PSYCHOLOGICAL APPROACHES CIC

INDEPENDENT SERIOUS INCIDENT INVESTIGATION REPORT

THE MENTAL HEALTH CARE AND TREATMENT OF M

25th March 2017

PSYCHOLOGICAL APPROACHES CIC

OUR ETHOS AND OUR TEAM

Psychological Approaches CIC is a not for profit community interest company focused on work with individuals with complex mental health needs – often associated with a history of offending and social exclusion – for whom services may be difficult to access, and sometimes poorly equipped to meet their needs.

Our ethos is one of collaboration and partnership with other organisations. Together, we can support the workforce with a focus on development in four areas: commitment to the task, competence and confidence in the delivery of the service, and containment of emotional states to improve staff well being. We attend to the evidence base for best practice, and in so doing, we help organisations to review and evaluate services in order to achieve better outcomes. We understand how important it is to focus on improved quality of care, delivered in ways to maximize efficiency and impact.

Our independent serious incident investigation team comprises five senior practitioners from a multi-disciplinary background with many decades of experience in forensic mental health services, and clinical governance. We adopt a whole team approach to independent serious incident investigations, with an emphasis on peer review and ratification of findings.

Lead investigator

The lead investigator for the inquiry into the mental health care and treatment of M is **Dr Deborah Brooke, Consultant Psychiatrist**.

TABLE OF CONTENTS

PSYCHOLOGICAL APPROACHES CIC 2

OUR ETHOS AND OUR TEAM 2

Lead investigator 2

EXECUTIVE SUMMARY 4

INTRODUCTION 5

TERMS OF REFERENCE 6

METHODOLOGY 6

MENTAL HEALTH CARE RECORDED FOR M FROM RECEPTION INTO PRISON UNTIL 9TH DECEMBER 2015: MAIN THEMES 6

INFORMATION FROM M'S DISCIPLINARY RECORD 7

DESCRIPTION OF THE HOMICIDE 7

INTERVIEW WITH M, 8TH FEBRUARY 2017 8

MEETING WITH HEAD OF HEALTHCARE, HMP PETERBOROUGH 8

Structure of Health Services in the Prison 8

The Prison's Response to Spice Use in 2015 9

MEETING WITH MENTAL HEALTH INREACH TEAM, HMP PETERBOROUGH 9

ADHD Management Protocol 9

Liaison Between Mental Health Services in HMP Peterborough 10

The In Reach Team's Response to Spice use in 2015 10

Psychiatrist's Consultation with M on 8th December 2015 11

Was there evidence for use of spice by M? 11

NOVEL PSYCHOACTIVE SUBSTANCES (NPS) 11

KEY ISSUES FROM M'S CARE AND TREATMENT 12

Diagnoses 12

Management 13

Alcohol dependency 13

Attention Deficit Hyperactivity Disorder 13

Mixed Personality Disorder 13

Risk Assessment 14

CONCLUSIONS 15

Could the homicide have been predicted? 15

Could the homicide have been prevented? 15

What factors contributed to the homicide? 16

Good practice 16

RECOMMENDATIONS 16

Health recommendations to reduce the adverse impacts of NPS in prison for the prison health care provider and services 16

Care of the acute situation 16

Interventions to promote prisoners' recovery from NPS misuse 17

Health interventions to prevent use of NPS in prison 17

APPENDIX: documents reviewed 19

EXECUTIVE SUMMARY

1. On 9th December 2015, M killed his cellmate in HMP Peterborough.

2. He was subsequently convicted of manslaughter on the grounds of diminished responsibility, thought to be due to intoxication with a novel psychoactive substance, spice.

3. M was known to have attention deficit hyperactivity disorder and substance misuse problems. This investigation has concluded that he also had a mixed personality disorder. All of these diagnoses were managed appropriately and within accepted guidelines by the prison in the months prior to the homicide.

4. The prison had implemented education and training initiatives during the summer of 2015 to reduce the use of spice by inmates.

5. This investigation has concluded that the homicide was neither predictable nor preventable.

INTRODUCTION

6. M was remanded to HMP Nottingham on 7th January 2014 with charges arising from incidents on two separate dates. He was convicted of affray, section 18 wounding and two counts of ABH and sentenced to six years' imprisonment. He moved to HMP Stocken on 21st July 2014, transferring to HMP Peterborough on 15th June 2015.

7. During the early morning of 9th December 2015, M killed his cellmate. The cause of death was recorded as: "Significant blunt force trauma to the face and chest". M was convicted of manslaughter on the grounds of diminished responsibility of his cellmate on 19 October 2016 at Peterborough Crown Court and sentenced to 14 years' imprisonment, to run concurrently with his previous sentence.

8. This independent investigation was commissioned by NHS England, to be conducted jointly with the Prison and Probation Ombudsman (PPO) Section 2 ECHR investigation into the death in custody of M's cellmate. The focus of the investigation commissioned by NHSE is on the mental health care and treatment of the perpetrator, M.

9. This report describes the themes in M's mental health care and treatment from the time of his reception into HMP Nottingham until the homicide, and considers the care and treatment he received with reference to current guidelines.

10. The Psychological Approaches lead investigator consulted with Dr Jackie Craissati, Consultant Psychologist, Dr Anne Aiyegbusi, Consultant Nurse and Mr. Paul Ralph, Social Worker on 20th February 2017.

TERMS OF REFERENCE

- Examine the provision of clinical care and treatment including both risk assessment and risk management
- Examine any secondary mental health care provided
- Identify any care or service delivery failings along with the factors that contributed
- Examine policy and practice
- Consider if M's treatment was appropriate for his diagnosis
- Consider if the cell sharing arrangement, from a clinical perspective, was appropriate
- Consider if there was any evidence that M was using synthetic cannabinoids drugs, whether the response to any such evidence was appropriate
- Consider health response to the use of synthetic cannabinoids within the prison
- Make timely, clear and sustainable recommendations for the prison health care provider and services
- Provide a written report that can both be part of the PPO Review and a standalone report that can be made public.

METHODOLOGY

11. As agreed with the commissioners, a single investigator, who discussed the report during its preparation with a multidisciplinary panel, undertook this investigation.

12. The lead investigator reviewed M's prison medical records and policy documents relating to the mental health care of prisoners detained in HMP Peterborough.

13. She met M in HMP Woodhill on 8th February; Investigator of the PPO's Office, and Head of Healthcare, at HMP Peterborough, on14th February, and members of the Mental Health In Reach Team for the prison (Psychiatrist, and Principal Counseling Psychologist and Lead Clinician), at the Cavell Centre in Peterborough on 22nd February 2017.

14. The documents reviewed are listed in the Appendix.

MENTAL HEALTH CARE RECORDED FOR M FROM RECEPTION INTO PRISON UNTIL 9TH DECEMBER 2015: MAIN THEMES

15. This information was extracted from M's prison medical records (Systm One). On reception into all three prisons, M was assessed as being fit for normal location, work and any cell occupancy. Throughout his imprisonment, appropriate psychological support was provided and physical health checks were completed.

16. Psychiatric assessment in HMP Nottingham (7th January – 21st July 2014) concluded that M had alcohol dependency syndrome and polysubstance misuse, on a background of childhood adversity and attention deficit hyperactivity disorder (ADHD). He described feeling depressed, and was on treatment for this. He was started on medication to treat ADHD, but he could not tolerate the side effects.

17. During his stay in HMP Stocken (2st July 2014 – 15th June 2015) depression and anxiety remained problematic for him, and he received appropriate medication. He attended group work for stress management, plus individual meetings for support and help with substance misuse.

18. In HMP Peterborough (15th June – 9th December 2015), M requested help with ADHD and substance misuse. Both of these were treated with appropriate medication and psychological help. He was last reviewed by the psychologist on 29th October 2015 and no concerns were raised. The psychiatrist reviewed him on 6th November, and again on 8th December 2015 (the day before the homicide); she adjusted his medication for anxiety and low mood in order to manage his symptoms, and he reported finding the medication for ADHD helpful. She observed that he appeared to get on well with his cell mate.

INFORMATION FROM M'S DISCIPLINARY RECORD

19. M had two adjudications following his move to HMP Peterborough: an allegation of assault against him in July 2015 was not proceeded with, and he was found to have damaged the observation panel in his cell in October 2015.

20. No positive Mandatory Drug Testing results were reported in HMP Peterborough.

DESCRIPTION OF THE HOMICIDE

21. It is not possible to know exactly what happened. This information relating to the homicide is taken from the statement of the prison officer on duty in Cavell Wing.

22. At approximately 1am in the morning of 9th December 2015, M notified the duty officer that he felt sick. The officer attended M's cell and asked M if he had been sick. M did not reply, but went towards the sink in the cell. His cellmate was lying on his bunk, appearing relaxed; he was described as lying "casually". The officer asked M if he had taken any substance, or spice, to which he replied, "I don't know". This caused the officer to suspect possible spice use, and he decided to call the nurse and tell her that M was behaving peculiarly and may have taken spice.

23. The nurse advised that M should drink plenty of water. The officer returned to the cell, where M was now in his bunk and appeared calmer. He was told to drink plenty of water, to which he replied “I’m OK now”. The officer told him that the nurse was coming anyway.

24. About five to ten minutes later, M called the wing office, saying, “I don’t know what I have done”, followed by mumbling. The officer returned to the cell to find M’s cellmate lying on the floor, obviously injured.

25. The officer called for emergency help and opened the cell. M said, “I’m sorry, I’m sorry”. He did not offer resistance to being handcuffed and secured in an empty cell.

26. At the trial, it was considered possible that M had used, possibly by mistake, spice and it had caused a sudden catastrophic disturbance in his mental state.

INTERVIEW WITH M, 8TH FEBRUARY 2017

27. M had shared a cell for four or five months. He said he had not had arguments with him, describing them as “good friends”. He said he did not know what had happened on the night of the homicide, saying that he remembers feeling panic, thinking that someone was coming to the door, and that he was being attacked. He expressed remorse.

28. He told me he had used spice once in HMP Nottingham, and it had made him feel hugely anxious, with a racing heart. He had not knowingly used it again.

29. He confirmed the positive effects he had experienced from stimulant treatment for his ADHD.

MEETING WITH HEAD OF HEALTHCARE, HMP PETERBOROUGH

30. The lead investigator met with the Head of Healthcare on 14th February 2017 in HMP Peterborough.

Structure of Health Services in the Prison

31. The Head of Healthcare confirmed that the psychiatric care of M was provided by in reach services from Cambridge and Peterborough Foundation Trust. His substance misuse care was provided by a general practitioner with a special interest in substance misuse. The psychosocial component of substance misuse treatment was provided by the Recovery Team, consisting of Sodexo prison officers. Recovery Team interventions were not recorded on Systm One (the prison health record) in 2015.

32. Enquiry from the Senior Officer in charge of the Recovery Team, confirmed that M had agreed to help from the Recovery Team on reception into HMP

Peterborough. He was referred and assessed within seven days, at which time he declined further interventions. M was given information on contacting the Recovery Team, if he would like their help in the future. They have no record of him doing so.

33. With regard to inmates with personality vulnerability, the prison has no specific service, but these common presentations are managed by custody staff and healthcare working together. In the event of serious difficulties in managing an inmate (such as enduring mental illness or sustained self-harm), their case would be discussed at the weekly multidisciplinary Complex Needs meeting, at which a care plan would be agreed between both custody and healthcare staff. M's difficulties in the prison had not been thought to need this level of intervention.

The Prison's Response to Spice Use in 2015

34. In June 2015, the Recovery Team gave a training session on novel psychoactive substances (NPS), including spice, at a full staff briefing. The presentation illustrated the different types of NPS, described the effects on users, and detailed the strategies used by both health care and custody staff to intervene with inmates suspected of using spice.

35. Information, dated July 2015, was distributed to highlight the issues and risks due to the use of NPS within the prison to both staff and inmates.

MEETING WITH MENTAL HEALTH INREACH TEAM, HMP PETERBOROUGH

36. The lead investigator met with the Psychiatrist, and Principal Counseling Psychologist / Lead Clinician, at the Cavell Centre in Peterborough on 22nd February 2017.

ADHD Management Protocol

37. We reviewed the Mental Health In Reach Team ADHD Pathway and confirmed that the management of M's ADHD had proceeded entirely as defined in this protocol. His condition had been complicated by buprenorphine (Subutex) misuse, so he was not accepted for stimulant treatment until he had shown abstinence from illicit drug use. He did not meet the criteria for management within the Care Programme Approach (CPA; a framework for delivering community mental health services for individuals with a diagnosed mental illness) because his mental health condition was neither sufficiently complex nor severe for this level of management. However, his need for further psychological help with the sequelae of his childhood trauma was recognized. This was planned to take place when his ADHD had been controlled by an optimal dose of stimulant medication (Concerta XL).

Liaison Between Mental Health Services in HMP Peterborough

38. The general practitioners in the prison, the drug treatment service (IDTS) and the mental health in reach team shared the clinical notes and messages on Systm One. The teams are co-located, and have weekly joint meetings. In 2015 there were guidelines for shared care when prescribing ADHD medications between prison health care services and the in reach team. The liaison between these services was described as good.

39. The main weekly meeting of the mental health in reach team was attended by the mental health lead, the consultant psychiatrist, nursing and psychology colleagues, psychiatrist and a substance misuse worker, who had a liaison role with the Recovery Team in the prison. The team reviewed current patients, and updated colleagues with the each patient's progress.

40. The minutes record that M was discussed at this meeting on three occasions. Throughout the minutes for November and December 2015, M was not recorded as a client who raised concern, either in terms of his mental state or because of any other risk. During M's time in HMP Peterborough, no threat was detected by the mental health in reach team; if any had been, or if they had a concern about M's placement in a shared cell, they would have alerted the prison authorities.

41. In addition, the team has a weekly Caseload Review meeting, at which each practitioner reviews their caseload with colleagues – this rotates through the whole team over a few weeks. The psychologist's caseload was reviewed on 15th September and 3rd November; at this meeting, no more psychology work was planned until his ADHD had stabilized, after which M could be offered psychological help with his early trauma. M's care was accordingly transferred from the psychologist to the psychiatrist.

42. The team has a fortnightly Risk Supervision meeting, which makes patient management decisions in response to a perceived increase in risk to self or others. M had never crossed the threshold for consideration at this meeting.

The In Reach Team's Response to Spice use in 2015

43. In 2015, spice was a new drug in the prison. It was causing profound risks to the health of some users, sometimes necessitating emergency treatment in hospital. It was not detectable on urine screening. The response of the in reach team was to tell individuals not to use, and advise them of the risks. Currently, symptoms are more recognized, and the legislation banning trading in spice has led to better recognition by potential users of the risks associated with spice.

Psychiatrist's Consultation with M on 8th December 2015

44. The psychiatrist had a good recollection of this meeting. She had gone to see him in the wing, as he had not kept two appointments with her in Health Care. She had never felt threatened by M, and so she had no anxiety about seeing him in a small side room, unaccompanied.

45. He was hopeful about his prospects on release and wanted to rebuild his life. He had a responsible job in the kitchen. However, he appeared distressed when talking about his break-up with his girlfriend, and so she increased the daily doses of antidepressant and the tranquillizer (this last had been reduced on 6th November because of sedating side-effects).

46. She asked if his cell mate was disturbed by M's tearfulness, and he replied that they got on well.

47. Her risk assessment at this meeting was informed by knowledge of his offending – she had assessed his attitude to his offence at their first meeting on 23rd September 2015.

Was there evidence for use of spice by M?

48. The psychiatrist described that it is her practice to ask every patient: "Are you using any substances on the wing?" M had denied this. She had never seen him intoxicated; in fact, he engaged with their services very well. She had no information from the prison authorities that M might have been using spice.

49. In the medical records, there are the results of two urine tests in HMP Peterborough, on 15 June when he arrived (positive for opiates, which M related to a recent codeine prescription) and 13 August which was positive for buprenorphine (Subutex), which he had presumably obtained illicitly on the wing.

50. In 2015, urine drug screens in prison could not detect spice or its metabolites.

NOVEL PSYCHOACTIVE SUBSTANCES (NPS)

51. Please refer to Appendix 1 for full references.

52. Spice is a street name for synthetic drugs which act at the cannabinoid receptor; that is, they mimic the effect of cannabis. They are within the group of novel psychoactive substances (NPS) previously known as "legal highs". They have never been permitted in prison. Stimulants and synthetic cannabinoids account for the vast majority of NPS. In 2016 the Psychoactive Substances Bill banned trading (but not possession) of all current and future NPS.

53. The actions of synthetic cannabinoids are complex and unpredictable, with short term risks of psychosis, paranoia, anxiety, agitation, confusion, slurred speech and cognitive impairment, plus a range of potentially fatal physical effects, including heart attacks and seizures. Longer term use carries risks of psychological dependence and addiction, and the development of psychotic illness (Baumeister et al; Tracy et al).

54. A review (Tait et al) of adverse effects arising from the use of synthetic cannabinoids, covering about 4000 reported cases, described major physical complications, such as heart attacks and seizures, leading to at least 26 deaths and psychiatric disorders including first-episode psychosis, paranoia, self harm and hyperemesis (sustained vomiting). The authors did not report any homicides in this review of over 4000 adverse outcomes following spice use.

55. Most presentations involved young males with increased heart rates (37-77%), agitation (16-41%) and nausea (13-94%). The survey found that these symptoms typically resolved with symptomatic care, such as encouraging fluids.

56. Severe adverse events are much less common. It is difficult to estimate their incidence because of the variety of synthetic cannabinoid compounds, difficulties in laboratory confirmation and the unknown number of exposed individuals.

KEY ISSUES FROM M'S CARE AND TREATMENT

Diagnoses

57. M was diagnosed in HMP Nottingham in March 2014 to have alcohol dependency syndrome and attention deficit hyperactivity disorder (ADHD).

58. In the opinion of the lead investigator, M had an additional diagnosis of a mixed personality disorder (F61 in the ICD-10) with emotionally unstable, antisocial and paranoid features.

59. This is recognized to be associated with the experience of childhood abuse and emotional deprivation. It is a cluster of maladaptive psychological and behavioural features including mood instability, irresponsibility and disregard for social norms, difficulties in trusting and sensitivity to others with self-referencing ideas. Impulsivity would also be part of this syndrome, and M was already prone to impulsivity because of his ADHD.

60. Personality disorders of this type affect about half the male prison population, most commonly antisocial personality disorder; combinations of antisocial and emotionally unstable personality disorders are also relatively common.

Management

Alcohol dependency

61. M's alcohol dependency syndrome, plus his light use of cannabis and occasionally, other street drugs, indicate that M had a pattern of using mood-altering substances. This continued in prison with his illicit use of buprenorphine.

62. In HMP Peterborough, he was prescribed tramadol as a combined painkiller and opiate substitute therapy in order to stop his use of illicit substances while receiving treatment for ADHD. Psychosocial therapy for substance misuse, a usual adjunct to substitute prescribing, was available to M in HMP Peterborough, but he declined this modality of help.

63. In addition to these scheduled interventions, M had numerous opportunistic interventions with staff recorded in his Systm One record at which his use of substances was discussed. M's engagement was intermittent, and he had difficulty in remaining abstinent from illicit mood-altering substances.

64. In the opinion of the lead investigator, M's substance misuse problems were managed appropriately and within accepted practice during his imprisonment.

Attention Deficit Hyperactivity Disorder

65. M was prescribed stimulant medication which reduced his symptoms of ADHD. Documents received from HMP Peterborough confirm that the management of his ADHD was entirely compliant with the local mental health practice and procedures.

Mixed Personality Disorder

66. From February 2015, prescribers responded to M's distressing levels of anxiety, and self-referential feelings, with a slow increase in quetiapine, an antipsychotic medication which is also used for severe anxiety. In addition, he was prescribed an antidepressant,

67. Psychological treatments are an important component of the management of mixed personality disorder. M attended stress management groups between 28th January and 11th March 2015. He was followed up by the mental health nurse who reviewed anxiety management techniques with him.

68. With reference to current guidelines, the National Institute for Health and Care Excellence (NICE) does not give specific guidance on the management of mixed personality disorder, but it is accepted practice to address all components of such complex personalities. The use of group work using a cognitive model is recommended for antisocial personality disorder, and M had appropriate group work with individual follow-up in HMP Stocken. M was

subsequently encouraged to engage with the anger management group in HMP Peterborough. Being offered access to relatively brief emotional self-management groups is consistent with a psycho-educational approach, which aims to enhance an individual's motivation to engage with and make use of psychological services.

69. The use of medication is endorsed by the NICE Quality Standards, focusing on anti-anxiety medication (in the case of M, this was citalopram, an antidepressant with anti-anxiety properties) and the use of tranquillisers for the short term management of crises. The use of quetiapine for M in view of his self-referential feelings was appropriate.

70. In the opinion of the lead investigator, the management of M's personality disorder was appropriate, and within current guidelines.

Risk Assessment

71. M's risk of self harm was regularly assessed, and, if considered necessary, was managed by the ACCT process which engages both healthcare and custody staff in supporting a prisoner who is vulnerable to self-harm.

72. M's risk to others was specifically assessed by the psychiatrist at her consultation on 23rd September 2015, when a risk to others was recorded because of his impulsivity due to untreated ADHD. After responding to treatment, M's risk to others was recorded as being low by the psychologist and the psychiatrist at their consultations on 25th September; 30th September; 6th November and 8th December.

73. On the 8th December 2015, in relation to the contribution that mental health issues made to his risk of violence, impulsivity had been managed by appropriate medication, plus psychological assessment and support on five occasions between 25th August and 16th October.

74. M's personality vulnerabilities had been managed by a daily dose of major tranquillizer at one-quarter of the maximum British National Formulary dose. This is an appropriate dose to reduce sensitivity and self-referencing ideas in patients who do not have a diagnosis of a psychotic illness.

75. He was on a robust dose of opiate substitution.

76. In the opinion of the lead investigator, the psychiatrist's conclusion that M presented a low risk to others on 8th December, based on his presentation and his response to treatment, was correct.

CONCLUSIONS

Could the homicide have been predicted?

77. The evidence is that M exhibited extreme violence towards a cell mate with whom he had a good relationship, and who had been seen to be "casually" lying on his bunk in the minutes preceding the homicide. This suggests that M's mental state suddenly deteriorated, possibly due to intoxication. He remembers feeling panic, thinking that someone was coming to the door, and that he was being attacked. He appeared distracted, and told the officer that he felt sick. This is a common presentation following the use of spice and the officer, suspecting spice use, sought nursing advice. The advice given – to drink water – was appropriate in view of the symptoms reported at that time. Most prisoners who used spice did not need emergency interventions, and the nurse said she would attend shortly.

78. Severe reactions to spice are rare and difficult to predict, due to the variety of compounds with varying effects, and the user's individual vulnerabilities to the effects of these substances. Therefore, the tragic events of the ensuing few minutes could not have been predicted.

Could the homicide have been prevented?

79. At reception into three prisons, M was assessed as suitable to share a cell. His profile of offending and his history in custody did not cause him to be regarded as posing special risk.

80. The risk assessments during the autumn of 2015 documented a decrease in risk due to the reduction in M's impulsivity following treatment for his ADHD. This medication is documented as having been administered to M on the evening of 8th December 2015. The mental health in reach team at HMP Peterborough did not detect unpredictability or threat from M in their extensive meetings with him during the autumn; in fact, he had a responsible job in the kitchen.

81. With reference to his other diagnoses, his opiate misuse in prison had been managed with opiate substitution therapy. He denied using spice. The manifestations of his personality disorder had been treated with psychological and pharmacological therapies. It is the view of the lead investigator that there was no additional treatment intervention that should have been offered to M.

82. HMP Peterborough's response to the use of spice by prisoners, as evidenced in the documents made available to this investigation, was appropriate. The prison issued information to inmates and staff describing both health care and custody interventions; health care undertook training of staff and the mental health in reach team prioritized this is their consultations.

83. In summary, preventive action was undertaken to address the risks that spice presented in the prison, and individual preventive action was taken with M to ameliorate his mental disorder. The lead investigator believes that these actions were appropriate and concludes that the homicide could not have been prevented.

What factors contributed to the homicide?

84. The contributing factors were exposure to spice and M's idiosyncratic response to intoxication, which appears to have been characterized by panic and paranoia, leading to a sudden and unpredictable episode of extreme violence.

Good practice

85. The management of M's ADHD in HMP Peterborough was an example of good liaison between teams, following clear guidelines for shared care and implementing a multidisciplinary care plan with both pharmacological and psychological components for a service user with multiple morbidities.

RECOMMENDATIONS

86. With regard to the care and treatment of M, the lead investigator has no recommendations to make.

87. His management in HMP Peterborough was conducted within accepted guidelines. There is evidence of good liaison between the providers involved in his care and a comprehensive care plan that addressed his multiple needs.

Health recommendations to reduce the adverse impacts of NPS in prison for the prison health care provider and services

88. The risk posed to prisoners' health by NPS has been recognized for some years and recommendations have been made for custody staff (Prison and Probation Ombudsman's Learning Lessons Bulletin; Independent Monitor; Users' Voice). The need for training prison staff in harm reduction and the psychosocial management of substance misuse is emphasised.

89. Management strategies for prison health services can be grouped under three headings:

Care of the acute situation

90. It is difficult to be sure what has been used, so each situation must be managed according to the presenting problem. The most common adverse effects of NPS use – nausea, increased heart rate and agitation – will respond to simple interventions, such as encouraging fluids, a calm and reassuring approach and the use of de-escalating techniques to reduce anxiety.

91. If the person fails to respond, or their condition is deteriorating, they will need to be in an environment where their safety can be maintained. On assessment, this may be a place with heightened levels of observation within the prison, or transfer to hospital may be necessary.

Interventions to promote prisoners' recovery from NPS misuse

92. Prison services have considerable expertise in delivering clinical and psychosocial treatments to substance misusers. Users of NPS can be offered the same range of interventions.

93. Prisoners who do not wish to stop using may benefit from motivational interviewing techniques to help them reflect on the part that substances are playing in their lives. Encouragement to explore the costs of using and the expected benefits of stopping might help the person incline towards a decision to reduce or quit.

94. Once the person is accepting of the need for change, evidence-based interventions include an individual assessment of treatment need, and both educational and therapeutic groups. This can include group work led by prisoners. Other self-help initiatives are the establishment of users' forums, and the use of peer mentors to offer support. This is a cost-effective and informal intervention, which has the potential to reach prisoners who choose not to present to services, because the possibility of incurring sanctions for using is a barrier to seeking treatment. Peer mentors will need training and support for the role.

95. Preparation for release should include specific advice about the risk of relapse, emphasizing that cannabis is a less risky choice than the synthetic cannabis in NPS.

Health interventions to prevent use of NPS in prison

96. Education is the main preventative health intervention, especially in preventing the proportion of users who use NPS for the first time in prison. Topics include drug refusal skills, risks to physical and mental health, and the unpredictable effects of NPS compounds as they are composed of different types of substances with varying and unpredictable strengths. Education should be available to all prisoners without the need for them to identify as a user.

97. Various methods of information sharing have been adopted, such as prison radio, poster campaigns and distributing leaflets and promotional materials. This should be a priority because prisoners report only patchy access to information, with particularly low levels of information on harm reduction such as keeping safe if using, and keeping others safe who are using.

98. The prime time for conveying this information is at reception into the prison; partly for the prisoner's safety but also to promote the culture that help with substance misuse issues is available. Specific vulnerabilities which may predispose to using in prison (such as past behaviours, or current mood disorder) can be detected at reception, and interventions offered.

99. Interventions utilising a health model, for example, adopting a harm reduction approach and viewing substance misuse as a psychological disorder, are more likely to promote the alliance between prisoners and staff which is necessary for the prison community to address widespread use of NPS.

100. The educational endeavour should include positive reasons not to use, such as progressing towards personal developmental goals.

APPENDIX: DOCUMENTS REVIEWED

Shared Care Guidelines: Methylphenidate, Dexamfetamine, Lisdexamfetamine and Atomoxetine for Adults with ADHD in HMP Peterborough. Cambridgeshire and Peterborough Clinical Commissioning Group, Jan 2015

Mental Health In Reach Team ADHD Pathway, undated

HMP & YOI Peterborough Recovery Strategy 2015 - 2016

Personality Disorders Borderline and Antisocial. National Institute for Health and Care Excellence (NICE) Quality Standard 88, June 2015

Drug Misuse and Dependence UK Guidelines on Clinical Management, Department of Health, 2007

Legal highs: staying on top of the flood of novel psychoactive substances. Baumeister, D; Tojo, L & Tracy, D. *Therapeutic Advances in Psychopharmacology*, 2015,1-36.

Novel psychoactive substances: types, mechanisms of action, and effects. Tracy, D; Wood, D & Baumeister, D. *British Medical Journal*, 2017; 356:i, 156-162.

A systematic review of adverse events arising from the use of synthetic cannabinoids and their associated treatment.
Tait, R; Caldicott, D; Mountain, D; Hill, S & Lenton, S. *Clinical Toxicology*, 2016, 54, 1.

Prison and Probation Ombudsman for England and Wales. Learning Lessons Bulletin. Fatal Incident Investigations Issue 9: New Psychoactive Substances, July 2015.

Independent Monitor magazine (Association of Members of Independent Monitoring Boards) March 2017, pp 8-10.

Spice: the bird killer. What prisoners think about the use of spice and other legal highs in prison. User Voice, May 2016.