Prison Mental Health In-reach Team

Operational Policy
<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>PAGE No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2.0 Aims</td>
<td>3</td>
</tr>
<tr>
<td>2.1 Historical Context</td>
<td>3</td>
</tr>
<tr>
<td>2.2 Evidence Based and Bradley Review</td>
<td>3</td>
</tr>
<tr>
<td>3.0 The Team</td>
<td>4</td>
</tr>
<tr>
<td>3.1 Hours of Operation</td>
<td>5</td>
</tr>
<tr>
<td>3.2 Models of Service Delivery</td>
<td>5</td>
</tr>
<tr>
<td>3.3 Additional Services Delivered</td>
<td>5</td>
</tr>
<tr>
<td>3.4 Psychiatrist and Medication</td>
<td>5</td>
</tr>
<tr>
<td>3.5 Psychology Clinic</td>
<td>5</td>
</tr>
<tr>
<td>3.6 Team Meetings</td>
<td>6</td>
</tr>
<tr>
<td>4.0 Team Key Objectives</td>
<td>6</td>
</tr>
<tr>
<td>5.0 Referral Procedure</td>
<td>7</td>
</tr>
<tr>
<td>5.1 Referrals Received by Prison In-reach</td>
<td>7</td>
</tr>
<tr>
<td>5.2 Appointments</td>
<td>7</td>
</tr>
<tr>
<td>5.3 Prison In-reach Documentation</td>
<td>7</td>
</tr>
<tr>
<td>5.4 Activity Collection</td>
<td>7</td>
</tr>
<tr>
<td>5.5 Referral Criteria</td>
<td>8</td>
</tr>
<tr>
<td>6.0 Assessment Procedure</td>
<td>8</td>
</tr>
<tr>
<td>6.1 Prison Mental Health Care Pathway</td>
<td>9</td>
</tr>
<tr>
<td>6.2 HMP Sudbury Pathway</td>
<td>10</td>
</tr>
<tr>
<td>6.3 Out-of-Hours Consultant Pathway</td>
<td>11</td>
</tr>
<tr>
<td>7.0 CPA Procedure</td>
<td>12</td>
</tr>
<tr>
<td>7.1 Discharge/Transfer/Non-alliance</td>
<td>12</td>
</tr>
<tr>
<td>7.2 Disengagement</td>
<td>12</td>
</tr>
<tr>
<td>8.0 Prison Mental Health Transfers Best Practice Flow Chart</td>
<td>13</td>
</tr>
<tr>
<td>8.1 Transfer to NHS Units</td>
<td>14</td>
</tr>
<tr>
<td>8.2 Transfer to another Prison</td>
<td>14</td>
</tr>
<tr>
<td>9.0 Therapeutic Interventions</td>
<td>14</td>
</tr>
<tr>
<td>10.0 Discharge from the Prison In-reach Team</td>
<td>15</td>
</tr>
<tr>
<td>10.1 Refusal of Prison In-reach Services (see Disengagement from Service)</td>
<td>15</td>
</tr>
<tr>
<td>11.0 Disclosure of Information and Confidentiality</td>
<td>15</td>
</tr>
<tr>
<td>12.0 Continual Service Improvement</td>
<td>15</td>
</tr>
<tr>
<td>13.0 Safeguarding Vulnerable Adults</td>
<td>15</td>
</tr>
<tr>
<td>14.0 References</td>
<td>16</td>
</tr>
</tbody>
</table>
1.0 Introduction

Prison Health Care is delivered through a formal partnership between the NHS and the Prison Service to achieve an effective and integrated service. The Prison Service continues to provide primary care whilst responsibility for secondary and specialist care rests with the NHS.

The Prison In-reach provide an integrated triage, primary and secondary service for females and males from 18 years at HMP Foston and HMP Sudbury, with mental health care equivalent to that available to those in the NHS.

Severe mental illness is associated with significant poorer physical health status therefore the team will, maintain close links with Healthcare encouraging and supporting prisoners in accessing primary health care and health improvement.

2.0 Aims

To ensure that the prisoner’s health and social care needs are met whilst in custody.

To achieve effective resettlement and rehabilitation on release from prison - in particular in addressing the prisoner’s mental health needs and other complex needs as well as ensuring personal and public safety.

2.1 Historical Context

Over the course of the last five years the Department of Health has taken responsibility for meeting the health needs of inmates, with the principle of equivalence of access to health services as in the community.

Specific funding streams for development of mental health services were established and since 2002 prison mental health In-reach services have been developed in prisons.

Within the prison service high levels of psychiatric morbidity are identified with 9 out of 10 prisoners having at least one of these five disorders; neurosis, psychosis, personality disorder, alcohol abuse, drug dependency.

Untreated mental disorders can be the underlying cause of a significant proportion of offending behaviour as well as contributing to the social exclusion that is the feature of so many offenders’ lives.

2.2 Evidence Based and Bradley Review

Changes to prison healthcare outlined in The Future Organisation of Prison Health Care (Department of Health, 1999) and Changing the Outlook (Department of Health, 2001), mean that prisoners are entitled to health provision - including mental health provision - equal to that available in the community. They should be able to access primary, secondary and tertiary care to the same standard as the Community.

The Department of Health’s Offender Mental Health Care Pathway (Department of Health, 2005), is a best practice template for dealing with MDO and should be used to develop both practice and strategies for effective care.

The Bradley Review (2009) and Improving Health, Supporting Justice (2009), published in response to Lord Bradley’s review contribute to key government initiatives around reducing re-offending and health improvement within prisons. They set out a number of recommendations for Prison in-reach at commissioner and Department of health level.

The Prison In-reach Team will, as a minimum, meet the relevant requirements of the following in so far as they relate to the services specified in this document.

- Procedures that are governed by Derbyshire Mental Health Partnership NHS Trust
- Her Majesty’s Prisons: Foston and Sudbury.
- CPA system
- Relevant advice, guidance and instructions issued by the Department of Health or other statutory NHS bodies.
- NSF for Mental Health Services and Women
- Relevant National Legislation for Health and Safety.
- Data Protection Act and Caldicott Guardian.
- NMC guidelines
- NICE Guidance
- Mental Health Act 1983 (Amended 2007)
- Mental Capacity Act
- Offender Care Pathway
- Professional Bodies and Code of Conducts.
- Prison Health Indicators

3.0 The Team

The team is an integral part of Prison Healthcare, working within the Prison alongside Healthcare staff.

It is a dedicated, appropriately skilled staff group with capacity for cross-cover and development of specialist skills which allows us to offer the access to female staff if required.

- **Team Leader (Band 7) 0.5 wte**
  Responsible for establishing an Operational and Clinical Service to the Prison

- **3 Community Psychiatric Nurses (Band 6) 3 wte**
  To provide evidence based care plans and risk assessments to assess and support patients with mental health problems.

- **1 Community Psychiatric Nurse (Band 5) 0.5 wte**
  Providing Computerised Cognitive Behaviour Therapy (CCBT)

- **1 Occupational Therapist (Band 6) - 1 wte**
  Provides a wide and varied range of therapeutic approaches all based in the underlying philosophy and principles of the profession.

- **2 Psychiatrists (8 sessions a month)**
  This includes: Remand, Sentenced and Sudbury

- **1 Psychologist (One session every week)**

- **1 Team Administrator (Band 2) 0.8 wte**
  Providing administrative support to the In-Reach team members.

3.1 Hours of Operation

The Prison In-Reach Team operates between the hours of 9.00am and 5.00pm, Monday to Friday (some flexibility with hours can be arranged, 8-4 + flexi-shift to meet the needs of the Service)

No crisis provision is made out of hours, but there is an ‘out of hours’ crisis protocol (spot purchase of an out-of-hours consultant)
3.2 Models of Service Delivery

The Prison In-reach Team for Foston and Sudbury was established May 2002. The role of the team has evolved and delivers the following models of service delivery.

- CMHT
- Triage Assessments
- Day Care Centre-Model of Human Occupation

3.3 Additional Services Delivered

The team delivers a psychiatric clinic weekly at HMP Foston on the Sentenced and 3 out of 4 weeks on the Remand side. HMP Sudbury receives one monthly session.

- Peer supervision and advice for Prison staff is on-going. The team deliver the Mental Health Awareness training and support the delivery of training in Assessment, Care, Custody and Teamwork (ACCT).

Referrals to the Psychiatric and Psychology Clinics are made by In-reach team members and patients needs are discussed with the relevant professionals.

3.4 Psychiatrist and Medication.

- The Psychiatrist will take responsibility for the clinical care of individuals within their session commitment.
- Clinic Template to be completed on system one and data onto Care Notes.
- The Team (includes the Psychiatrist) is responsible for the prescribing, monitoring of psychotropic medication as indicated by clinical need.
- Maintain close and effective links with the primary healthcare team where the administration of medication is carried out.
- Strategies to improve concordance with medication regime will be put in place.
- Structured side effect monitoring will be used routinely.
- Provide education on medication regime to patients, support staff and primary care team workers.
- Information on medication for all patients.

3.5 Psychology Clinic

- Deliver psychological assessment and treatment of complex high risk cases
- Provide consultation on treatment modalities through MDM

3.6 Team Meetings

- Weekly Referral meetings on Monday at 10.30 and complex cases discussed within the MDM on Thursday.
- Triage Clinics
- Weekly psychiatric clinics -Sudbury once per month.
- Progress and outcomes regularly monitored.
- Weekly Psychology Clinic - Thursday morning
- Prison meetings to attend, written information or apologies to be sent to the following:-
1. Lifer Board/Review
2. Public Protection
3. Middle Management
4. Drugs and Therapeutic
5. Safer Custody
6. Healthcare Management Meetings
7. SPG - Report forwarded to Healthcare Manager for distribution.

4.0 Team Key Objectives

The team delivers care across the continuum of mental health problems.

The principles surrounding the role of the Prison In-Reach Team are:

- Offering a Care Pathway that systematically ensures that mental health problems/significant risk/self-harm are identified and assessed.

Some of whom may have a dual-diagnoses, self-harm, severe and enduring mental health problems including personality disorder who can be difficult to engage with and present as a higher risk to self and others.

- Provide a mental health triage clinic and make appropriate referrals to secondary, tertiary mental health, prison departments and primary care services

- To work in partnership with the prison GP to develop an effective interface between primary and secondary mental health care.

- To provide support and advice on the management of Mental Health problems to the multi disciplinary team, prison staff and healthcare staff.

- Provide advice and supervision to prison staff managing patients with mental health problems on the prison wings.

- Increase the mental health awareness of establishment staff through training and advice.

- Provide detailed treatment and care plans with specific interventions and regular reviews in collaboration with the individual. Through individual and group work.

- To secure improvements in health status and prevent or decrease morbidity and disability associated with mental ill health.

- Provide appropriate transfer to mental health establishments for those with severe and enduring mental Health problems.

- Provide effective, evidence-based treatment to reduce and shorten distress and suffering but also to maximise personal development and fulfilment.

- Encourage prisoners to work in collaboration with their treatment and care.

- To ensure the civil rights, including confidentiality of individuals are respected and that these are balanced with the safety of the public, carers, relatives and professionals.

- To deliver the highest quality of care by multi-professional input.

- To develop case collaborative and inter-agency working.

- To develop effective measures of service performance, clinical audit and quality of Care.

- Participate in the data collection and auditing process and feed this data to local and national organisations.

- Attempt at all time to meet the equivalent standards of care promoted or equal to the NHS Standard.
• Work within the constraints of the establishment and do so in an effective and efficient manner using resources to the optimum level.

• Provide CPA structure within the mental health service.

5.0 Referral Procedure

All mental health referrals will be initially screened by the Primary Mental Health Team (Healthcare), and then forwarded to the Prison In-reach Team to be discussed at the Monday meeting for appropriate referral. If a Mental Health Triage Assessment is required then an appointment will be made within 3 working days.

The patient/prisoner will be informed of this appointment by letter and referrer by System One.

Options following Mental Health Triage Assessment:

• Devise Care plan for prisoners with mild to moderate in conjunction with wing staff, primary care team and other agencies if necessary.

• Refer to Prison In-reach Team

• Refer to Occupational Therapy Groups

• CCBT ‘Beating the Blues’, (to be referred if necessary after completion of course)

  Beating the Blues (Ultrasis plc) is a CBT-based package for people with anxiety and/or depression. It consists of a 15 minute introductory video and eight 1 hour interactive computer sessions. The sessions are usually at weekly intervals and are completed in the Healthcare/In-reach building. Homework projects are completed between sessions and weekly progress reports are delivered to the GP or other healthcare professional at the end of each session. These progress reports include anxiety and depression ratings and reported suicidality. No minimum reading age is specified.

• Refer to visiting specialists for further mental health assessments

• Refer to other professional - counselling/psychology.

• ACCT prison care planning process initiated for those at risk of self-harm or suicide.

• Offer leaflet and self-help information to staff and prisoners.

5.1 Referrals Received by Prison In-reach

All referrals and assessments are discussed at the Referral Meeting (Mondays at 10.30)

The outcome is recorded on the Trust data base, System One and MDT Minutes. A letter will be sent to the prisoner of the outcome.

5.2 Appointments

Patients will be informed of any cancellations or alterations as soon as possible. The team will contact the wing directly.

5.3 Prison In-Reach Documentation

The team make entries into the following: System One, and CareNotes

Care Notes and System One are electronic systems for DMHS and Prison Service.

5.4 Activity Collection

The team records and monitors activity by a local data base and input into the Trust System-CARE NOTES. This information forms part of the performance indicators.
5.5 **Referral Criteria**

The Prison In-reach will see referrals for:

- Prisoners diagnosed with severe mental disorder with high degree of clinical complexity

This includes:

- Functional psychoses
- Severe Depression
- Personality Disorder
- Eating Disorder
- Prisoners requiring interventions under the Mental Health Act 1983
- Integrated care of co-morbidity between behavioural, substance misuse and mental disorders.

- Prisoners transferred from other establishments who have been managed and/or seen by other Mental Health In-reach Teams.

- Prisoners with a current or significant history of serious self-harming or suicide attempts e.g. Self-poisoning, suspension, wounds that require hospitalisation or serious concerns about a prisoner’s health and safety due to their mental state.

- Prisoners identified via the Triage Risk Assessment as having a mental health problem or significant risk issues.

6.0 **Assessment Procedure**

Outcomes following assessment:

- Refer back to primary care CCBT or Healthcare with advice and support to develop a care plan.

- Place prisoner on CPA following the multidisciplinary care management process, initiate care plan of interventions and act as care co-ordinator during prison sentence

- For prisoner on CPA - liaise with care co-ordinator.

- Refer to occupational therapy

- Transfer process

Priority will be to identify and appropriately care for those with serious mental health needs. Where a full assessment is required this will be undertaken within a 5 working days from the date of referral, depending on the assessment urgency.

The prisoner will receive an informative letter.

Following Assessment, recommendations will be made regarding intervention (if any). A copy of the Assessment and Care Plan will be placed on System One and all interactions will be discussed with the prisoner and documented.

Prisoners assessed by the In-Reach Team who require a psychiatric/psychological opinion, will be referred to the visiting Psychiatrist or Psychologist.

Once the assessment process is completed, prisoners will be allocated a named worker, who will be responsible for devising their programme of care and maintaining contact throughout their detention period.
Prison Mental Health Care Pathway

IN-REACH TRIAGE ASSESSMENT

Reception Screening:
Mental Health problem identified

New Mental Health Problem Identified

ACCT Review Indicates Referral Required to MH Services

YES

PRIMARY CARE HEALTHCARE TEAM ASSESSMENT
Arrange the completion of the Screening Tool and referral to the MH Triage

YES

PRIMAR

Are they currently on In-Reach caseload?

NO

YES

Primary Care Services:
- Psychologist
- GP
- CCBT
- Counselling
- Primary Care Groups

Discuss with the appropriate case manager within the In-Reach team. Document in ACCT all correspondence/actions

SECONDARY

In-Reach Services:
- OT Groups
- 1:1 Sessions-CPN
- Psychiatrists
- Psychologists
- Transfers
HMP Sudbury Pathway

RECEPTION/TRIAGE BY HEALTHCARE

Mental Health Problems

Primary Care

Secondary Care

Refer to In-Reach

Continue Caseload

CPA Arrangements

Further Assessment

Refer to Counselling

The Prison In-reach Team visit Sudbury for 2 sessions per week.

Self-Help
Short-term input
Ref to Counselling
Ref to CARAT’s

Refer to Primary Mental Health
7.0 CPA Procedure

Refer to Derbyshire CPA Policy
The decision about the need for CPA is taken once someone has been accepted by the In-reach Team. This is a professional decision made at an allocation meeting or review. Refer to CPA Procedures for Derbyshire Mental Health Trust for criteria for CPA.

Prisoners needing the support of CPA can expect:

- The support of a CPA care co-ordinator.
- An assessment of their health and social needs
- A comprehensive formal written care plan including management of risk and direct payments where appropriate.
- Formal multi-disciplinary, multi-agency review at least once a year.
- Carers identified and informed of their rights to their own assessment.

The team will ensure that relevant information accompanies the prisoner during transition through the offender pathway.

7.1 Discharge/Transfer/Non-Alliance

Refer to CPA Procedures for Derbyshire Mental Health Trust.

7.2 Disengagement from Service

Each patient will require an individual response to the situation.

In the event of a patient refusing to attend or take part in their care pathway or attend arranged appointments, an initial meeting should be held and a care plan established. Consideration must consider the degree of risk and mental state of the patient. The care co-ordinator/team member should ensure all attempts are made to implement the care plan and continue to engage the patient.

Collaborative working is to be encouraged and modified to ensure patient compliance.

If the patient meets the criteria for enhanced CPA, they should not be discharged on the grounds of the refusal. Efforts should be made to develop a relationship that will enable increased care in the long term.

In all cases the situation should be kept under review, and discussed with the psychiatrist and at the Weekly Team meetings.
### PRISON MENTAL HEALTH TRANSFERS BEST PRACTICE FLOW CHART

**Key**
- Mental Health Unit, Home Office (MHU)
- Primary Care Trust (PCT)
- Regional Forensic Commissioner (RFC)/Secure Services Commissioner (SSC)
- Head of Healthcare (HHC)
- Healthcare Administration Staff (HC Admin)

<table>
<thead>
<tr>
<th></th>
<th>Who</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General Practitioner (GP) or Psychiatrist</td>
<td>Initial Medical Assessment (supported by info from healthcare/Prison Mental Health In-Reach). Transfer to a hospital deemed necessary.</td>
</tr>
<tr>
<td>2a</td>
<td>Healthcare In-reach Admin Staff</td>
<td>Inform the MHU (Fax H1003 - Prisoners details) and Forensic Case Manager must include offence and previous conviction (where applicable).</td>
</tr>
<tr>
<td>2b</td>
<td>HHC and In-reach Clinicians</td>
<td>Arrange a 2nd Medical Assessment preferably by a Doctor from an appropriately secure unit, able to provide a bed*</td>
</tr>
<tr>
<td>3a</td>
<td>HHC and In-reach HC Admin</td>
<td>Inform the MHU (Fax HT014 from each Doctor and H1003) as well as prisoner’s particulars and include report.</td>
</tr>
<tr>
<td>3b</td>
<td>Head of HC In-reach</td>
<td>Inform the appropriate PCT**</td>
</tr>
<tr>
<td>4</td>
<td>Head of HC In-Reach</td>
<td>Liaise with the Hospital to arrange movement of the prisoner.</td>
</tr>
<tr>
<td>5</td>
<td>Hospital Service Provider</td>
<td>Prisoner returning from Hospital to prison ensure Continuity of Care (i.e. Section 117 Aftercare)</td>
</tr>
</tbody>
</table>

* One of the 2 doctors must be approved under Section 12(2) of The Mental Health Act  
** LHB (Local Health Board) in Wales

- In the first instance the HHC will lead, in conjunction with the Mental Health In-Reach Team (care co-ordinator as lead from In-Reach)
- Each transfer will have a nominated staff member from the In-Reach Team who will work in conjunction with HH
8.1 **Transfer to NHS Units**

This procedure is for those patients with acute mental health problems, which cannot be treated in prison, and are transferred to hospital setting appropriate to their health and security need.

The aim is to improve the efficiency, effectiveness, quality and speed to hospital of patients in prison who have acute mental health problems who meet the criteria under Section of Mental Health Act 1983.

As a principle of best practice refer to ‘Transfer of Prisoners to Hospital under the Mental Health Act 1983’, Department of Health document 2005.

8.2 **Transfer to another Prison.**

Ensure that all relevant information is passed on to reception staff of the receiving prison and liaise with their Prison In-reach Team.

As a principle of best practise and taking into account NHSE and HMP Service Guidelines this policy aims to implement the guidance laid out in ‘Discharge Arrangements and On-going Care for Prisoners with Mental Illness’, dated July 2000 and the Department of Health’s ‘Offender Mental Health Care Pathway’ 2005

9.0 **Therapeutic Interventions**

These are based on the following models and within the framework of CPA:

- Bio-psychosocial model
- Psychosocial Interventions
- Stress vulnerability
- Solution focused interventions
- Recovery model
- Model of Human Occupation
- Cognitive Behavioural Therapies
- Cognitive Analytical Therapies
- Compassionate Mind Therapies

Which includes:

- Treat mental illness and relieve symptoms.
- Harm minimisation
- Reduce challenging behaviour
- Encourage participation in planning of care
- Enhance self-esteem and coping skills
- Relapse prevention
- Facilitate reintegration into community.
- Recovery

When patients are participating in other treatments in the prison, the team will discuss at the weekly meeting whether it is clinically appropriate for the Prison In-reach services to cease during the participation in other treatments. All parties will be informed of decision with rationale.
10.0 **Discharge From The Prison In-Reach Team**

Once the patient, Consultant Psychiatrist and team member are satisfied that the Prison In-reach Services/Day Centre Service has met all its treatment aims for a patient or where a patient is unwilling or unable to continue to work with the team. The Named Therapist will write a Discharge Report. The patient may be re-referred at a later date if it is felt appropriate. Refer to Derbyshire CPA Policy.

10.1 **Refusal of In-Reach Services (see also Disengagement from Services)**

If a prisoner refuses an assessment or no longer requires the service, the following should take place.

- Liaise with the referrer
- Multi-Disciplinary Meeting to discuss the/any risk factors involved.
- Discuss opportunities to re-engage or query a change of named worker.
- If risk factors are not significant, or if care is no longer required a closure of the case can take place after discussion with the MDM.

11.0 **Disclosure of Confidentiality**

The team currently work in accordance with the Data Protection Act 1998, Derbyshire Partnership Forum Information Sharing Protocol. This framework provides guidance to ensure that sensitive information is securely transferred and that information shared is justifiable on a ‘need to know’ purpose.

All agencies with whom we are required to share information with are co-signatories of the Derbyshire-wide Information Sharing Protocol, which ensures that they uphold the standards of the Data Protection Act 1998.

Assessments can only take place with persons consent. Prior to assessment individuals are informed that details disclosed during the interview are confidential and will be entered on an NHS database. Individuals are also informed that information regarding risk to themselves and others or relating to a serious offence will be disclosed to other appropriate parties.

12.0 **Continual Service Improvement**

DMHS is committed to improving the service provided and informing development of practice of colleagues in local Mental Health and Criminal Justice services. The DMHS is actively developing a programme of audit with regard to service practice and evaluation of outcomes. This includes feedback from users of the service. The Clinical Audit Programme will be discussed at the Practice Development Meetings.

The DMHS has a regular programme of Performance Reviews in which the team feedback there position within the framework of the Trust Performance Indicators and the Prison Mental Health Indicators.

13.0 **Safeguarding Vulnerable Adults**

All Team members have regard to and are bound to operate within the guidance of legislation. They are aware of their responsibilities under and have a working knowledge of the Human Rights Act 1998, Mental Capacity Act 2005 Code of Practice, Deprivation of Liberty Safeguards and Safeguarding policy and procedures. All staff are trained by Derby City Health and Social Care Safeguarding Vulnerable Adult Learning and Development Forum.

The team have a safeguarding link professional who maintains links with the DMHS Co-ordinator.
REFERENCES

1. A Review of Mental Health Services and Prisoners - (Dec 2002)
   C Brooker, J Repper, C Beverley, M Ferriter and N Brewer - University of Sheffield

   Department of Health, London

   Department of Health

   Department of Health

5. HM Prison ACCT Documentation

6. Schizophrenia: Core Intervention in the Treatment and Management of Schizophrenia in Primary and
   Secondary Care
   NICE (Dec 2002)

7. Mental Health: The Primary - Secondary Care Interface Paper for Department of Health
   M Pringle (July 2002)

8. The CPA Handbook
   The Care Programme Approach Association (Feb 2001)

9. The NHS Plan
   Department of Health (2000)

10. Women’s Mental Health: Into the Mainstream
    Department of Health (2002)

11. Offender Mental Health Care Pathway
    Department of Health (2005)

    Department of Health

13. Transfer of Prisoners under the Mental Health Act 1983
    Department of Health (2005)

14. Code of Professional Conduct
    NMC (2002)

15. Administrations of Medicines
    NMC (2002)

16. Code of Practice Mental Health Act 1983

17. NSF for Women (2008)


20. Mental Health Act (1983)


22. New CPA Refocusing the Care Programme Approach (2008)
