Consultant Nurse Contribution to the Introduction of Matched Stepped-Care and Low Intensity Psychological Interventions in NHS Forth Valley Prison Mental Health Settings
1. Background

On 01 November 2011, the responsibility for prison health care services transferred to the NHS. This shift in responsibility was designed to ensure that prisoners have access to the same quality and range of health care services as the general population, and the same rights in relation to mental health care as other patients, in accordance with the Mental Health (Care & Treatment) (Scotland) Act, 2003 and the Equality Act, 2010. It was also designed to align Scotland with European and other international prisoner healthcare standards. Further, it was thought that this move to increase access and availability of health care services could assist in reducing reoffending rates by, for example, helping to equip those prisoners with identified mental health needs with effective coping skills to help them better manage stressful and potentially destabilising situations after their release from custody.

Whilst this transfer of care had significant implications for all health boards in Scotland, this was especially noteworthy for NHS Forth Valley, given that this health board is responsible for c.17% – 25% (1190 – 1750 prisoners) of the overall Scottish prison population’s healthcare needs at any given time (c. 7000 prisoners at December 2016, Scottish Prison Service).

In February 2012, the Forensic Network appointed a Consultant Nurse in Psychological Therapies. One key area of responsibility for this post-holder was to support the operationalisation and rollout of the matched stepped-care model of psychological service delivery, as outlined in The [Forensic] Matrix, across the forensic estate in Scotland, including, where appropriate, in prison mental health care settings. This involved a system of joint working between the School of Forensic Mental Health (SoFMH) (on behalf of the Forensic Network) and NHS Education for Scotland (NES). In July 2013, the consultant nurse was contacted by a senior member of NHS Forth Valley’s prison mental health care team to explore the possibility of gaining some support to assist them with their current and future psychological service provision. A series of consultation meetings were then arranged. During these initial meetings, it was speculated that the majority of prisoners’ mental health needs across all three NHS Forth Valley prisons (i.e. HMP Glenochil, HMYOI Polmont and HMP/YOI Cornton Vale) would be for ‘low intensity’ (LI) psychological therapies. These are brief interventions aimed at current distress or transient or mild mental health problems (e.g. anxiety, mood regulation, sleep problems, stress management, drug and alcohol problems). (This initial estimation of need was subsequently confirmed after a series of robust needs analyses were undertaken).

Following this consultation process, a rollout strategy was agreed. This strategy was underpinned by both the governance principles set out by the Forensic Matrix Implementation Group (FMIG), and by key principles related to implementation

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1 The matched stepped-care approach is a way of organizing services to ensure patients’ needs are appropriately met within service resources. Matched stepped-care should ensure that patients have access to the appropriate level and intensity of treatment required to meet their needs at a given time.


3 The Forensic Matrix Implementation Group (FMIG) was established by the Forensic Matrix Steering Group to help drive forward the agenda for the implementation of the Forensic Matrix and support service delivery across Scotland.
which were highlighted by NES. (For example, several questions related to NES’ guidance to support effective implementation of psychological services were asked of, and appropriately attended to, by prison health centre managers, prior to 
this work beginning. These are detailed in Section 4 below). Also, in support of the 
agreed rollout strategy the consultant nurse subsequently provided regular strategic 
and clinical input to this health board, at a rate of up to one day/week for a period of 
c. 30 months, i.e. until the provision of LI psychological services was fully established 
across all three NHS Forth Valley prisons.

This paper provides detail on the overall process involved in the provision of this 
temporary support and contribution to this service, and highlights the outcomes that 
were achieved as a result of this. It also includes conclusions and possible 
suggestions for the provision of future, similar support, to other prison mental health care services throughout the NHS in Scotland.

2. The [Forensic] Matrix and Matched Stepped-Care

In keeping with Scottish Government policy, psychological therapies should be 
delivered in accordance with guidance contained in Mental Health in Scotland: A 
Guide to Delivering Evidence-Based Psychological Therapies in Scotland – The 
Matrix (NHS Education for Scotland and the Scottish Government, 2011, updated 

Figure 1 below provides details of the different levels and intensities of the range of 
psychological interventions currently available in forensic mental health services in 
Scotland. In the past, specific professional groups such as psychologists and 
psychotherapists (from a variety of different core disciplines) would deliver most 
psychological interventions, but the growing evidence base that psychological 
interventions work for many mental health and problem behaviours has led to an 
increase in the number of patients requesting, or being referred for, these 
interventions. This increase in demand has grown much faster than the resources 
available to meet it. However, we also now know from clinical practice that many 
patients can achieve good outcomes from less resource-intensive, i.e. ‘low-intensity’ 
interventions that are delivered by professionals with a less specialised level of 
psychological training. This newer approach has the added benefit of ensuring 
services continue to provide appropriate and effective LI treatments, whilst enabling 
them to free up more specialist practitioners elsewhere in the service to provide 
‘high-intensity’, ‘specialist’ and ‘highly-specialist’ interventions to patients with more 
complex difficulties.

Given the potential to (relatively quickly) build capacity across the wider workforce to 
assist in the delivery of psychological interventions, the FMIG recommended that the 
development of LI treatment protocols and LI practitioners trained to deliver these, 
should therefore be identified as an initial priority area. Following this, the consultant 
nurse began working with colleagues in NES and in all forensic mental health

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4 Implementation science refers to “the study of methods to promote the integration of research findings and evidence into healthcare policy and practice”. (Ref https://www.fic.nih.gov/researchtopics/pages/implementationscience.aspx)
services in the NHS in Scotland, including NHS Forth Valley prison mental health services, to support the development and rollout of this initiative.

Figure 1. ‘The Matrix’ (2011)

3. Low Intensity Protocols and Practitioner Training

3.1 Low Intensity Protocols

Two LI treatment protocols were developed by the consultant nurse and colleagues from the FMIG. These are ‘transdiagnostic’ in nature in that they encompass underlying treatment needs related to various diagnoses, including: trauma (both complex trauma and post-traumatic stress disorder), personality difficulties/personality disorder, anxiety, depression, substance misuse and psychosis. The two protocols are:

(1) ‘On the Road to Recovery’. This currently comprises 2 modules*. Module 1: Awareness and Recovery which provides psychoeducational material designed to address the common underlying needs encountered by forensic patients, and Module 2: Looking after Yourself which has been designed to teach patients a myriad of coping skills to help them manage their presenting problems (e.g. drug and alcohol dependency, and to address the associated underlying treatment needs emanating from these - e.g. problems managing impulsivity and poor emotion regulation skills that may have led to them experiencing problems with drug and alcohol dependency in the first instance). (*Please note, a third module for this protocol, entitled ‘Making Healthy Changes’ is in the final stages of development. This module focuses
on other issues related to substance misuse and other unhealthy lifestyle choices, including substance misuse paralleling behaviours – e.g. switching from using illicit drugs to excessive caffeine and/or dietary intake - and difficulties with engagement and motivation).

(2) ‘Knowing Me’. This programme focuses on engagement with psychological treatment and life history work and provides an introduction to self-formulation.

At time of reporting the above protocols are also undergoing some further minor revisions by the consultant nurse and FMIG to increase their focus on the provision of trauma-informed care and their applicability in prison mental health care settings.

### 3.2 Low Intensity Practitioner Training

The consultant nurse and colleagues from the FMIG also developed a 5-day practical skills and competences based training package under the guidance of Professor Kate Davidson, Professor of Psychological Therapies, University of Glasgow, and former Chair of ‘The Matrix’ original development group. The development of this training package was also informed by other pre-existing LI practitioner training programmes, such as those developed in the NHS in England and Wales to support the establishment of ‘Psychological Wellbeing Practitioner’ (PWP) posts. These types of LI practitioner posts were introduced to help build capacity within mental health services to enable increased access to psychological services for patients in their area. This 5-day training programme is therefore fairly rigorous in nature and requires participants to pass both a written and skills-based assessment. The content of the training includes: underlying psychological concepts and principles, risk-needs-responsivity principles, cognitive behavioural therapy (CBT), engagement and ‘containment’ skills (including guidance in keeping with ‘safety and stabilisation’ - i.e. trauma-informed, training), group-work skills, use of distraction, focusing, distress-tolerance and self-soothing skills, relaxation techniques, behavioural activation, motivational interviewing and problem-solving skills.

To date a total of 270 (mainly nursing) staff have been trained across 10 major health boards in Scotland, with 10 out of these 10 health boards now having a small pool of LI practitioner training graduates who are currently delivering the protocols, to varying degrees, within their forensic services. This includes 20 nursing staff who were trained from across all three NHS Forth Valley prison mental health services. There are also forthcoming plans for the SoFMH and NES to deliver this training to the remaining 2 major health boards, thereby ensuring that both the LI protocols and the associated LI training package can potentially be accessed by all 13 NHS prison mental health care services in Scotland.

### 4. Rollout Strategy, Needs Analyses, Governance Arrangements and Building Infrastructure for Programme Sustainability

Professional consultancy and guidance was given to NHS Forth Valley prison mental health service staff to produce a strategic paper for consideration by their health
centr

e managers and their local Psychological Therapies Implementation Strategy Group. This paper highlighted a number of challenges and priorities and made specific recommendations to address these (see Section 5 below for further detail). In particular, it was recommended that a series of robust needs analyses should be conducted across all three prisons as a starting point for this work. These needs analyses were subsequently undertaken by a senior nurse in liaison with health centre colleagues, i.e. mental health nurses, visiting psychiatrists and GPs. The same recognised and validated assessment tool that was employed by the NHS Forth Valley Prison Addiction Clinical Psychology Service (Kreis et al, 2016) was used for this purpose. Appendix 1 details the outcomes of the needs analyses for HMP Glenochil and HMYOI Polmont. The needs analysis for HMP/YOI Cornton Vale is included in the aforementioned Prison Addiction Clinical Psychology Service’s paper. The results of all three analyses established that there was indeed a need for the provision of LI psychological interventions in each service.

The aforementioned strategic paper also recommended that the governance principles set out by the FMIG, and the implementation science principles set out by NES for the provision of psychological services, should be adopted (see also Section 1 above). In the case of the latter, to ensure effective implementation and produce desired outcomes, prior to the delivery of LI staff training, all health centre managers were asked, and appropriately addressed, the following questions:

1. Who will be responsible for the assessment of patients’ suitability for psychological interventions and how will this be assessed?
2. Who will be attending the LI training?
3. What are the clinical supervision arrangements for these LI trainees?
4. What are the plans for starting a LI group within your service, including capacity, when it will run and who will facilitate it?
5. Who will complete pre and post LI group evaluations?

Having achieved appropriate answers to all of the above, it was then agreed to run a series of pilot LI groups across all three prisons. This enabled us to explore in more depth the potential feasibility, acceptability and utility of running these programmes in these services. Also, in keeping with other NES implementation science guidelines, it was further agreed that the consultant nurse would continue to contribute to this delivery process by providing initial clinical supervision and consultancy to the all three prison mental health nursing teams, on a weekly basis. This particular strategy also created an opportunity for the existing senior nurse in the team (i.e. a Band 7, CBT nurse therapist), who worked across all three NHS Forth Valley prisons, to ‘shadow’ the consultant nurse when undertaking this supervisory role. This enabled the senior nurse to develop their pre-existing generic supervision competency skills to a level where they could undertake this role by themselves in the future. At this point the consultant nurse, in turn, received clinical supervision from one of the clinical psychologists attached to the [temporary] Prison Addiction Clinical Psychology Service, at a rate of one hour/month. (This arrangement not only ensured that there was appropriate supervision in place up to ‘highly specialist’ level,

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but it also ensured that there was an appropriate tie-in back to the overall NHS psychological service’s governance structure).

Over time the consultant nurse was then able to gradually withdraw from delivering clinical supervision to LI practitioners, i.e. as the senior nurse’s competences to assume full responsibility for this were attained. Having then moved away from the role of providing direct clinical supervision to the LI practitioners, the consultant nurse continued to provide further support – again in keeping with the NES guidance related to effective implementation of psychological therapies – by providing an additional period of coaching and modelling of the LI group interventions. This involved the consultant nurse participating in the direct delivery of the LI group programmes, again at a rate of up to one day/week. This enhanced and prolonged agreed supportive implementation strategy, thereby ensured that the mental health nursing care teams across all 3 prisons could successfully train their staff, pilot the interventions by running LI groups in their area, provide weekly supervision to all nursing staff involved in LI programme delivery and develop the clinical supervision skills of their senior nurse, whilst at all times working within agreed and robust NHS governance structures. Appendix 2 provides a brief timeline that sets out the detail of each of the above stages, i.e. from initial contact with the consultant nurse through to the establishment of LI interventions across all 3 prisons.

5. Challenges and Priorities

The strategic paper also acknowledged and considered a number of specific challenges and priorities for NHS Forth Valley in relation to the provision of psychological services in their prison mental health care settings. These are highlighted as follows:

1. **Closing gaps in relation to equity and access to mental health services.** In terms of LI psychological interventions, this included being able to provide a service similar to that which is currently available in primary health care settings, e.g. brief interventions for stress management. This was achieved by being able to give patients access to the same LI protocols that are used in other NHS [forensic] psychological services in Scotland.

2. **High level of complex and severe mental health needs.** It was anticipated, and later clarified through the needs analyses, that whilst many of the prisoners in these establishments would have LI needs, many would also have a number of concurrent higher intensity needs. This was important to acknowledge and to help ‘contextualise’ individual prisoners’ overall psychological needs.

3. **Criminogenic needs and risk.** As with the above, it was important to acknowledge that most prisoners would also have criminogenic and risk needs and that these will, at times, overlap with underlying psychological needs and should therefore be considered in relation to overall response to treatment.

4. **Fragmented service provision.** It was acknowledged that within prison settings, criminogenic and risk needs remain the responsibility of SPS. Thus, this continued ‘fragmentation’ of overall care provision presents a number of challenges specific to this population. This is something of an ongoing
dilemma that is currently being discussed and explored by, for example, the Advisory Committee for Psychological Therapies in Prisons commissioned by the former Director of Health and Justice (Scottish Government).

5. **Need to create a culture/climate for good psychological work.** Good psychological work requires the support of a positive and ‘therapeutic’ environment. When this is achieved, treatment responsivity can be significantly increased. However, it is acknowledged that in order to achieve such an environment within prisons, some work will be required to support the development of this type of climate and culture, e.g. by providing mental health awareness training to prison officers and other staff groups within each establishment.

6. **Cognisance of whole system in state of ‘flux’ at present.** Again, in relation to environment and context, it was important to acknowledge that the entire prison system in NHS Forth Valley was in a state of ‘flux’, particularly with regards to women’s services, e.g. plans for a new women’s prison had been shelved and replaced by the transfer of a large number of women prisoners to HMYOI Polmont in Autumn 2016. It was also important to acknowledge the massive resource constraints that existed across all three prisons.

7. **Alignment with NHS – especially governance structures.** Other challenges included the need to align prison mental health care delivery with other NHS/ NHS Forth Valley structures, especially governance structures. As before, this was achieved by ensuring that the rollout strategy adopted the governance principles set out by the FMIG.

8. **Informed by robust needs analyses.** In keeping with best practice guidelines and governance standards elsewhere in NHS Forth Valley, it was important to ensure that service provision was underpinned and significantly informed by robust needs analyses. This was achieved as outlined in Section 4 above.

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6. **Outcome Data and Summary of Potential Utility, Feasibility and Acceptability of Pilot LI Groups**

Some provisional outcome data, and a brief commentary on our findings in relation to this work is provided in Figures 2 and 3 and below.
Figure 2. Patient Demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>n = 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender, n (%)</td>
<td>11 (85%) male, 2 (15%) female</td>
</tr>
<tr>
<td>Age, years (mean, (s.d.), range)</td>
<td>26.5 (7.5); 19 – 45</td>
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<tr>
<td>Time in prison prior to group, months (mean, (s.d.), range)</td>
<td>24.5 (30.0); 5 - 120</td>
</tr>
<tr>
<td>Marital status:</td>
<td></td>
</tr>
<tr>
<td>Single, n (%)</td>
<td>12 (92%)</td>
</tr>
<tr>
<td>Married/cohabiting, n (%)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>Index Offence:</td>
<td></td>
</tr>
<tr>
<td>Murder</td>
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</tr>
<tr>
<td>Assault</td>
<td>6</td>
</tr>
<tr>
<td>Sexual assault/rape</td>
<td>4</td>
</tr>
<tr>
<td>Fireraising</td>
<td>1</td>
</tr>
<tr>
<td>Drug-related</td>
<td>1</td>
</tr>
<tr>
<td>Primary Diagnosis:</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>8</td>
</tr>
<tr>
<td>Depression</td>
<td>3</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1</td>
</tr>
<tr>
<td>PTSD</td>
<td>1</td>
</tr>
<tr>
<td>Previous mental health referral, n (%)</td>
<td>11 (85%) yes</td>
</tr>
</tbody>
</table>

Figure 3. Clinical Outcomes in Routine Evaluation (CORE) Scores

Potential *Utility* of Pilot LI Groups

The **CORE-OM 34** is a 34-item generic self-report measure of psychological distress comprising of 4 domains (well-being, symptoms, functioning, and risk). The above table shows the CORE-OM 34 scores for 13 patients who completed treatment over the course of the delivery of five small LI pilot groups across the three prisons, from 2014 to 2016. (17/30 patients recruited did not complete treatment as outlined below). All patients were recruited from the caseload of referrals made to the mental health teams at that time. Pre-group scores were completed 2-weeks prior to
treatment beginning, post-group scores were completed 2-weeks after the group ended and follow-up scores were completed at 3-months after the end of treatment. Each group was delivered by two trained LI nurse practitioners and one senior nurse who was present to provide additional coaching/modelling of the intervention. Clinical supervision for the LI nurse practitioners was delivered on a weekly basis. The senior nurse practitioners received clinical supervision on a monthly basis. From the scores highlighted in Figure 3 above, the following conclusions were able to be drawn:

- Pre-group levels of distress were noted to be significantly higher than expected. I.e. they were higher than levels typically noted for patients in other forensic mental health services, e.g. high-secure in-patient cohorts (McIntosh et al, in preparation)\(^6\)
- There were 2 participants with incomplete time points, thus we were unable to make a judgement on their outcomes
- One patient showed a slight increase in their post-group score. It later transpired that this individual was in receipt of a trauma-based intervention from a third sector service. Regrettably, this was not revealed at the point of recruitment, despite having been specifically asked about. (The whole issue of how to overcome difficulties managing the co-ordination and governance of third sector services providing input to prisons has been noted and is currently being raised within other groups, e.g. the Advisory Committee for Psychological Therapies in Prisons, as before)
- Of the remaining 11 participants, 8 showed a clear drop in total score (which indexes psychological distress) from pre to post; 8 scored in clinically distressed range pre-group, and 4 of this 8 dropped to the sub-clinical range post-group; 3 (of 11) showed no real change
- Follow-up scores (where available) indicated a stable pattern or continued reduction

Whilst it is acknowledged that the number of participants is too small to draw more definite conclusions, the trend noted in the above data-set would suggest that these programmes appear to have utility in these services.

**Potential Feasibility of Pilot LI Groups**

A number of key learning points were noted over the course of the delivery of the pilot groups. These are summarised below:

- It is important to consider the full range of clinical needs of the patients. These included high levels of complex trauma and low levels of coping strategies
- It is important to consider the sequencing of the LI interventions, i.e. it was preferable to deliver the ‘On the Road to Recovery’ protocol before the ‘Knowing Me’ one
- Recruitment of patients can be challenging (e.g. due to length of sentences, prison transfers, mental health stigma/fear of appearing vulnerable)

\(^6\) McIntosh, Hartop, Purcell and Thomson (in preparation). *Study of the use of the CORE-OM in The State Hospital: Psychometric properties and test structure.*
A high attrition rate was noted – 17/30 (56%), but this compares to similar community-based groups (Mette Keis, personal communication, July 2016). Of the 17 non completers: 3 were transferred to other establishments (2 were transferred because of security concerns), 7 dropped out of treatment (2 were physically ill and unable to attend due to concurrent treatment for their physical conditions), 3 were released from prison (one was in receipt of a ‘home detection curfew’), and the remaining 4 patients were transferred into ‘offending behaviour’ programmes.

It is important to consider the impact of the environment – i.e. the ‘milieu’, as this was not always conducive to the provision of good psychological work

SPS prisoner programmes are central to prisoners’ progression; group work can therefore hold certain connotations for prisoners, perhaps making them reluctant to engage in therapeutic groups

Staff availability for group facilitation was sometimes impacted by sickness/absence or by leaving posts

The support of senior managers was essential to the delivery of these programmes (see also earlier comments re NES implementation science guidance)

The prison regime, security implications and challenges securing appropriate facilities within a custodial setting can all impact on the safe delivery of the programmes

Robust clinical governance structures need to be in place

NHS FV prisons benefitted from input from the Consultant Nurse (Forensic Network); this helped to support and ensure the embedding of programmes within existing resources, albeit with this temporary additional direct clinical input from the Forensic Network

Potential Acceptability of Pilot LI Groups

Qualitative feedback from patient participants included the following statements:

- “Before going to the group I was having 7 or 8 episodes of anxiety and panic attacks every day; now some days I don’t have any. My family have noticed a positive change in me; so have some prison officers”
- “I found the group really helpful. I have learned how to self-soothe and the importance of having me time”
- “The group was good. I now realise I am not the only person with problems. It was good to share experiences and help each other in the groups and in the house blocks”
- “I feel much better in myself. I have a lot of physical health problems and have noticed that since learning better ways to cope, my physical health is also better”

7. Conclusions

Following the publication of the Royal College of Nursing’s report “Five Years On: Royal College of Nursing Scotland Review of the Transfer of Prison Health Care from the Scottish Prison Service to NHS Scotland” in December 2016, and the
recent call for written views about healthcare in prisons issued by the Health and Sport Committee (Scottish Parliament, February 2017), it is hoped that the production of this report will be received as both timeous and helpful to these, and other, similar groups.

As a result of this joint SoFMH and NES undertaking, the following conclusions have been made, together with suggestions for the possible provision of future LI psychological services in other prison mental health care services throughout the NHS in Scotland.

1. The delivery of this pilot series of LI groups across all three NHS Forth Valley prison mental health services achieved results that appear to support the view that they have potential utility, feasibility and acceptability in these and similar services.
2. The timeline for this work would appear to indicate that LI psychological services can be established relatively quickly using the rollout strategy and associated ‘implementation science’ principles that were adopted in this specific programme of work.
3. NHS Forth Valley prison mental health care services appeared to derive significant benefit from the contribution made by the consultant nurse, the SoFMH and NES, and it is anticipated that future, similar input, could be offered more widely across NHS prison mental health care services in Scotland.
4. All results and outcomes highlighted in this report were achieved within existing resources, albeit that these were temporarily augmented with direct clinical input from the consultant nurse, at a rate of up to one day per week. (No additional staff were recruited to deliver these LI interventions. The costs for the training of LI practitioners – i.e. venue, catering, training packs and trainers, for the development of the LI protocols and for the Consultant Nurse’s and Principal Educator’s (NES) time were shared by the SoFMH and NES).
5. This pilot works aligns well with the operationalisation of the matched stepped-care approach across the entire forensic estate in the NHS in Scotland.
6. Whilst no specific health economy calculations were produced in relation to this work, it would appear that the delivery of LI groups by a largely nurse-led service offers excellent value for money, which again aligns well with the ethos of ‘matched stepped-care’ service provision.
7. In relation to some of the nursing profession-specific issues raised in the RCN’s “Five Years On” report (i.e. opportunities for advanced nursing practice, staffing pressures, opportunities to maximise current nursing skills, continuous professional development opportunities and concerns regarding the morale of the nursing workforce in prisons), this model would appear to support the development of a potential enhanced career pathway for nurses in these services, perhaps through the adoption/creation of more ‘Advanced Nurse Practitioner’ posts. This model also supported the development of nursing skills, it created increased opportunities for continuing professional development for nurses, it facilitated increased access to and frequency of clinical supervision provision, and it appears to have had a significant and positive effect on nurses’ morale. Of additional note in relation to this last point; the NHS Forth Valley prison mental health nursing team’s combined efforts have been recognised and rewarded at a national level. In November 2016, they received the national Mental Health Nursing Forum’s ‘Excellence in Mental Health Nursing Practice – Increased
Access to Psychological Therapies’ category winner award, and they have also
recently been notified that they have been shortlisted from a group of 600
entrants, for a possible national RCNi Nurse Award. The aforementioned RCN
“Five Years On” report also highlighted this work in NHS Forth Valley prisons
under the heading “What is Working Well” (RCN, 2016 p. 16, section 5.2.2).
Again, this public recognition and validation of the group’s efforts has done much
to further boost the morale of the nurses working within this service.

8. This work appeared to support the view that NHS prison mental health care
services could benefit by adopting both the FMIG’s governance principles and
NES’ implementation science principles.

9. This work also aligns with the ‘living well’ element of the life journey highlighted in
the new Mental Health Strategy7.

10. Based on current occupancy figures, this pilot work resulted in the establishment
and availability of LI psychological services to meet the LI needs of up to 25% of
the SPS’s current prisoner population.

11. The SoFMH and NES have also produced a staff education programme entitled
“New to Forensic – Essentials of Psychological Care”. This programme was
developed to increase psychological-mindedness and psychological literacy
across the wider workforce. It is suggested that this programme could potentially
be offered within prisons, e.g. to prison officers, to support additional mental
health awareness training needs.

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7 Mental Health in Scotland – a 10 year vision. (Scottish Government, 2016).
Acknowledgements

The following individuals have contributed to or otherwise supported this work and the development of this report.

- Professor Lindsay Thomson, Medical Director, Forensic Network
- Mr Mark Richards, Director of Nursing and Allied Professions, The State Hospital
- Ms Nicol Shadbolt, Forensic Network Manager
- Ms Heather Meacham, CBT Nurse Therapist, NHS Forth Valley Prisons
- Dr Mette Kreis, Clinical Psychologist, NHS Forth Valley, Forensic Mental Health Service
- Mental Health Nursing Team, NHS Forth Valley, HMP Glenochil
- Mental Health Nursing Team, NHS Forth Valley, HMP & YOI Cornton Vale
- Mental Health Nursing Team, NHS Forth Valley, HMYOI Polmont
- Mr John Porter, National Nurse Advisor for Prisoner Healthcare, NHS Healthcare Improvement Scotland
- Ms Leona Gilhooley, Health Centre Manager, NHS Forth Valley, HMP Glenochil
- Ms Darline Reekie, Health Centre Manager, NHS Forth Valley, HMP/YOI Cornton Vale and HMYOI Polmont
- Ms Rosemary Duffy, Clinical Manager, NHS Forth Valley, HMP Glenochil
- Ms Jackie McKeich, Clinical Manager, NHS Forth Valley, HMP & YOI Cornton Vale
- Ms Denise Allan, Clinical Manager, NHS Forth Valley, HMYOI Polmont
- Ms Fiona Gordon, Service Manager Prison Healthcare and Specialist Community Services, NHS Forth Valley
- Dr E Flynn, Consultant Forensic Clinical Psychologist, NHS Forth Valley, Forensic Mental Health Service
- Dr C MacLean, Forensic Educational Projects Manager (NHS Education for Scotland)
### Appendix 1 – Psychological Service Provision: Needs Analyses for HMP Glenochil and HMYOI Polmont (2014)

<table>
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<th>Glenochil (n=31) % of caseload with this need</th>
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<tbody>
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### Appendix 2 – Timeline

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<tr>
<th>Date</th>
<th>Activity/Event</th>
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<td>July 2013</td>
<td>Consultant Nurse contacted by senior nurse from NHS FV prison mental health care</td>
</tr>
<tr>
<td>September/October 2013</td>
<td>Senior Nurse (NHS FV) meeting with heads of health care, Consultant Forensic Clinical Psychologist (NHS FV) and Consultant Nurse (FN)</td>
</tr>
<tr>
<td>December 2013</td>
<td>Strategic paper presented to heads of health care</td>
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<tr>
<td>January 2014</td>
<td>Needs analysis of MH caseload at HMP Glenochil</td>
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<td>February 2014</td>
<td>First cohort of LI practitioners trained at HMP Glenochil</td>
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<tr>
<td>April 2014</td>
<td>Needs analysis of MH caseload at HMYOI Polmont</td>
</tr>
<tr>
<td>October 2014</td>
<td>LI training of nurse practitioners at HMYOI Polmont</td>
</tr>
<tr>
<td>November 2014</td>
<td>Pilot LI group at HMP Glenochil</td>
</tr>
<tr>
<td>June 2015</td>
<td>Pilot LI group at HMYOI Polmont</td>
</tr>
<tr>
<td>July 2015</td>
<td>Clinical Psychology needs analysis for HMP &amp; YOI Cornton Vale undertaken</td>
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<tr>
<td>October 2015</td>
<td>LI training for HMP &amp; YOI Cornton Vale nursing staff and new nurse recruits from HMP Glenochil and HMYOI Polmont</td>
</tr>
<tr>
<td>January 2016</td>
<td>Second LI group delivered at HMP Glenochil</td>
</tr>
<tr>
<td>February 2016</td>
<td>LI pilot group at HMP &amp; YOI Cornton Vale</td>
</tr>
<tr>
<td>May 2016</td>
<td>Second LI group at HMYOI Polmont</td>
</tr>
<tr>
<td>June 2016</td>
<td>Review and evaluation of all NHS FV prison LI groups</td>
</tr>
<tr>
<td>November 2016</td>
<td>Consolidation of all initial outcome data and presentation of results at national conference. NHS FV nursing team receive national MHNF award for their work</td>
</tr>
</tbody>
</table>