study is funded by and is being carried out by the University of Manchester.

Who has reviewed the study?

The study has been reviewed by an NHS Ethics Committee, the Health Research Authority Confidentiality Advisory Group and local Trust Research Governance department.

Further information and contact details

If you have any concerns or other questions about this evaluation please contact:

Sarah Leonard (Doctoral researcher):

Email sarah.leonard-2@posgrad.manchester.ac.uk Telephone: 0161 306 8010

What do I do now?

Think about the information on this sheet and ask me about anything that you are not sure about. If you agree to take part, we will go ahead.

THANK YOU FOR READING THIS

Appendix K: Staff consent form (Study 2a)



The University of Manchester

the validation of new risk assessment instruments for use with patients discharged from medium secure services (VoRAMSS)

CONSENT FORM

Staff focus group

Name _____

Please initial in each box

- | | | |
|----|--|--------------------------|
| 1. | I confirm that I have read and understood the attached information sheet and have had the opportunity to ask questions. | <input type="checkbox"/> |
| 2. | I understand that I can withdraw from the study at any time without having to give any reasons and that my professional role or prospects within this role will not be affected. | <input type="checkbox"/> |
| 3. | I understand that relevant sections of my data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. | <input type="checkbox"/> |
| 4. | I give permission for these individuals to have access to this data. | <input type="checkbox"/> |
| 5. | I understand that any focus groups in which I participate will be audio recorded and consent to this recording. | <input type="checkbox"/> |
| 6. | I understand that anonymous brief quotes from these focus groups may be used in publications associated with this project. | <input type="checkbox"/> |
| 7. | I hereby give consent to be involved in the focus group and for the focus group information to be used in representations of research findings; with any restrictions that I have set in place. | <input type="checkbox"/> |

_____ Name of Participant	_____ Signature of Participant	_____ Date
_____ Name of Researcher	_____ Signature of Researcher	_____ Date

Appendix: L Focus group interview guide

The University of Manchester

VoRAMSS project - staff focus group topic guide

Introduction

- Thank you for agreeing to take part
- Explanation of research and details of participation
 - Voluntary (can withdraw at any time)
 - Confidential
 - Audio-recording of data and data protection
 - Length of focus group
- Gain verbal consent
- Questions?

Health professional background

Can you introduce yourself, where you work and describe your professional role?

Prompts

- Current roles
- How long worked in secure services
- Working patterns
- Responsibilities in secure services
- Areas of special interest
- Involvement in research

Current management of prisoner patients: service provision

Can you tell me about your experiences of working with prisoner-patients in secure services? (Define prisoner-patient if necessary)

Prompts

- Managing mental health problems
- What types of mental health problems
- Impact of CJS status
- Challenges? Areas which work well? Areas that don't?

Experiences of prisoner-patient discharge

What is your experience of discharging prisoner-patients?

Prompts

- Explain the process
- Specific examples – recent experiences
- Factors that influence discharge from services
 - Engagement and compliance
 - Clinical outcome
 - Rehabilitation
 - Bed availability
- Factors that determine discharge destination
 - Engagement and compliance
 - Risk factors
 - Diagnosis
 - Court orders/sentence/tariff/PP sentences

- Criteria applied to community vs. prison – CJS status
 - Risk

What do you see as the challenges associated with discharge of prisoner-patients into the community?

What do you see as the challenges associated with remitting prisoner-patients back to prison?

Attitudes to prisoner-patient discharge pathways

Can you describe your views on the discharge pathways available to prisoner-patients?

Prompts

- How do you think discharge destination impacts on patient care?
- What types of patient do you think it will impact?
- Experiences and examples of remitting patients back to prison
 - Mental health needs met?
 - Prisoner relapse?
 - Follow-up conducted?
 - Evidence of outcomes?
- CJS procedures - court decisions
- Follow-up of patients remitted back to prison
 - Conducted by inreach/local services?
 - Adequate follow-up? – engagement?
- Differences between remand and sentenced prisoners
 - Criminal and policy decisions vs. clinical decisions
- What works well? What doesn't work well?

Key messages

Ask each participant (round robin)

- What ONE thing could improve the transfer and remission of prisoner patients?
- Say ONE thing (good or bad) about your view of the care pathways available to prisoner-patients

Appendix: M Staff Information sheet (Study 2b)

The University of Manchester

The validation of new risk assessment instruments for use with patients discharged from medium secure services (VoRAMSS)

INFORMATION SHEET

Staff

Introduction

The VoRAMSS study is a project that examines the validity, reliability and practical utility of violence risk assessment tools for use in mental health services, whilst also investigating the clinical pathways in and out of medium secure care.

As part of the study, we wish to conduct qualitative interviews with clinicians who are involved in the decision making and transfer of prisoner-patients from medium secure services.

What is the purpose of this study?

Discharge from medium secure services represents a significant event for patients in their care pathway. Understanding the clinical contexts and circumstances influencing who leaves medium secure services, what factors influence discharge destination and what happens to patients once they move on is important to ensure that the needs of patients are met post-discharge.

Whilst research involving the follow-up of patients discharged from medium secure services is quite extensive, less attention has been given to the follow-up and direct study of those patients discharged to settings other than the community, particularly those prisoner-patients who are remitted back to prison.

Preliminary findings from the main VoRAMSS project have identified some key differences between specific subgroups of prisoner-patients at time of discharge. Of particular interest are the differences between those prisoner-patients remitted back to prison and those discharged into the community. For example, those remitted back to prison had a significantly shorter length of stay than the community discharges.

In this context, the current project seeks to better understand these apparent differences by drawing on the experiences of clinicians who make decisions and arrangements for the discharge/transfer of prisoner-patients, in particular, experiences of remitting patients back to prison from medium secure services.

It is the hope that this research will add substantially to the project initial findings and help to embed the observational data in clinical context, whilst also bringing to light experience of the hospital-prison care pathway from the clinical team perspective.

* For the purpose of this study, a prisoner-patient is defined as a patient admitted to medium secure services directly from prison.

Why have I been invited?

You have been invited to take part in this study because you have been involved in the care and management of prisoner-patients discharged from medium secure services.

What will I have to do if I take part?

If you agree to take part in the study, I will interview you about your experiences of managing the transfer of prisoner-patients back to prison or into the community. Prior to the meeting you will be given the opportunity to discuss the nature of the project, this information sheet and your role in the project. If you are happy to continue to participate you will be asked to sign a consent form.

Interviews will take place in person, in a venue convenient for you. The interviews will follow a loose interview schedule to support the flow of the interview but will not be relied upon extensively, and will be audio-recorded to aid future analysis.

Audio recording can be stopped at any time and words deleted or replaced. Audio recordings will be transcribed in such a way that individual participants become anonymous. Quotations from these meetings may be presented, anonymously, in publications relating to the project.

You will need to allocate 40-50 minutes of your time for the interview.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part you do not have to give a reason and no pressure will be put on you to try and change your mind. You can change your mind about taking part at any time. If you decide not to take part, or withdraw at any stage, your professional role or prospects within this role will not be affected.

If I agree to take part what happens to the information?

All the information you give us will be confidential and used for the purposes of this study only. The information will be used in a way that will not allow you to be identified individually.

What will happen to the results of the research study?

It is hoped that the results of the study will be used to improve the assessment and management of risk for patients discharged from Medium Secure Services. Each of the 33 Medium Secure Services will be provided with a summary of the final report.

What if there is a problem?

Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Coordinator on 0161 2757583 or 0161 2758093 or by email to research-governance@manchester.ac.uk.

Harm

In the event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against The University of Manchester but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Who is organising and funding the research?

This study is funded by and is being carried out by the University of Manchester.

Who has reviewed the study?

The study has been reviewed by an NHS Ethics Committee, the Health Research Authority Confidentiality Advisory Group and local Trust Research Governance department.

Further information and contact details

If you have any concerns or other questions about this evaluation please contact:

Sarah Leonard (Doctoral researcher):
Email sarah.leonard-2@posgrad.manchester.ac.uk Telephone: 0161 306 8010

What do I do now?

Think about the information on this sheet and ask me about anything that you are not sure about. If you agree to take part, we will go ahead.

THANK YOU FOR READING THIS

Appendix: N Staff consent form (Study 2b)



The University of Manchester

The validation of new risk assessment instruments for use with patients discharged from medium secure services (VoRAMSS)

CONSENT FORM

Staff individual interview

Name _____

Please initial in each box

1. I confirm that I have read and understood the attached information sheet and have had the opportunity to ask questions.
2. I understand that I can withdraw from the study at any time without having to give any reasons and that my professional role or prospects within this role will not be affected.
3. I understand that relevant sections of my data collected during the study may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research.
4. I give permission for these individuals to have access to this data.
5. I understand that any focus groups in which I participate will be audio recorded and consent to this recording.
6. I understand that anonymous brief quotes from these focus groups may be used in publications associated with this project.
7. I hereby give consent to be involved in the focus group and for the focus group information to be used in representations of research findings; with any restrictions that I have set in place.

Name of Participant Signature of Participant Date

Name of Researcher Signature of Researcher Date

Appendix: O Staff interview guide (Study 2b)

The University of Manchester

VoRAMSS project - staff individual interview topic guide

Introduction

- Thank you for agreeing to take part
- Explanation of research
- Details of participation
 - Voluntary (can withdraw at any time)
 - Confidential
 - Audio-recording of data and data protection
 - Length of interview
- Gain verbal consent
- Questions?

Roles and responsibilities

Can you describe your professional role?

Prompts

- Current roles
- How long worked in secure services
- Working patterns
- Responsibilities in secure services
- Areas of special interest
- Involvement in research

Prisoner-patients in secure services

Can you tell me about your experiences of working with prisoner-patients in secure services? (Define prisoner-patient if necessary)

Prompts

- Managing mental health problems
- What types of mental health problems
- Impact of CJS status
- Challenges? Areas which work well? Areas that don't?

Experiences of prisoner-patient discharge

What is your experience of discharging prisoner-patients?

Prompts

- Explain the process
- Specific examples – recent experiences
- Factors that influence discharge from services
- Factors that determine discharge destination
- Criteria applied to community vs. prison – CJS status
- How or if destination changes practice
- Impact or changes to the care for the patients
- Positive / negative aspects of service provided
- How could it be improved?

1

What do you see as the challenges associated with discharge of prisoner-patients into the community?

What do you see as the challenges associated with remitting prisoner-patients back to prison?

Attitudes to prisoner-patient discharge pathways

Can you describe your views on the discharge pathways available to prisoner-patients?

Prompts

- How do you think discharge destination impacts on patient care?
- What types of patient do you think it will impact?
- Experiences and examples of remitting patients back to prison
- CJS procedures - court decisions
- Follow-up of patients remitted back to prison
- Differences between remand and sentenced prisoners
 - o Criminal and policy decisions vs. clinical decisions
- What works well? What doesn't work well?

2

Appendix P: Follow-up data collection proforma

Prison Discharges

Project ID: _____

Site: _____

Date of discharge _____

Residency at discharge

Prison Name _____

Same prison as at discharge Yes No

Residency at Follow-up

Prison Name _____

Number of prison transfers during follow-up: _____

Details (dates): _____

Community (if community, complete community based questions in community discharge proforma)

Supported living Own home Family home Hostel

Other

Evidence of mental health discharge planning Yes No

Details: _____

Evidence of liaison with CMHT: Yes No

Details: _____

Hospital Name _____

Acute MSU Other

Section MHA (if applicable) _____

Treatment

MHIR on prison reception

Yes No

Date of 1st MHIR contact _____

Prison services at discharge from MSU

MH inreach PMHT Other

Name: _____

Still under same services

Yes No

If no, date of discharge from service: _____

Reason no longer under services

Discharged Disengaged Lost to follow-up

Moved prison Name: _____

In hospital In the community Other

Prison services at follow-up

MH inreach PMHT Other

Name: _____

ACCT at follow-up

Yes No

Date started: _____

Number of times on ACCT during follow-up: _____

Details (dates): _____

Time spent on healthcare wing during follow-up

Yes No number _____

Details (dates): _____

Enhanced cell observations during follow-up

Yes No number _____

Details (dates): _____

Time spent in segregation during follow-up

Yes No number _____

Details (dates): _____

Adjudications during follow-up

Yes No number _____

Details (dates): _____

Professionals involved at follow-up

RC/psych Frequency _____

CPN Frequency _____

Social Worker Frequency _____

Psychologist Frequency _____

Support worker Frequency _____

Drug worker Frequency _____

Other Frequency _____

Treatment received

Medication _____

Current _____

Previous _____

Therapies Details _____

Drug programme Details _____

Support groups Details _____

Other Details _____

Clinical characterises

Current diagnosis Name: _____

New diagnosis Name: _____

- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| DSH during follow up | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| DSH 1 st 6 months | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| DSH last 6 months | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Suicide attempt during follow up | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Suicide attempt 1 st 6 months | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Suicide attempt last 6 months | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Drug use in the last 1 st 6ms | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Drug use in last 6 months | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Alcohol use in first 6 m's | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Alcohol use in last 6 m's | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Hospital admissions in first 6 m's | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Hospital admission in last 6 m's | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Criminal variable

Violence during follow-up Yes No

Measure using the Macarthur Community violence scale on standardised measures proforma

Offending during follow-up Yes No

Details of offences in including convictions (If application)

Appendix Q: Deviations from normality

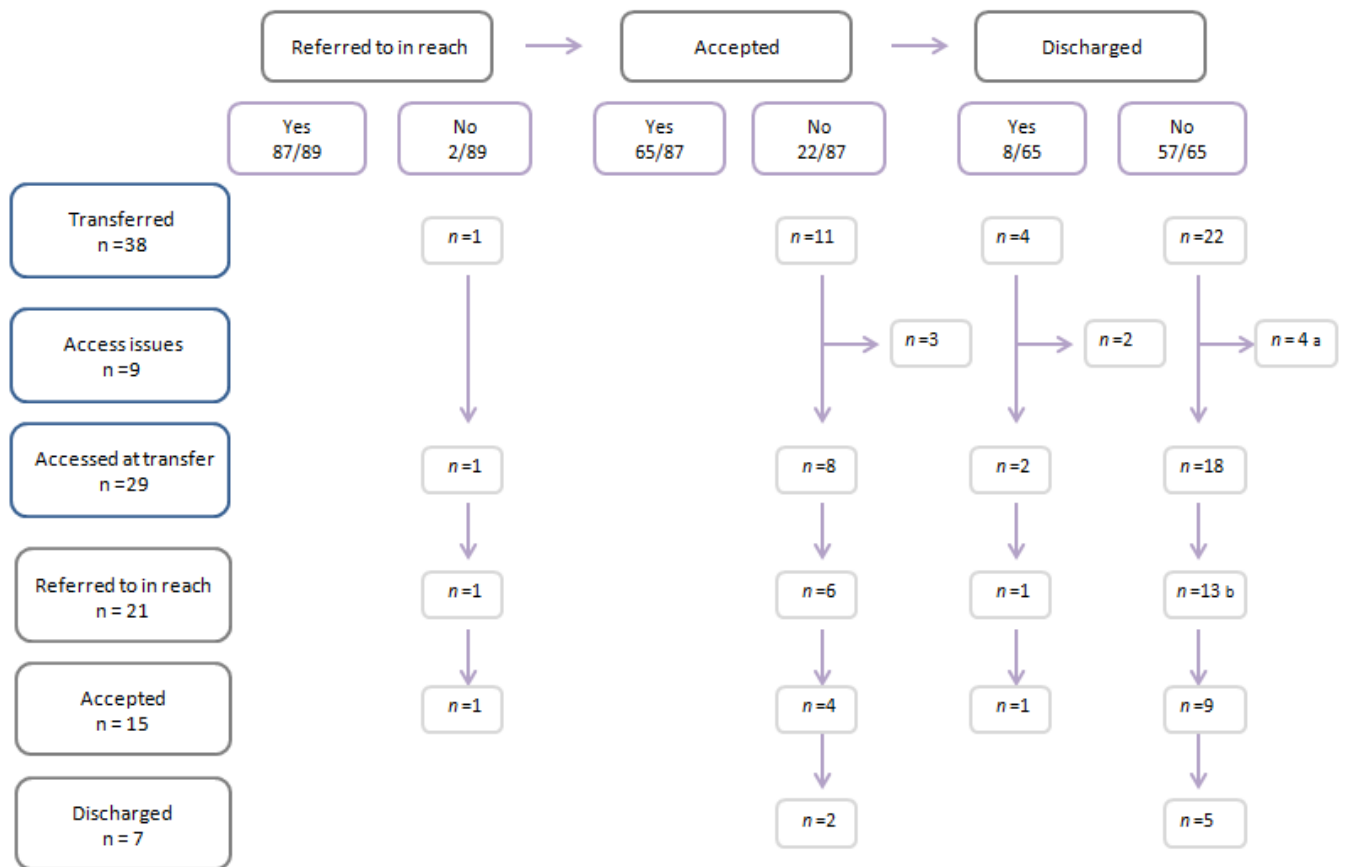
Table A2. Shapiro-Wilk test of normality for variables across community discharges and prison remissions

	Community <i>D (df)</i>	<i>p</i>	Prison <i>D (df)</i>	<i>p</i>
Length of stay	.876 (43)	<.001	.718 (80)	<.001
Age at baseline	.887 (43)	<.001	.952 (80)	.004
Age at admission	.952 (43)	.002	.948 (80)	.003
Severity of Index Offence	.907 (43)	.002	.928 (80)	<.001
Age at index offence	.726 (43)	<.001	.766 (80)	<.001
N previous convictions	.544 (43)	<.001	.862 (80)	<.001
N previous sentences	.524 (43)	<.001	.608 (80)	<.001
Age at first conviction	.836 (43)	<.001	.348 (80)	<.001
Age at 1 st contact psych	.948 (43)	<.051	.928 (80)	<.001
N previous hosp admissions	.589 (43)	<.001	.635 (80)	<.001

Table A3. Shapiro-Wilk test of normality for assessment scores across community discharges and prison remissions

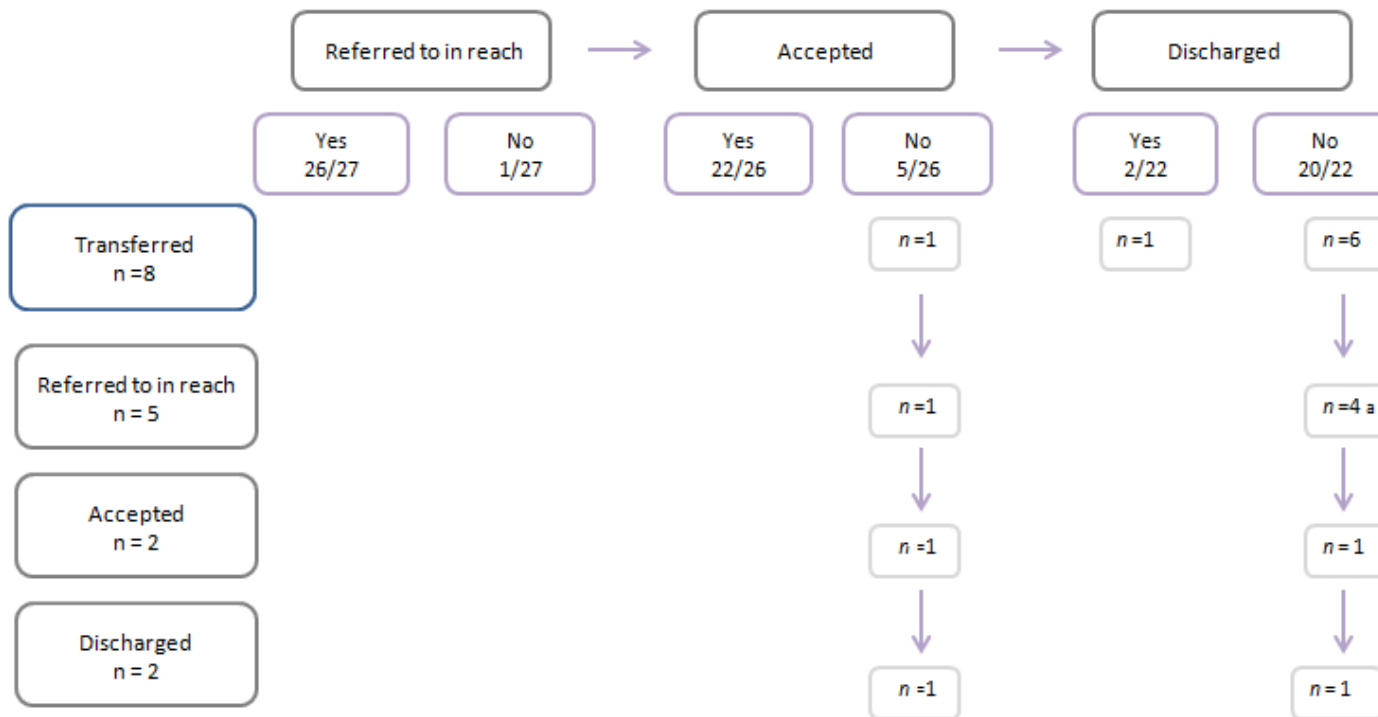
	Community <i>D (df)</i>	<i>P</i>	Prison <i>D (df)</i>	<i>P</i>
Historical clinical-risk Management 20, version 3				
<i>Historical</i>	.935 (49)	.010	.956 (92)	.004
<i>Clinical</i>	.862 (49)	<.001	.941 (92)	<.001
<i>Risk</i>	.3948 (49)	.031	.955 (92)	.003
<i>Total</i>	.983 (49)	.708	.957 (92)	.004
Structured assessment of protective factors for violence risk				
<i>Internal</i>	.919 (49)	.002	.946 (92)	.001
<i>Motivational</i>	.927 (49)	.005	.931 (92)	.006
<i>External</i>	.895 (49)	<.001	.895 (92)	<.001
<i>Total</i>	.956 (49)	.063	.965 (92)	.013
Medium security recidivism assessment guide				
<i>Acquisitive</i>	.968 (49)	.193	.929 (92)	<.001
<i>Serious</i>	.970 (49)	.232	.943 (92)	<.001
<i>Total</i>	.978 (49)	.469	.953 (92)	.002
Psychopathy checklist revised, screening version				
<i>Interpersonal</i>	.807 (45)	<.001	.931 (86)	<.001
<i>Social Deviance</i>	.961 (45)	.135	.887 (86)	<.001
<i>Total</i>	.962 (45)	.145	.962 (86)	.013

Appendix R: Figure A1 Access to MHIR services throughout one year follow-up



a 4 of those who were lost to follow-up at transfer had been referred to MHIR by their remittal MHIR team
 b 8 had been referred to MHIR by their remittal MHIR team

Appendix S: Figure A2 Access to MHIR services throughout one year follow-up for prison releases



^a 3 had been referred to MHIR by their remittal MHIR team