Report on

NEW PRISON RECEPTION HEALTH SCREENING ARRANGEMENTS:

the results of a pilot study in 10 prisons

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EXECUTIVE SUMMARY

Background

On entering prison all new prisoners undergo a health assessment intended to identify those with health care needs. This has traditionally been in the form of a two stage screening process: on the day of reception into prison an initial assessment is undertaken by a nurse or Health Care Officer using a standard questionnaire, followed by a further assessment carried out by a doctor that usually takes place immediately after but which in any case must occur within 24 hours.

Although of potential value, the existing prison health screening procedures have been shown to be of limited value. Because of this, the Prison Health Policy Unit commissioned a redevelopment of screening procedures that were then introduced on a pilot basis in 10 remand prisons (6 adult male, 2 female and 2 YOI). The new health screen splits health assessment into an initial triage and a later general health assessment. The screening instrument contains well defined protocols for dealing with prisoners who “screen positive”, which vary to some extent between prisons. The general health assessment is modelled on the type of assessment that takes place in the community when a patient joins a new general practice. Various prison service requirements that have become established over time but whose value has never been demonstrated, in particular the need for all new prisoners to see a doctor within 24 hours of reception, were suspended at the 10 pilot prisons.

The new screening procedure was rolled out in a phased manner over a fifteen month period. An audit of its use in each prison was carried out 3 months after introduction, and in 4 prisons a reaudit took place at 6 months. In addition, 15 prisoners from each establishment received a more lengthy diagnostic assessment (150 prisoners in total) to determine the efficacy of the screening procedures.

Results

About two thirds of all inmates screened positive for at least one current health problem in the form physical health, mental health or dependence on substances. The lowest incidence was in the YOI population, the highest in the women, with the adult males in between. The 16 to 21 year old females were more similar to adult women than to the young offender males. One third of prisoners had a completely negative health screen, which meant that no further immediate assessment or referral was necessary.

Few F2052SHs were opened as a result of the screen, and only 4 in the weeks following reception. However, during the audit periods there were no suicides in any of the prisons, nor were there any incidents of serious self harm documented in the inmate medical records, suggesting that the screen did not appear to be missing new prisoners at high risk of self harm over this time period. However, because suicide and serious self harm are relatively uncommon, much longer follow-up will be needed to determine the numbers of high risk individuals who may not be identified by the screen, and the reasons for this.
Only 2 instances of missed physical health problems (unsymptomatic asthma) and one case of severe mental illness was picked up in the diagnostic interviews, indicating that the screen had a high sensitivity. Specificity ranged from 73% for physical health problems to 94% for substance dependence. Many fewer prisoners (20%) screened as false positives for severe mental illness than was expected.

Completion of the later general health assessment was problematic, with lack of clarity about what should be included in it, and difficulties in arranging for the assessments to take place after prisoners had passed through reception. Various health issues were identified in the general health assessments that did take place, however, with associated opportunities for health promotion.

Healthcare staff completed the questions properly in almost all of the initial screens and adhered to the local protocols. Referrals and further assessments took place for 99% of those who screened positive for physical or mental health problems, or substance dependence. Staff reported that the new screening procedure did not take any longer to use than the old screen. Screening was most effective when carried out regularly by experienced staff, who were also more comfortable in the use of the new procedures compared with those who only undertook reception screening occasionally.

Aspects of the new screening procedure that were found to be particularly successful were:

i. The identification of immediate health needs using the reception screening instrument
ii. The substantial improvement in the detection of prisoners with severe mental illness
iii. The use of written, standardised protocols
iv. The efficient secondary assessment and management of prisoners with immediate health problems
v. The discontinuation of automatic doctor review within 24 hours

Features of the new screening procedures that need further attention:

i. The content and delivery of the general health assessment
ii. The physical design of the screening documents
iii. Ongoing staff education and training
iv. Continuous audit and evaluation of the screening process
Based on the findings of the evaluation, the following recommendations are made:

1. Three standard screening instruments should be used (one for each type of establishment), with new questions be added only if supported by evidence that they will improve the efficacy of the screen.

2. Protocols for managing health needs identified by the initial screen should be developed locally but agreed by the Prison Health Task Force.

3. The general health assessment should be delivered as an adjunct to, but not confused with, the initial screen until the difficulties associated with it are resolved.

4. The requirement for all new prisoners to see a doctor within 24 hours of reception should be formally discontinued.

5. There should be a core team of staff responsible for reception screening in each prison.

6. A formal training programme should be established which staff must attend if they are to carry out reception screening.

7. Procedures should be established to monitor the implementation of health screening in reception.

8. Procedures separate from standard health screening should be established to assess prisoners who have had a change in circumstances.

9. Professional input should be sought to improve the design of the screening documentation, but the wording should be left largely unmodified.
ACKNOWLEDGEMENTS

We would like to thank wholeheartedly the health care staff in all of the ten pilot prisons, whose enthusiasm and expertise made our task enjoyable and easier than we could have expected. Working in the prisons is always an educational experience. We would also like to thank Professor David Wooff and Mr Ben Wyllie from the University of Durham who assisted with the analysis of the Leeds suicide risk scale. Finally, we must express our gratitude to Rannoch Daly, whose intimate knowledge of the workings of the prison system resolved even the knottiest of problems.
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INTRODUCTION

On entering prison all new prisoners undergo a health assessment intended to identify those with health care needs. This has traditionally been in the form of a two stage screening process: on the day of reception into prison an initial assessment is undertaken by a nurse or Health Care Officer using a standard questionnaire, followed by a further assessment carried out by a doctor that usually takes place immediately after but which in any case must occur within 24 hours. These assessments focus primarily on issues relating to physical and mental health problems, substance use, and the risk of suicide or self harm, although other tasks are also addressed at this time, such as certifying inmates as "fit" for normal location in the prison, the gym, and work in the kitchen.

Although health screening of new prisoners is of obvious theoretical value, its efficacy in practice has been questioned. In a longitudinal study in which all new remands to Durham Prison were assessed for psychiatric morbidity over a seven month period, it was found that the prison health screen identified only about a quarter of men with significant mental health problems (Birmingham, Mason, & Grubin, 1996; Grubin, Birmingham, & Mason, 1998). Similar findings were reported in relation to women newly remanded to custody (Grubin, Parsons & Walker, 2000; Parsons, Walker & Grubin, 2001). The fact that the risk of self harm (in the form of an open F2052SH) was identified in less than 25% of those committing suicide in the weeks immediately following reception into prison (figures from the Safer Custody Group relating to the late 1990's) suggests that suicide risk is also not being detected reliably. The efficacy of the screen in terms of identifying physical health problems and substance dependence is simply not known.

There are a number of reasons why prison health screening on reception is not working. Some relate to procedural issues. In busy remand prisons large numbers of inmates must be seen in a limited time, and there is pressure to process prisoners quickly so that they can be moved on to their cells. In many of the older prisons, the reception area is uncomfortable and lacks privacy. Harried staff in unconducive surroundings does not lay a foundation for successful health screening.

But there are also fundamental flaws to the screening process itself that mitigate against it working effectively:

First, the purpose of the screen is conceptually confused. It seeks to elicit information of three types: i) regarding immediate needs such as acute mental illness, withdrawal from substances, or risk of self harm; ii) relating to more general health issues such as smoking, immunisation, and diseases running in an inmate's family; and iii) of no apparent relevance, for example whether the prisoner has had any operations in the past. Clearly only the first of these areas is relevant to an individual's first few days in prison.

Second, the discriminative worth of the questions being asked is uncertain. For example, the screening questionnaire used on the first night contains 10 questions relating to the risk of self harm, and yet as indicated above the majority
of those who commit suicide in the weeks after reception into prison are not identified as being at risk.

Third, it is not clear what counts as "screening positive", nor what action to take in such cases. Because of this, potential problems may be identified but not recognised, or recognised with nothing being done about them.

Fourth, screening is undermined by various requirements that have become established over time but whose value has never been demonstrated. For example, the reason for every new inmate being seen by a doctor within 24 hours is unclear, and as such the content of this second assessment is unfocused and variable. Health Care Standard 1.2 instructs the doctor to take full medical and psychiatric histories, to make a systematic enquiry for any signs or symptoms suggestive of disease, substance use or risk of self harm, and to carry out full physical and mental state examinations. It has been estimated that done properly this would take approximately 50 minutes per new inmate, or eight and a half hours of a doctor's time for every 10 new receptions. It should not be surprising that in practice the medical assessment is brief, and often duplicates what has already been done by Health Care Staff.

Fifth, the screen carries with it a variety of what were once tasks for the doctor but which are now essentially non-medical in nature. For instance, assessments are meant to be made about whether an inmate is fit to work in the kitchens or go to the gym, or is able to reside on normal location. More recently it has been suggested that the health screen should identify those who are not safe to share cells with others. Although information relating to all these areas may emerge during the screen, none are enquired about specifically, and to rely on the screen to provide meaningful answers to them is illusory.

Having identified these problems inherent to the current reception health screening process, the Prison Health Policy Unit commissioned us to develop a new reception screening procedure. This report describes that procedure, and the results of it having been piloted in 10 remand prisons.

The New Health Screen

If health screening on reception into prison is to work effectively, then all of the issues referred to above need to be addressed. In doing so, the purpose of health screening must be made explicit. Its role is not to make definitive diagnoses or to establish detailed management. Instead, it seeks to identify those inmates with a higher likelihood of having significant health needs, and who therefore require a more thorough assessment later. This is equivalent to how screening works in other medical areas: for example, in screening for cervical cancer, the results of a cervical smear are used to determine which women are at higher risk of having cervical cancer, and who therefore need more detailed investigation.

Thus, the initial health screen on first reception should be reasonably quick, singling out those who require further assessment for specific conditions. It should function as a
screen, not a detailed assessment. But to work in this manner, there needs to be a clear definition of what “screening positive” means for each condition about which enquiries are made, and there must be protocols in place describing how those who screen positive are to be managed.

In addition, given the pressures of time and space inherent in the prison reception process, it seems reasonable to limit screening on immediate reception to health problems that need to be identified in the first few days of imprisonment (immediate physical or mental health problems), risk of withdrawal from drugs or alcohol, or risk of self harm. Other health concerns, such as immunisation status, cardiovascular risk, or smoking are almost certainly better detected and discussed in a more relaxed setting at a later time.

With these principles in mind, the new health screening process we have developed has the following characteristics:

1. Screening is split into two parts: triage that takes place on the first night of reception that seeks to detect health needs which are immediately relevant, and a general health assessment that takes place some time later, similar to the assessment that takes place when someone in the community registers with a new general practitioner.

2. A screening instrument for use on reception by prison health care staff that provides a clear indication of when prisoners have “screened positive” for specific conditions. It also contains prompts and protocols for action to be taken when prisoners screen positive for different conditions.

3. A second form relating to the general health assessment, modelled on those used in community general practice, again containing prompts and protocols, relates specifically to this additional evaluation.

4. The protocols for dealing with prisoners who screen positive vary between prisons to reflect differences in practice.

5. Health screening on reception is only carried out by those who have received training in the new instruments and procedures.

In addition, in introducing the new health screening procedures, current prison service requirements and practices that contribute little to health assessment have been identified and where necessary changed.

The new screening instrument for initial reception

An instrument for use by reception staff containing 15 basic screening questions (slightly more for women prisoners) replaces the existing 35 question standard form. This forms the basis of triage. Information is sought about problems relating to physical and mental health, recent injuries, medication, withdrawal from alcohol or drugs, and risk of self harm. Although this instrument is essentially the same for each
prison, because of differences in catchment populations there is slight variation in the forms used between prisons. For example, the London prisons ask specifically about sickle cell disease and tuberculosis, the women prisons about dependants, while the young offender institutions added a question about the recent death of family or close friends.

The instrument was designed so that there is a reason for every question asked. In relation to screening for mental health problems, earlier research (Birmingham et al, 1996; Grubin et al, 1998) identified four characteristics that were good at detecting those with severe mental illness: a history of psychiatric treatment, a history of deliberate self harm outside prison, having been prescribed antipsychotic or antidepressant medication, and being charged with murder or manslaughter (such features, of course, are also likely to be found in those with less severe illnesses). A positive answer in respect of any of these characteristics is considered to be a "screen positive" for severe mental illness. It was predicted that about 40% of remand prisoners would screen positive for mental health problems on this basis, which would include 80% of those with severe illnesses. As will be seen, fewer prisoners than expected in fact screened positive, but the pick up rate was nevertheless above 80%.

It was expected that using the new instrument the initial health screen should take between 5 and 10 minutes. This was in fact what we found.

**General health assessment**

Contrary to expectations, little research appears to have been carried out in respect of initial health screening in general practice, nor was there much in the way of standard instruments in use. Because of this, the general health assessment focused on areas that appeared to be relevant to the general health of a prison population, for example, relating to smoking, sexually transmitted diseases, or the need for hepatitis vaccination.

The intention was for this second, more general assessment to take place in the days following reception, carried out by a nurse in a routine clinic. In most of the prisons, however, it was stated that logistically this could not be done, and that the general health assessment had to occur in reception or not at all. In these cases a compromise was reached whereby the general health assessment was separated out from the immediate screen, but delivered immediately after, in the belief that at some point in the future it might be possible to move it to a more sensible time.

**Protocols**

Because of differences in the ways in which the prisons chose to manage various health care needs, protocols for dealing with positive screens were developed separately for each. Although these were often similar to each other, there were some areas in which practices differed markedly. For example, in some prisons those who screened positive for mental illness were further assessed by a mental health nurse, while in others this was done by the prison doctor. Detoxification regimes also varied.
With the development of protocols there was a need to review a range of current practices and requirements that have grown up over time without any formal evidence base. Most problematic was the requirement for all prisoners to see a doctor within 24 hours of reception. This did not feature in the new protocols, in which the doctor only sees prisoners when there is a reason to do so. In removing this requirement, the prisons needed to put in place new procedures for dealing with some of the tasks normally carried out at this time, such as “fitting” for the kitchen or gym, or indeed reconsider whether such “fitting” was necessary at all. In addition, some staff were initially concerned that if the doctor did not see everyone they would lose an important safety net if things went wrong, but soon accepted that the establishment of clear protocols meant that such a safety net was not actually necessary.

INTRODUCING THE NEW SCREENING PROCEDURES

Introduction and Implementation of the New Procedures

Between August 2001 and June 2002, the new screening procedure was introduced to 10 prisons in a rolling programme. Of the ten establishments, six were adult male remand prisons (Leeds, Wandsworth, Holme House, Liverpool, Manchester and Durham), two were for female remand prisoners (Eastwood Park and New Hall) and two were Young Offender Institutions (Feltham and Glen Parva). The two female prisons included both adult and women aged 16-21 years.

At each prison, the process of introducing the new procedure involved:

• meetings to agree modifications to the screening instruments and to establish written local protocols;
• staff training;
• observation of the first few days of the launch;
• a review at one month to identify and resolve any difficulties;
• audit and formal evaluation after three months;
• re-audit after six months in the four establishments where it was first introduced.

Agreement of the screening instruments and local protocols

Initial meetings were held with health care staff at each prison to describe the new procedures. At these meetings issues associated with modifying the initial screening and general health assessment instruments to suit local needs were discussed, and the process of establishing written protocols that detailed the management of prisoners screening positive for different conditions was started. The participants in these meetings varied between prisons, and could include doctors, nurses, and health care management. A meeting with the senior governor usually, but not always, also took place.
Over the following weeks the initial screening instrument, the general health assessment, and the protocols were agreed. Near final drafts were used in staff training, which allowed them to be further modified based on the observations of those who would be carrying out the screening procedures.

**Staff training**

Training was organised for all staff who would be using the new screening process, and any other healthcare staff who would be affected by its introduction. Training normally took one day (although time constraints sometimes meant this was condensed into a half day), and included an explanation of the background to the screen and the way in which it was intended to function. Terms were explained, the protocols described, and the importance of using the questions as prompts was emphasised. By the end of each session it was expected that staff would be competent to use the screen unsupervised. In addition, in each prison one or two staff members were chosen to act as “trainers” to introduce the screen to new staff.

The core training was common to all establishments, but the number and length of sessions varied widely, depending on the number of staff and time available. Groups ranged in size from 3 to 12 (although in one prison was done on an individual basis within the Reception area during the course of an afternoon/evening). Most sessions were separated into two sections. The first introduced the theory of screening in general and then the reason for each question in the new instruments. The second section involved each staff member using the new screen either on an existing prisoner (who had volunteered to take part) or another member of staff playing a prisoner (who were often more realistic than the prisoner volunteers).

**Launch of the new screen**

When the new procedures were introduced, staff were observed using the screening instrument with new prisoners upon their reception into prison. The aim was to ensure staff competency using the tool, and address any confusion or areas overlooked during the preparation period.

**One month review**

Contact was made with each prison when they had been using the new procedures for approximately one month. This usually took the form of a day spent with staff while they carried out reception screening. At this time information was gathered informally about how the process was being received. Where problems were identified these were addressed to improve the screening procedure in that prison, but also to inform the process in prisons where it had not yet commenced.
**Evaluation at Three Months**

The main evaluation of the modified screening procedures took place in each establishment three months following its introduction. This was intended to provide an audit of the new process, to evaluate the use of the new screening instruments, and to determine staff response. Information was gathered from three sources: the Inmate Medical Records (which included the screening instruments) interviews with prisoners, and both formal and informal staff feedback.

**Inmate medical records**

A sample of the medical records of at least 20% of new remands coming into each prison over the preceding 4 weeks were reviewed (records of people who were no longer resident in the establishment were unavailable). Information was collected in respect of how the screening forms were completed, the information contained on them, whether screen positives were correctly identified, and the subsequent actions taken by the person carrying out the screening.

**Prisoner interviews**

In each prison fifteen prisoners, selected at random, were interviewed at length with a structured interview to determine the presence of physical health, mental health and substance misuse problems; the Schedule for Affective Disorders and Schizophrenia – Lifetime Version (SADS-L) was used to detect and classify current and lifetime mental disorders (Endicott & Spitzer, 1978). The findings were compared with the outcome of the screen completed by prison healthcare staff to ascertain what, if any, health problems had been missed during the screening process; the interviewer did not know the outcome of the screen at the time of the interviews. Of the 150 prisoners interviewed, 46 (31%) were interviewed within three days of their reception into prison, 109 (73%) within five days, and all within a week.

Each prisoner who was interviewed was told of the purposes of the research interview and gave his or her informed consent. These confidential interviews, which lasted an average of 30 minutes, took place between one and eight days following their reception into prison. Information was obtained regarding sociodemographic details, offending history, personal background and current and past physical health, mental health, and alcohol and drug use. Blood pressure, pulse, respiratory peak flow rate and general physical observations were also recorded. It was initially intended to test urine for glucose, proteins and other indicators of possible ill health, but the facilities to do this were not available in most cases.

In respect of alcohol and drug use, it was not possible in the context of this evaluation to test objectively the self report of inmates. Thus, although we were able to determine whether prisoners were missed by the screen who subsequently developed withdrawal symptoms (false negatives), we could not ascertain whether those who were detected as being at risk of withdrawal and thus in need of intoxication were wrongly identified (false positives) except if they admitted to this.
Staff feedback

During the evaluation period the opinions and observations of staff were obtained both informally, and by way of a short anonymous questionnaire relating to their experience of the new screening procedures. We wanted to know what they liked about the screen, what they didn’t like, how it could be improved, and how long it took to use. A reminder was sent to staff who did not reply within three weeks.

Reaudit at 6 Months

The first four prisons to use the modified screening procedures (HMP Leeds, Wandsworth, Eastwood Park and YOI Feltham) were evaluated a second time six months after the introduction of the screen. As in the 3 month audit, the Inmate Medical Records of over 20% of the new prisoners received into the prison over the previous four weeks were assessed. Records were only available for prisoners still within that establishment.
RESULTS

Audit of Initial Reception

Over the course of the evaluation 1306 sets of Inmate Medical Records were examined (after approximately three months in all prisons and additionally after 6 months in the four re-audited prisons). Of these, 775 (59%) were from adult male prisons, 246 (19%) from female prisons, and 285 (22%) from the Young Offender Institutions.

Health screen on reception

As can be seen from Table 1, about two thirds of all inmates screened positive for at least one current health problem in the form physical health, mental health or dependence on substances. The lowest incidence was in the YOI population, the highest in the women, with the adult males in between. The 16 to 21 year old females were more similar to adult women than to the young offender males.

The most common reason for screening positive in the adult population was for possible substance dependence, but in the male YOI population it was for physical health reasons. Screening positive for more than one indication was not uncommon, particularly amongst women, of whom one in five required further assessment in respect of all three categories.

Overall, one third of prisoners had completely negative health screens, with this being the case for about a quarter of the adult men and nearly 60% of male young offenders. In contrast, just 14% of the adult women prisoners and 4% of the under 21 women screened negative. However, if substance dependence is excluded, then 29% of the adult women, 35% of the under 21 women, 57% of adult males, and 67% of male young offenders had otherwise negative screens.

A completely negative health screen means that no further immediate assessment or referral is necessary, and a secondary screen by the doctor is not required. Of those individuals who screened negative, only a very small number (less than 10) requested to see the doctor, but in no case did immediate health problems emerge following this.

Suicide/self harm

During the audit periods, there were no suicides in any of the prisons, nor were there any incidents of serious self harm documented in the inmate medical records. We are aware of one serious self harm attempt in one of the prisons outside the audit period in an adult male prisoner who screened positive for substance dependence and was undergoing detoxification, and one suicide in an adult male prisoner who had not been screened at all.
Table 1. Results of positive responses to the initial health screen based on audit of records of a sample of those screened in the 10 prisons over a 4 week period 3 months after the introduction of the screen, and over a 4 week period 6 months after the introduction of the screen in 4 prisons (the 16-21 year old females included 3 who were 16 years of age and 12 who were 17).

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<th>ADULT FEMALE</th>
<th>16-21 FEMALE</th>
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<td>285</td>
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<td>Physical Health</td>
<td>294 (38%)</td>
<td>71 (25%)</td>
<td>98 (50%)</td>
<td>21 (40%)</td>
<td>484  (37%)</td>
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<td>Substance Use</td>
<td>354 (46%)</td>
<td>53 (19%)</td>
<td>130 (67%)</td>
<td>27 (52%)</td>
<td>564  (44%)</td>
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<td>Mental Health</td>
<td>202 (26%)</td>
<td>33 (12%)</td>
<td>89 (46%)</td>
<td>26 (50%)</td>
<td>350  (28%)</td>
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<td>134 (17%)</td>
<td>18 (6%)</td>
<td>69 (36%)</td>
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<tr>
<td>PH/MH</td>
<td>113 (15%)</td>
<td>12 (4%)</td>
<td>58 (30%)</td>
<td>13 (25%)</td>
<td>196  (16%)</td>
</tr>
<tr>
<td>SU/MH</td>
<td>106 (14%)</td>
<td>12 (4%)</td>
<td>65 (33%)</td>
<td>15 (29%)</td>
<td>198  (17%)</td>
</tr>
<tr>
<td>PH/SU/MH POSITIVE</td>
<td>58 (8%)</td>
<td>6 (2%)</td>
<td>39 (20%)</td>
<td>10 (19%)</td>
<td>113  (10%)</td>
</tr>
<tr>
<td>SCREEN NEGATIVE</td>
<td>213 (28%)</td>
<td>58% (161)</td>
<td>28 (14%)</td>
<td>2 (4%)</td>
<td>33%  (404)</td>
</tr>
</tbody>
</table>

Of the 1306 prisoners included in the audits, 79 (6%) had open F2052SHs. At least 24 (30%) of these were already open before the prisoner arrived at the prison, but it was not clear from the documentation how many of the others were opened before as opposed to after reception screening (and in only some cases did the F2052SH registers held by the prisons clarify when the forms were opened). Thirty-eight prisoners (3%) responded positively to the screening question that asked whether they currently felt suicidal: 6 were 18-21 year old males (3% of this group), 2 were in 16-21 year old females (4%), 6 were in adult females (3%), and 24 in adult males (3%). Of these, 34 also screened positive for mental illness, while 2 screened positive for substance dependence; thus, just two prisoners in the entire sample screened positive only on this question.
In four cases no concerns were identified at reception, but F2052SHs were subsequently opened in the weeks following: one related to a prisoner withdrawing from drugs, one was for a young offender who was being bullied, one was for a young offender who was noted to be “distressed” a week after reception, and one was in a woman who was thought to be “low”.

In HMP Leeds, a 16-item suicide risk scale was in use, and this continued as part of the new screening procedures in this prison. An F2052SH is automatically opened for any new prisoner who scores over 10 on this scale. When evaluating the scale, a larger sample was used than was reviewed in the audit period. In total, the scales of 463 prisoners were considered, of whom just 6 deliberately harmed themselves in the month after reception. F2052SHs were opened for 71 inmates, but in 47 of these cases the score was under 10 (mostly because they had been opened prior to arrival at the prison). Thirty prisoners scored over 10, with F2052SHs not being opened for 6.

It was found that prisoners who reported feeling suicidal also tended to be rated by nursing staff as being “pessimistic”, “hopeless”, and “poor copers”, but their ratings were of course not being made blindly, and were not defined in the same way by the various people doing the assessments. The most significant triggers for the opening of an F2052SH were a past history of self harm, being a “poor coper”, and “pessimism”.

**General health assessment**

The general health assessment in the male prisons was not undertaken in about a quarter of new remands (Table 2). On occasions this was because of a lack of time at reception or poor command of English by the prisoner, but the vast majority of cases occurred in the two adult male prisons where it was carried out the day following reception. In some instances this was because prisoners were not readily available the next day, and in others because prisoners declined to attend, believing there was little to be gained from the assessment.

Of the general health assessments reviewed, 91% had at least one positive response indicating an issue relating to the general health. However, the majority of these, 48%, were positive responses relating only to the smoking of tobacco (93% in total smoked). The next most common reason for a positive response (30%) related to a family history of illnesses such as cardiac disease or diabetes, but in only 3% of these cases was this the only positive answer. Agreement to Hepatitis B vaccination was obtained in 40% of 18-21 year old males compared with 13% of the other prisoner groups. Blood pressure was not taken, or at least the results were not entered, in 55% of the general health assessments.
Table 2. General health assessment results.

<table>
<thead>
<tr>
<th></th>
<th>Adult Male</th>
<th>18-21 Male</th>
<th>Adult Female</th>
<th>16-21 Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>528 (89%)</td>
<td>245 (90%)</td>
<td>171 (97%)</td>
<td>48 (96%)</td>
<td>992 (91%)</td>
</tr>
<tr>
<td>Negative</td>
<td>64 (11%)</td>
<td>28 (10%)</td>
<td>6 (3%)</td>
<td>2 (4%)</td>
<td>100 (9%)</td>
</tr>
<tr>
<td>Total carried out</td>
<td>592</td>
<td>273</td>
<td>177</td>
<td>50</td>
<td>1092</td>
</tr>
<tr>
<td>Not done</td>
<td>183 (24%)</td>
<td>12 (4%)</td>
<td>17 (9%)</td>
<td>2 (4%)</td>
<td>214 (16%)</td>
</tr>
<tr>
<td>Total</td>
<td>775</td>
<td>285</td>
<td>194</td>
<td>52</td>
<td>1306</td>
</tr>
</tbody>
</table>

Completion of documentation

Three months into the study period, staff completed the majority of the new documentation satisfactorily. However, half of the screens had information omitted. This mainly related to the front page containing general background information about the prisoner, but also to the concluding summary sheet (planned action). Very few of the screening questions themselves were left unanswered (less than 5%).

The protocols were being followed appropriately in almost all cases. In eight of the prisons 99% of prisoners who screened positive were being dealt with correctly. In the other two prisons, however, the protocols were not always being followed, with 25% of referrals in one and 11% in the other not being made. Each of these prisons was re-audited, and at 6 months the situation had improved, with 99% of those screening positive being referred for further assessment. With very few exceptions, the additional assessments required were all carried out.

In addition to completion of screening questions, healthcare staff were also expected to briefly record their observations of the physical and mental health condition of each inmate. Even though this was emphasised in training, this was omitted in two thirds of cases overall.

Although the documentation was not always complete the healthcare staff carried out the appropriate actions (according to local protocols). When referred, the secondary assessment was performed in 97% of cases.
**Prisoner Assessment Interviews**

Diagnostic interviews were carried out for 150 prisoners, and the results compared with the screening interviews and Inmate Medical Records.

In only 2 subjects (1%) were physical health problems missed. In both cases the prisoner suffered from asthma and used inhalers but gave negative responses to the screening staff when asked specifically about asthma and prescribed medication. Both were unsymptomatic when seen in the diagnostic interview, and peak flows in each case were in the normal range.

In one case severe mental illness was missed. This was in a male young offender whose answers to each of the 4 mental health screening questions were (correctly) negative. His only positive responses were to being homeless prior to coming into prison, drinking alcohol within recommended limits and using cannabis. On the more detailed questioning of the diagnostic interview he reported auditory hallucinations occurring every day for at least one year, and which were still present. He also displayed thoughts suggestive of persecutory delusions but was guarded in his account of these.

There were no instances where substance dependence and risk of withdrawal had been missed (although some admitted to more drug use than they had to screening staff). Similarly, in no cases did it appear that individuals at risk of self harm had been missed.

About 20% of prisoners were rated as false positives for physical health problems. This was the result of a physical problem being reported or medication being taken but on further assessment this proved not to require further intervention. The 13% false positive rate for serious mental health problems was much lower than expected, as was the 3% rate for substance dependence. However, in terms of the latter it must be remembered that apart from self report there was no way to confirm what the prisoners were saying about their substance use. Figures relating to false positive and false negative rates can be found in Table 3.
Table 3. False positive and false negative rates based on differences between 150 screening and diagnostic interviews: physical health, mental health and substance dependence.

<table>
<thead>
<tr>
<th></th>
<th>Adult male (n=90)</th>
<th>Female (n=30)</th>
<th>Male YOI (n=30)</th>
<th>Total (n=150)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screen positive</strong></td>
<td>42 (47%)</td>
<td>18 (60%)</td>
<td>10 (33%)</td>
<td>70 (47%)</td>
</tr>
<tr>
<td><strong>Interview positive</strong></td>
<td>26 (29%)</td>
<td>12 (40%)</td>
<td>5 (17%)</td>
<td>43 (29%)</td>
</tr>
<tr>
<td><strong>False positives</strong></td>
<td>18 (20%)</td>
<td>6 (20%)</td>
<td>5 (17%)</td>
<td>29 (19%)</td>
</tr>
<tr>
<td><strong>False negatives</strong></td>
<td>2 (2%)</td>
<td>0</td>
<td>0</td>
<td>2 (1%)</td>
</tr>
</tbody>
</table>

**Physical Health**

**Mental Health**

<table>
<thead>
<tr>
<th></th>
<th>26 (29%)</th>
<th>17 (57%)</th>
<th>6 (20%)</th>
<th>49 (33%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interview positive</strong></td>
<td>17 (19%)</td>
<td>11 (37%)</td>
<td>2 (7%)</td>
<td>30 (20%)</td>
</tr>
<tr>
<td><strong>False positives</strong></td>
<td>9 (10%)</td>
<td>6 (20%)</td>
<td>5 (17%)</td>
<td>20 (13%)</td>
</tr>
<tr>
<td><strong>False negatives</strong></td>
<td>0</td>
<td>0</td>
<td>1 (3%)</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

**Substance Dependence**

<table>
<thead>
<tr>
<th></th>
<th>44 (49%)</th>
<th>22 (73%)</th>
<th>2 (7%)</th>
<th>68 (45%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interview positive</strong></td>
<td>40 (44%)</td>
<td>21 (70%)</td>
<td>2 (7%)</td>
<td>63 (42%)</td>
</tr>
<tr>
<td><strong>False positives</strong></td>
<td>4 (4%)</td>
<td>1 (3%)</td>
<td>0</td>
<td>5 (3%)</td>
</tr>
<tr>
<td><strong>False negatives</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
The sensitivity and specificity of the screen based on the results of the diagnostic interviews are given in Table 4. It can be seen that the negative predictive values for each area is high, which means that one can be confident that those who screen negative are unlikely to have significant health problems. Specificity and positive predictive values were also good (and much higher than expected), but in terms of substance dependence it must again be emphasised that there was no objective confirmation of prisoner's self report. Efficiency can be defined as the total of true positives and true negatives divided by the total number screened (in other words, the proportion of screen results that are accurate).

Table 4. Sensitivity, specificity, positive and negative predictive values, and efficiency rates in the new screen for physical health, mental health and substance dependence.

<table>
<thead>
<tr>
<th>Area</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Positive Predictive Value</th>
<th>Neg. Predictive Value</th>
<th>Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>95%</td>
<td>73%</td>
<td>59%</td>
<td>98%</td>
<td>79%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>97%</td>
<td>84%</td>
<td>60%</td>
<td>99%</td>
<td>86%</td>
</tr>
<tr>
<td>Substance Dep.</td>
<td>100%</td>
<td>94%</td>
<td>93%</td>
<td>100%</td>
<td>97%</td>
</tr>
</tbody>
</table>

*Homelessness*

Being of no fixed abode during the year prior to prison was associated with significantly more physical and mental health morbidity than expected; as is demonstrated in Table 5.

Table 5. The association between screening positive to physical and mental health problems and dependence on alcohol and drugs and being of no fixed abode within the previous year.

<table>
<thead>
<tr>
<th>Area</th>
<th>No Fixed Abode</th>
<th>Rest of population</th>
<th>Chi Squared</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Health</td>
<td>149 (43%)</td>
<td>335 (35%)</td>
<td>8.12</td>
<td>p&lt;0.01</td>
</tr>
<tr>
<td>Mental Health</td>
<td>122 (36%)</td>
<td>228 (24%)</td>
<td>18.23</td>
<td>p&lt;0.001</td>
</tr>
<tr>
<td>Substance Dep.</td>
<td>203 (59%)</td>
<td>361 (37%)</td>
<td>48.52</td>
<td>p&lt;0.001</td>
</tr>
</tbody>
</table>
Staff Response

Questionnaire

Questionnaires were sent after 3 months to 205 staff from the 10 prisons who were reported to have been involved in the new screening procedures. Replies were received from 94 members of staff (response rate 46%). On average, the respondents had used the new screen during 16 reception sessions.

Staff reported that the new screening process took a similar length of time to complete as the old screen. Estimates ranged from an average of 7 minutes for a straightforward case, to 14 minutes where the inmate's presentation was more complex. When the General Health Assessment was included as part of the initial screen, a further 3 to 5 minutes was required. This compared with estimates of 8 to 17 minutes for the old health screen.

Most staff preferred the new procedures, although about a third expressed a preference for the old screen. Negative responses were mainly from two prisons, and the reasons for this related primarily to the physical design of the reception screening instrument, the wording of particular questions (although staff had been told that questions should be modified to suit their own styles), and the General Health Assessment (which was seen as being unnecessary). Those who were positive about the new procedures commented on them being more concise, comprehensive and taking less time to complete. Other positive replies related to the removal of the automatic need for a doctor review of prisoners.

Staff were asked to rate their confidence in detecting health problems with the new screening instrument. All categories of health problems scored positively, with substance use problems highlighted as being particularly well detected. The practice of written protocols was also reported to be of benefit to screening staff.

Respondents' views about ways in which the new procedures could be improved followed on from their earlier comments. These were largely dominated by comments on changing the physical design of the screen, although suggestions were also made regarding the specific protocols that were in place.

Informal comments

When staff were asked for their informal observations of using the screening process one, a number of themes emerged.

First, opinions regarding the first night screening instrument were predominantly positive. Staff said that they had no significant difficulties using it but most reported that it had taken some time to achieve this – initially it could take twice as long to complete the new screen compared with the old, but the time taken reduced to that referred to above within two or three screening sessions. Those who did not carry out reception screening on a regular basis were more uncomfortable in its use, with the most positive reports coming from staff who worked more routinely in reception.
majority wanted to continue to use the new instrument after the study period ended (albeit with the changes referred to above); those who preferred to return to the old screen had usually used the new process on fewer occasions.

The second major theme related to the general health assessment, which was the main topic discussed in all feedback. Most of it was negative in nature. Overall, most believed that carrying out this type of assessment was in theory good but extremely problematic in practice, particularly in terms of separating it from the initial health screen; only one establishment (YOI Glen Parva) had no problems in delivering the general health care assessment on a day after initial reception. When this was tried in the other establishments, it was found that arranging assessments once the inmates had left the reception area was difficult, even when an identified “first night” landing was in operation: prisoners might be involved in a range of activities (for example, other assessments or visits), but they were also unmotivated to attend as they believed they had little to gain from the clinic. Interestingly, it was also observed that those who did attend for the general health assessment tended to have problems that needed to be addressed.

The third main theme related less to the screening procedures themselves, and more to the way in which the protocols were carried out. This was a particular issue in relation to mental health assessments where inmates who screened positive for mental health problems were referred to a mental health nurse for further evaluation. The additional demands on these nurses were not always recognised by managers, and the task was simply added to their existing workload. Overall these initial difficulties were usually resolved by the three month stage.

Health Economics

Set-up costs

Set up costs relate to the establishment of local screening instruments and protocols, and to training staff in the use of the new screening procedures. In the current study this entailed an initial meeting at the prison followed by further work on the procedures (a further 2 days), and an average of three or four training sessions per establishment in which two trainers were involved.

If rollout on a national basis was carried out in a similar manner, then about 7 days time for two outside providers would be needed per prison, with further input needed to deal with new staff. The cost of this would depend on the rates charged by the outside providers, but assuming an overall charge of between £500 to £1000 per day, and 60 remand prisons, the approximate initial set up costs would be from £210,000 to £360,000 (if the “outside providers” were employees of HM Prison Service, then this cost might be less). This estimate does not include the cost of freeing staff in each establishment to develop the protocols and to attend training.

Apart from the inherent difficulties in developing over 60 individual packages, and the length of time that would be required to bring all remand prisons on stream, the above calculation does not take into account the need to observe the initial days in which the
screen is being used, or ongoing input to resolve difficulties that may arise. It also does not address the problem of training new reception staff.

Models will need to be developed in which protocols and training can be carried out on a regional basis limiting the amount of outside provider time required – protocols could be developed jointly, and 6 monthly training carried out for large numbers of staff, with a system for interim training of new staff between regional sessions. If prisons were clustered into 6 groups of 10, each requiring perhaps 10 days input for protocol development and training at £500 to £1000 per day, followed by 2 days training at an interval of 6 months, then the set up costs excluding initial site observation and ongoing input would amount to £36,000 to £72,000 in the first year.

Process costs

Process costs relate to the additional expenses incurred as a result in the differences in time and staff requirements needed to deliver the new screen. If the general health assessment is carried out immediately following the initial screen, there are no real differences in the time required and health care staff employed. The removal of the need for all prisoners to see the doctor reduces the number of referrals he or she needs to see by about a third overall (and the doctor’s time with prisoners should now be more focussed), but in busy remand prisons a doctor’s presence will still be necessary. However, depending on protocols, it may be possible in less busy prisons for a doctor to only be on call – for example, if detoxification is managed by specialist nurses, thus resulting in less cost.

If the general health assessment is delivered on a separate day, then there is an additional cost for a nurse to run a dedicated clinic on a daily basis (although in less busy prisons this could be run less often). In many prisons this can be done without extra cost through a reorganisation of working practices.

Post screen costs

Post screen costs represent additional resources needed for secondary assessments to deal with screen positives and the further health care needs detected by the new screen that were previously missed. Although the likelihood of missing cases are reduced in the new screen, more resources will need to be devoted to sorting the true-positives from the false-positives. In order to assess the potential impact on resources in terms of medical and nursing staff time and the cost of external referrals, it is necessary to compare the sensitivity and specificity of the old and new screens, from which an estimate can be made of the additional health input required. Figures on which to base this are available only in terms of severe mental illness (Table 6).

Based on the figures in Table 6, and assuming an incidence of severe mental illness of 20% in new prisoners as described in Table 3, then for every 100 new receptions, the old screen will identify 5 of the 20 with severe mental illness (sensitivity 23%), and will wrongly identify as suffering from mental illness 3 of the 80 who are not in fact mentally ill (specificity 96%). The new screen will detect 19 of the 20 with severe
mental illness (sensitivity 97%), and will wrongly identify as suffering from mental illness 13 of the 80 who do not.

Table 6. Comparison of sensitivity and specificity rates in respect to severe mental illness between the old and new prison health screens (data for the old screen comes from Grubin et al, 1998).

<table>
<thead>
<tr>
<th></th>
<th>OLD SCREEN (n=569)</th>
<th>NEW SCREEN (n = 150)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>23%</td>
<td>97%</td>
</tr>
<tr>
<td>Specificity</td>
<td>96%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Assuming that the identification of a prisoner with severe mental illness will involve an additional 30 minutes of assessment by a mental health nurse following a screen positive, and excluding severe mental illness in a prisoner who is a false positive takes 15 minutes, then the following calculations can be made:

Old screen: 5 prisoners with severe mental illness = 2.5 hours
3 false positives = 0.75 hours
Total: 3.25 hours per 100 prisoners

New screen: 19 prisoners with severe mental illness = 9.5 hours
13 false positives = 3.25 hours
Total: 12.75 hours per 100 prisoners

Thus, for every 100 new prisoners, an additional 9.5 hours of mental health nursing time will be required in the period immediately following reception. At a busy remand prison receiving about 20 prisoners a day, this additional amount of time would be needed weekly. The impact of this on staffing needs at each prison and across the service as a whole will depend on the extent to which this added demand can be absorbed within existing resources.

In addition, an extra 14 prisoners per 100 will require ongoing psychiatric input.

Because sensitivity and specificity rates are not available for the old screen in respect of the detection of physical health problems, substance dependence and suicide risk,
similar calculations in these areas cannot be made. Estimates of need, however, can be arrived at based on the figures contained in Table 3, with 47% of prisoners overall screening positive for a physical health problem of whom 61% had identifiable physical health needs (29 of every 100 new receptions), and 45% screened positive for substance dependence of whom 93% were thought to be dependent on alcohol or drugs and in need of detoxification (42 of every 100 new receptions).

General Observations

Reception environment

In no prison was the environment in which the screening interviews carried out ideal. Many reception areas lacked privacy, and most interviews took place in locations that were cramped, with inadequate ventilation and often cluttered. Healthcare staff in some prisons reported that they were expected to perform basic physical examinations (such as measuring blood pressures, heights and weights) in the absence of functioning equipment.

Staffing

The healthcare component within the overall reception process worked best in establishments where a core group of staff worked on reception regularly. They held better relationships with other staff groups and inmates, and showed more confidence in their ability to expedite their work. Generally the atmosphere in these prison reception areas was more open and relaxed.

Reception screening became problematic when the first language of the inmate or staff member was not English. In the case of the former, some prisons used the Language Line (an interpreter service available by telephone), while others used other inmates to interpret, with obvious implications for confidentiality. When staff did not speak English well, few attempts were made to overcome resulting difficulties, and health screening in such cases was often poor.

The overall reception process

Reception into prison is a lengthy procedure. Prisoners are interviewed by a variety of staff, and engage in a range of procedures (e.g. showering, changing clothes, and logging property). The reception area is divided into two: a “dirty” area, where inmates wait until they have been searched, and a “clean” area. Most healthcare staff reported that they were instructed to have contact with inmates only in the clean area for reasons of safety. However, this means that prisoners are not available to healthcare until late in each session, when there is less time to deal with them, they are more tired and irritable, and they are less amenable to interview. These problems are exacerbated by the fact that in many cases prisoners have spent several hours on the “dirty” side, unoccupied and simply waiting to be moved.
Interaction with other staff groups

When doctors had taken an active role in the preparation of the screen, there was a greater amount of mutual support and assistance between them and health care staff. In prisons where this did not occur, doctors frequently seemed unaware of the changes that had been made or the reasons for them, and often did not adapt their roles accordingly. Interactions between healthcare and discipline staff varied considerably in the ten study prisons. Those where relationships were best tended to have healthcare staff who worked either entirely or predominantly in the reception area.
DISCUSSION

The results of this pilot project indicate that the new health screening procedures operated satisfactorily within busy local prisons over an extended period of time. The new screening instrument successfully identified prisoners who were likely to have health care needs, and ensured that appropriate further assessment took place for those who screened positive. Importantly, once staff became familiar with the modified procedures, reception screening took no longer than it had done previously, even when the general health assessment was undertaken on reception.

The broad subject matter covered by the screen and the prompt further assessment of those who screened positive, in accordance with clear protocols, increased staff confidence when screening prisoners. Some staff initially found it difficult to work within a screening rather than a diagnostic remit, but over time they found this preferable as it reduced interview times. For example, on occasions staff had to be reminded that it was unnecessary to take a detailed drug and alcohol history once the need for a further assessment relating to dependence had been identified. Most appreciated the increased role they were given in the healthcare process, assuming more responsibility, particularly in relation to prisoners who screen negative.

One of the most notable benefits of the screen was its high detection rate for severe mental health problems. Although a false positive rate of up to 40% was expected as a consequence of this, the rate of false positives was in fact much lower. It would be possible to reduce false positives further – for example, an American study that made use of an instrument called the Referral Decision Scale reported specificity of nearly 99% (Teplin and Swartz, 1989). However, this instrument is composed of 14 questions that focus exclusively on the diagnoses of schizophrenia, manic depression, and major depression; this is nearly as many questions as are in the entire screening instrument used here, in which physical health problems, alcohol and drug dependence, and the risk of self harm are also covered. Enhancing specificity comes with a price.

The screening questions for severe mental illness were developed on the basis of research carried out with adult prisoners. Further work will be necessary to determine whether these are also the most appropriate questions for young offenders, although for the time being it would appear that they are working reasonably well in this group.

The detection of those at risk from withdrawing from drugs or alcohol was also good, particularly given that by the time of the diagnostic interview symptoms of withdrawal would have become apparent in those missed by the screen. However, there may have been "overdisclosure" by prisoners seeking to obtain medication which they don't really need. Part of the training for the screen focused on these issues, but clearly the response of prisoners will also depend on the nature of detoxification and treatment regimes in individual prisons. In the longer term, increased attention to confirming drug or alcohol histories, for example through urine testing, is probably the only effective way to determine the false positive rate.

Identifying those at risk of suicide or self harm is especially problematic. The screen enquires about past attempts and current intentions, and it also detects other important risk factors such as severe mental illness and substance dependence. Whether other
indicators could improve the detection of those who will go on to self harm is unclear, but there was little evidence in these pilots to suggest that reception health screening was missing those most at risk. However, because suicide and serious self harm are relatively uncommon, much longer follow-up will be needed to determine the numbers of high risk individuals who may not be identified by the screen, and the reasons for this. In the meantime, rather than lengthen the initial screen with further queries about self harm that will be of questionable benefit, it would appear to be of more value to address the issue of vulnerability for self harm during the secondary assessment of those at increased risk, that is, prisoners who screen positive for severe mental illness or substance dependence, or in whom F2052SHs have been opened. The general health assessment also offers another opportunity to identify those who may not express any difficulties at the time of reception, but for various reasons may become more unsettled in the following days.

Being of no fixed abode in the year before prison was included in the screen on theoretical rather than empirical grounds. Our findings indicate that being recently homeless was associated with a significant psychiatric and physical morbidity. Although this in itself does not mean that, alone, it is a good discriminator of those with healthcare needs, it was of interest that the two cases of physical health problems that were missed, and the one case of severe mental illness had all been homeless in the last year before coming into prison. We believe, therefore, that it makes sense to leave it in the screening document.

Protocols

The introduction of formal protocols to be followed for all inmates who screen positive has ensured standardised practice within an establishment. Before their implementation, staff in many of the prisons were usually given no formal guidance relating to the management of health related problems within the prison. Consequently clinical practice could vary significantly. This was not the case with the new screening procedures.

All ten prisons in the study had similar protocols for physical health and substance dependence. In both instances, screening positive resulted in initial referral to a doctor. Detoxification regimes themselves differed between prisons, but this issue goes beyond what was addressed in this study.

The main difference between protocols related to inmates who screened positive for severe mental illness. In some cases they were initially referred to a doctor (most of whom had little in the way of psychiatric training), while in others referral was to a mental health nurse. Although this had additional resource implications in terms of the latter, informal observations suggested that this resulted in a more thorough assessment. Mental health nurses were also able to detect when prisoners had less severe mental health problems, and who might need further monitoring or other interventions.
Discontinuation of automatic review by doctors

With the modified screening procedures and the presence of formal protocols for healthcare staff to follow, the need for automatic review of all prisoners by the doctor within 24 hours was discontinued. Instead, inmates who screened negative, and were thus considered to be fit and well, were told how they could access healthcare facilities in the future. In such cases, they were also declared fit for kitchens, gym, and similar activities; previously the doctor declared prisoners fit, but no particular examinations or tests were undertaken in reaching this decision.

Before using the modified screen, a number of staff expressed concern about the responsibility associated with a negative screen; a common comment was that they would override the protocols and refer all inmates to the doctor regardless of the outcome of the screen, rather than worry that they had missed something important or would be held accountable if anything happened to the inmate at any time in their time in prison. However, once staff became familiar with the new process their confidence rapidly increased and no such problems were encountered. Indeed, most staff valued the recognition of their abilities that this implied. Very few doctors raised any concerns about this change in their practice, and welcomed the reduced number of unnecessary referrals.

The removal of automatic medical assessment has had the most significant impact in Young Offender Institutions where less than half of new prisoners required medical review. Staff there believe this figure could be reduced further if specialist nurses rather than doctors carried out the secondary assessment for those who screen positive for substance dependence. Female prisons, on the other hand, have been least affected as almost all of their new receptions screened positive for some immediate health problem.

General health assessment

The general health assessment, which is meant to mirror registering with a new general practice in the community, has given rise to the most difficulties associated with the revised procedures. These problems began at the design stage when, perhaps reflecting lack of clarity regarding this type of assessment in the community, it was difficult to agree on the questions and procedures to be incorporated, with arguments about what was relevant to the prison population.

Once the content of each general health assessment was agreed, there was further debate about when it should be carried out. Although designed to take place some time after reception, five establishments made it clear that they could not facilitate this at present, and the assessment had to take place during the reception interview. Of the five establishments that initially agreed to a two stage process, two reverted to a single assessment within a week of the introduction of the new screen, having found that staff members were spending inordinate amounts of time locating prisoners, many of whom declined the assessment once found.
Three prisons persevered with the two stage assessment process. One of these prisons, which already had something similar in place, reported no difficulties with this, conducting the general health assessment as part of a Reception Board held the morning after admission to prison (this is a time when all new prisoners are held together in one area for the purposes of a range of meetings and assessments). The other two prisons encountered a great deal of difficulty in attempting to implement the new system. Staff in one of these, where dedicated staff time and a clinic room were put aside for the assessment the day following reception, reported that the response from inmates was initially favourable, and most attended and complied with the assessment. However, within two months the attendance rate had reduced dramatically, as prisoners gave it a low priority compared with activities such as domestic visits and general association.

In the other prison, no staff or facilities were dedicated to the assessments, and health care staff who were otherwise working on the two wings where new inmates were housed asked to carry out the assessments in addition to their existing workloads. It was expected that the assessments would be completed the afternoon following a prisoner’s reception. Although prisoners were usually willing to attend the assessment, and staff thought it was of benefit, about half of all inmates were never approached for the general health assessment either because they could not be located or because staff did not have time to carry it out.

To date, the problems associated with carrying out the general health assessment in the way in which it was attended have not been solved in nine of the ten prisons. This is unfortunate, as this health review provides an opportunity both for health promotion, and identify new prisoners who may not be settling well and thus are at increased risk of self harm. Linking the general health assessment into the induction programme, and perhaps recognising it as a form of purposeful activity, might help resolve some of these difficulties. Support from senior prison service managers in overcoming procedural hurdles will almost certainly be necessary if the general health assessment is to be delivered in the way intended.

Staff and training

Most of those carrying out the screen had nursing qualifications, but screens were also undertaken by healthcare assistants and healthcare officers (terms that were also confusingly used on occasions to describe qualified nursing staff). There was no difference between the qualities of the screens carried out by the different groups. What was more important was the whether the member of health care staff worked regularly in reception. Where dedicated screening staff were used, the standard was usually high, screening time kept to a minimum, fewer mistakes made, and staff were more positive and confident in implementing the new procedures. This was the case even where one member of healthcare who carried out screening regularly staff was paired with a less experienced individual, as the latter was able to ask about any concerns or uncertainties.
It was noted that screening could be poor when the member of staff carrying it out did not speak English well. The ability to communicate well in English will also need to be assessed during staff selection and training.

Most staff achieved the desired level of understanding of the principles of screening and competency in using the modified screening process during the formal training sessions. However, this was not always the case for those who missed the formal training and were instead introduced to the screen by “internal trainers”, who do not appear to have had the time to do more than describe the screening instrument itself. The most common error in screeners who had been trained in this way was to continue to use the new instrument as a diagnostic rather than screening tool, adding many more questions of their own (these same staff were also amongst the minority who did not like the changes and took longer to screen prisoners). However, when the problem was identified, extra training was given, and the matter rectified. Similarly, it was noted that in prisons where training sessions were shorter or more pressured, there were higher levels of dissatisfaction and more errors were made.

In terms of completing the screening instrument itself, the most common failing was for staff to omit filling in their general observations regarding the physical condition and mental health of prisoners. It is not clear why this should be so, although the most likely explanation appears to be that nothing out of the ordinary was noted. However, this too should be documented, and to correct this the instrument will need to be modified so that staff are reminded to record negative findings.
CONCLUSION AND RECOMMENDATIONS

The results of this pilot study support the introduction of the new health screening procedures throughout the remand establishments. However, for this to be implemented successfully, a number of issues need to be resolved:

1. The screening instrument consists of fifteen basic questions, with the option of adding extra questions if a case can be made for them by individual prisons. However, every added question adds extra time to the assessment, often without eliciting further information of value in what is designed to be a screening and not a diagnostic interview. Some variety will be necessary depending on whether adult males, women, or young offenders are being screened, but otherwise we strongly advise that the temptation to insert new questions or to seek more background, "helpful" or "interesting" information should be resisted.

We recommend that three standard screening instrument should be used nationally, one for adult male, one for female, and one for male young offender prisoners. New questions should be added only if supported by clear evidence demonstrating that they will increase the efficacy of the screen.

2. Although the screening process successfully identifies immediate health care needs, individual prisons still need to develop protocols to deal with these needs once detected. These protocols are dependent on local circumstances. Although most were similar between the ten pilot establishments, there were differences, and a decision needs to be taken about how closely individual protocols should be vetted, or indeed whether they should be centrally imposed. The issue is probably most pressing in response to detoxification procedures.

We recommend that protocols for managing health needs identified by the initial screen continue to be developed locally, with the final protocols for each prison agreed by the Prison Health Task Force.

3. The general health assessment remains problematic. Of benefit would be the design of a standard instrument for the assessment (but again different for the three population types), and investigation of the procedural difficulties faced by prisons delivering this at a dedicated clinic subsequent to the reception process. Discussions with the prison where it works well would be a sensible first step, and consideration could be given to including it in the general induction programme as well as recognising it as a form of purposeful activity. Not only are a number of health related needs detected during the general health assessment, but it also provides a good opportunity for health promotion and presents an opportunity to identify prisoners who are not settling well and are thus at risk of self harm.

Until the difficulties associated with the general health assessment are resolved, we recommend that it should continue to be delivered as an adjunct to the initial screen on first reception. It is important that the
concept of a separate general health assessment should be maintained, and is not confused with the triage of first reception.

4. The results of the pilot study demonstrated that the requirement for all new prisoners to be assessed by the prison doctor within 24 hours of reception is redundant.

We recommend that the requirement for all new prisoners to see a doctor within 24 hours of reception should be formally discontinued.

5. Screening procedures are most effectively administered by staff who are experienced in their practice and continue to use them regularly. They are able to screen prisoners more quickly, they make fewer mistakes, and they are generally comfortable with the format. Such staff also improve the performance of less experienced staff working alongside them.

We recommend that there should be a core team of staff responsible for reception screening.

6. Training is essential if the new screening procedures are to be administered properly, but it often takes second place to operational contingencies. The importance of training therefore needs to be given a high priority by the management of individual prisons, with staff given the time to attend regardless of whether this takes place locally or regionally. Attention also needs to be given to the qualities of the trainers, and how they are to attain the skills needed to teach the elements of the new screen. In addition, the ability of staff to communicate well in English needs to be confirmed as part of selection and training.

We recommend that a formal training programme should be established, ideally on a regional basis, which staff must attend if they are to carry out reception screening.

7. Once the new screening procedures are introduced, continued audit and evaluation of them is important to avoid slippage in delivery, both in terms of the use of the screening instruments and the following of protocols. In addition, further research into screening methods and the prevalence of specific health problems in the reception population should be undertaken to ensure that the screen remains effective and relevant to the health needs of prisoners.

We recommend that national procedures should be established to monitor the implementation of health screening on reception.

8. The new procedures relate only to new receptions. Issues regarding health screening, however, also arise in respect of prisoners transferred from other establishments, and those in whom there has been a change of circumstances, for example, following a conviction in a remand prisoner. Although a full health screen is clearly unnecessary in such cases, a shortened assessment focussing on mental health and risk of self-harm may be of benefit.
We recommend that procedures should be established on a national basis to assess prisoners who have had a change of circumstance.

9. Finally, the screening forms used in the pilots were not professionally designed, and consequently attracted a good deal of criticism, at times deterring from their content. The wording of some questions was also at times criticised. Amendments were made to the documents in the course of the pilots, and are reflected in the templates appended to this report. However, we agree with the aesthetic comments that have been made regarding the layout of the forms.

We recommend that professional input should be sought to improve the design of the documentation used in the screening procedures, but that the wording should be left largely unmodified.
MODIFIED FIRST RECEPTION HEALTH SCREEN TO BE USED IN ADULT MALE PRISONS

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<td>First Names</td>
<td>Date</td>
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<tr>
<td>Home Address</td>
<td>Date of Birth</td>
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**Home Address**

**Postcode**

**GP Name**

**GP Address**

**Current Charge**

**Prisoner Status:**
- Remand
- Detainee
- Convicted - not sentenced
- Convicted - sentenced

**Medical/Psychiatric Report Required**

**Health Information Received from Outside Source**

**Have You Been Homeless in the Last Year?**

**Have You Been in Prison Before?**

*If charged with homicide, refer to mental health nurse.*
PHYSICAL HEALTH

1. IN THE LAST FEW MONTHS HAVE YOU SEEN A DOCTOR?  
   No □  Yes □  
   If so, why?  
   Do you have any outstanding hospital or doctor's appointment?  
   When?  
   With whom?  

2. ARE YOU RECEIVING ANY PRESCRIBED MEDICATION?  
   No □  Yes □  
   What type of treatment?  

3. HAVE YOU RECEIVED ANY PHYSICAL INJURIES OVER THE PAST FEW DAYS?  
   No □  Yes □  
   If yes, when and what injuries, what treatment received?  

4. DO YOU HAVE PROBLEMS WITH:  
   ASTHMA  
   No □  Yes □  
   DIABETES  
   No □  Yes □  
   EPILEPSY OR FITS  
   No □  Yes □  
   CHEST PAIN  
   No □  Yes □  
   TUBERCULOSIS  
   No □  Yes □  
   SICKLE CELL DISEASE  
   No □  Yes □  
   ALLERGIES  
   No □  Yes □  

5. DO YOU HAVE ANY (OTHER) CONCERNS ABOUT YOUR PHYSICAL HEALTH?  
   No □  Yes □
Record any health related observations about the prisoner's physical appearance. If nil of note, please document.

If "Yes" recorded to any of questions 2 - 5 refer to doctor or relevant clinic.

Substance use

6. DO YOU DRINK ALCOHOL? 
   - No □ Yes□

   If yes, how much do you usually drink?

   In the week before coming into custody, how much were you drinking?

If more than about 20 units daily or showing signs of withdrawal, refer to doctor.

7. IN THE PAST MONTH HAVE YOU USED:
   - None □

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<th>Urine Result</th>
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Do you any of these intravenously? 
   - No □ Yes□

If using more than once per week or positive urine test, refer to doctor and nurse led drugs service.

8. DO YOU USE ANY OTHER DRUGS? 
   - No □ Yes□

   If so, what and how much?
MENTAL HEALTH

9. HAVE YOU EVER SEEN A PSYCHIATRIST OUTSIDE PRISON?  
   No [ ] Yes [ ]
   If yes, what was the nature of the problem?
   Have you ever stayed in a psychiatric hospital?  
   (Detail most recent discharge date and name of hospital/consultant)
   Do you have a psychiatric nurse or care worker in the community? 
   Who, and where?

10. HAVE YOU EVER RECEIVED MEDICATION FOR ANY MENTAL HEALTH PROBLEMS? 
    No [ ] Yes [ ] (Answer yes if antidepressants or antipsychotics)
    If yes, when and what?
    If current, what dose?

11. HAVE YOU EVER TRIED TO HARM YOURSELF?  
    No [ ] Yes (in prison) [ ] Yes (outside prison) [ ]  
    Refer to Mental Health Nurse
    Details of most serious and most recent

12. FOR SOME PEOPLE COMING INTO PRISON CAN BE DIFFICULT, AND A FEW FIND IT SO HARD THAT THEY MAY CONSIDER HARMING THEMSELVES. DO YOU FEEL LIKE THAT?  
    No [ ] Yes [ ]
    IF YES TO QUESTIONS 11 OR 12 CONSIDER OPENING A F2052SH.

RECORD YOUR IMPRESSION OF THE PRISONER'S BEHAVIOUR AND MENTAL STATE. (If nil of note, please document.)

IF YES TO QUESTIONS 9 - 11 REFER TO MENTAL HEALTH NURSE FOR PSYCHIATRIC ASSESSMENT

I do not have any more specific questions. Is there anything you would like to ask me, or anything about your health that you think I should know?

IF NO INDICATIONS FOR MEDICAL REFERRAL:  
DO YOU THINK THERE IS ANY REASON WHY YOU MIGHT NEED TO SEE A DOCTOR?  
   No [ ] Yes [ ]
PLANNED ACTION

HEALTHCARE SERVICES INFORMATION LEAFLET GIVEN  

NO IMMEDIATE ACTION REQUIRED  

REFER TO DOCTOR (DR __________)  

PHYSICAL HEALTH  

SUBSTANCE USE  

REFER TO NURSE LED DRUGS SERVICE  

REFER TO MENTAL HEALTH NURSE  

OPEN F2052SH  

OTHER REFERRAL ...............................  

FIT FOR NORMAL LOCATION, WORK AND ANY CELL OCCUPANCY  

YES  

REFERRED TO DOCTOR  

Health Care Worker _______________________ Date __________  

PRINT NAME _______________________________
1. If the screen is entirely negative, the inmate is offered the opportunity to see the doctor. If he declines he is advised how to contact health services in the future and no further action is taken.

2. If the inmate does not require referral to a doctor, the nurse can indicate that the inmate is fit for work, kitchens and normal location. Otherwise the decision will follow a doctor’s assessment.

3. If the screen is positive for physical health problems a referral is made to the doctor for further assessment.

4. If the screen is positive for mental health problems a referral is made to a mental health nurse for further psychiatric assessment.

5. If the screen indicates a risk of deliberate self harm, an F2052SH is opened.

6. If the screen indicates a risk of withdrawal from alcohol or drugs, a referral is made to the doctor for treatment or chemical detoxification. The inmate is also referred to the nurse led drugs service.
GENERAL HEALTH ASSESSMENT

SURNAME ______________________ PRISON NUMBER ______
FIRST NAMES ____________________ DATE ______
DATE OF BIRTH __________________

NEXT OF KIN ____________________ COMMUNITY CONTACTS __________________
ADDRESS ______________________ ______________________
______________________________ ______________________

HEIGHT: ______________________ WEIGHT: ______________________

1. IS THERE A HISTORY OF ANY SERIOUS ILLNESS IN YOUR FAMILY (eg heart
disease, diabetes, epilepsy)?

No □ Yes □

If so, what?

IF YES, OFFER ADVICE AND APPROPRIATE INVESTIGATIONS.

2. ARE YOU WORRIED ABOUT INFECTIOUS DISEASES (eg HIV, hepatitis)?

No □ Yes □

CONSIDER REFERRAL TO HIV COORDINATOR

3. WOULD YOU LIKE TO BE VACCINATED AGAINST HEPATITIS B?

No □
Already vaccinated □
Yes □ Refer to Hep B Clinic

4. DO YOU SMOKE?

No □ Yes □

Would you like help to give up?

No □ Yes □

REFER TO SMOKING CESSATION CLINIC
5. ARE YOU AWARE OF THE NEED TO DO TESTICULAR SELF-EXAMINATION?

Would you like more information?  
No [ ] Yes [ ]

6. HAVE YOU ANY OTHER WORRIES REGARDING YOUR HEALTH?

No [ ] Yes [ ]

7. WOULD YOU LIKE FURTHER INFORMATION ON ANY ASPECTS OF HEALTH PROMOTION?

No [ ] Yes [ ]

8. DO YOU HAVE ANY DISABILITIES THAT YOU CONSIDER TO BE A PROBLEM?

No [ ] Yes [ ]

What and how do they affect you?

PLANNED ACTION

NO FURTHER ACTION REQUIRED [ ]

ADVICE GIVEN [ ]

REFER TO HIV COORDINATOR [ ]

REFER TO HEPATITIS B CLINIC [ ]

REFER TO SMOKING CESSATION CLINIC [ ]

REFER TO DOCTOR [ ]

OTHER REFERRAL [ ]

Health Care Worker ___________________________ Date ____________

Print Name _________________________________
## MODIFIED FIRST RECEPTION HEALTH SCREEN TO BE USED IN FEMALE PRISONS

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| Prisoner Status: Remand | □ until .................. |
| | □ Detainee |
| | □ Convicted - not sentenced |
| | □ Convicted - sentenced □ length .................. |

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<th>Health information received from outside source</th>
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<tr>
<th>Have You Been Homeless In The Last Year?</th>
<th>No □ Yes□</th>
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<tr>
<th>Have You Been In Prison Before?</th>
<th>No □ Yes□</th>
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If yes, where and when were you last in?

*If charged with homicide, refer to mental health nurse*
PHYSICAL HEALTH

1. IN THE LAST FEW MONTHS HAVE YOU SEEN A DOCTOR?  
   No □  Yes □ 
   If so, why?  
   Do you have any outstanding hospital or doctor's appointment?  
   When?  
   With whom?  

2. ARE YOU RECEIVING ANY PRESCRIBED MEDICATION?  
   No □  Yes □ 
   What type of treatment?  

3. HAVE YOU RECEIVED ANY PHYSICAL INJURIES OVER THE PAST FEW DAYS?  
   No □  Yes □ 
   If yes, when and what injuries, what treatment received?  

4. DO YOU HAVE PROBLEMS WITH:  
   ASTHMA □  Yes □  
   DIABETES □  Yes □  
   EPILEPSY OR FITS □  Yes □  
   CHEST PAIN □  Yes □  
   TUBERCULOSIS □  Yes □  
   SICKLE CELL DISEASE □  Yes □  
   ALLERGIES □  Yes □  

5. HAVE YOU ANY REASON TO BELIEVE THAT YOU MAY BE PREGNANT?  
   No □  Yes □ 
   If yes, note details  
   If reports 10 weeks + pregnant, contact local maternity unit and refer to midwife  

6. WOULD YOU LIKE A PREGNANCY TEST?  
   No □  Yes □  

39
7. DO YOU HAVE ANY (OTHER) CONCERNS ABOUT YOUR PHYSICAL HEALTH?  

Record any health related observations about the prisoner’s physical appearance. IF NIL OF NOTE, PLEASE DOCUMENT.

IF “YES” RECORDED TO ANY OF QUESTIONS 2 - 7 REFER TO DOCTOR OR RELEVANT CLINIC.

SUBSTANCE USE

8. DO YOU DRINK ALCOHOL?  

If yes, how much do you usually drink?

In the week before coming into custody, how much were you drinking?

IF MORE THAN ABOUT 14 UNITS DAILY OR SHOWING SIGNS OF WITHDRAWAL, REFER TO DOCTOR

9. IN THE PAST MONTH HAVE YOU USED: None

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<th>Frequency</th>
<th>Last Used</th>
<th>Urine Result</th>
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DO YOU ANY OF THESE INTRAVENOUSLY?  

IF USING MORE THAN ONCE PER WEEK OR POSITIVE URINE TEST, REFER TO DOCTOR AND NURSE LED DRUGS SERVICE.

10. DO YOU USE ANY OTHER DRUGS?  

If so, what and how much?

No □ Yes □
MENTAL HEALTH

11. HAVE YOU EVER SEEN A PSYCHIATRIST OUTSIDE PRISON?  
   No  Yes
   
   If yes, what was the nature of the problem?

   Have you ever stayed in a psychiatric hospital?  
   (Detail most recent discharge date and name of hospital/consultant)

   Do you have a psychiatric nurse or care worker in the community?  
   Who, and where?

12. HAVE YOU EVER RECEIVED MEDICATION FOR ANY MENTAL HEALTH PROBLEMS?  
   No  Yes
   (Answer yes if antidepressants or antipsychotics)

   If yes, when and what?

   If current, what dose?

13. HAVE YOU EVER TRIED TO HARM YOURSELF?  
   No  Yes (in prison)  Yes (outside prison)
   
   Refer to Mental Health Nurse

   Details of most serious and most recent

14. FOR SOME PEOPLE COMING INTO PRISON CAN BE DIFFICULT, AND A FEW FIND IT SO HARD THAT THEY MAY CONSIDER HARMING THEMSELVES. DO YOU FEEL LIKE THAT?  
   No  Yes

   IF YES TO QUESTIONS 13 OR 14 CONSIDER OPENING A F2052SH.

   RECORD YOUR IMPRESSION OF THE PRISONER'S BEHAVIOUR AND MENTAL STATE. (If nil of note, please document.)

   IF YES TO QUESTIONS 11 - 13 REFER TO MENTAL HEALTH NURSE FOR PSYCHIATRIC ASSESSMENT

   I do not have any more specific questions. Is there anything you would like to ask me, or anything about your health that you think I should know?

   IF NO INDICATION FOR MEDICAL REFERRAL:
   DO YOU THINK THERE IS ANY REASON WHY YOU MIGHT NEED TO SEE A DOCTOR?  
   No  Yes
PLANNED ACTION

HEALTHCARE SERVICES INFORMATION LEAFLET GIVEN

NO IMMEDIATE ACTION REQUIRED

REFER TO DOCTOR (DR ________)

   PHYSICAL HEALTH

   SUBSTANCE USE

REFER TO NURSE LED DRUGS SERVICE

REFER TO MENTAL HEALTH NURSE

REFER TO MIDWIFE

OPEN F2052SH

OTHER REFERRAL .........................

FIT FOR NORMAL LOCATION, WORK AND ANY CELL OCCUPANCY

   YES

  REFERRED TO DOCTOR

Health Care Worker ___________________________ Date ________

PRINT NAME ___________________________
PROTOCOLS FOLLOWING RECEPTION HEALTH SCREENING

1. If the screen is entirely negative, the inmate is offered the opportunity to see the doctor. If she declines she is advised how to contact health services in the future and no further action is taken.

2. If the inmate does not require referral to a doctor, the nurse can indicate that the inmate is fit for work, kitchens and normal location. Otherwise the decision will follow a doctor’s assessment.

3. If the screen is positive for physical health problems a referral is made to the doctor for further assessment.

4. If the screen is positive for mental health problems a referral is made to a mental health nurse for further psychiatric assessment.

7. If the screen indicates a risk of deliberate self harm, an F2052SH is opened.

8. If the screen indicates a risk of withdrawal from alcohol or drugs, a referral is made to the doctor for treatment or chemical detoxification. The inmate is also referred to the nurse led drugs service.

9. If the screen indicates a pregnancy of ten weeks gestation or more, a referral is made to the midwife for further management.
# GENERAL HEALTH ASSESSMENT

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1. **IS THERE A HISTORY OF ANY SERIOUS ILLNESS IN YOUR FAMILY** (eg heart disease, diabetes, epilepsy)?
   - No [ ] Yes [ ]

   If so, what?

   **IF YES, OFFER ADVICE AND APPROPRIATE INVESTIGATIONS.**

2. **ARE YOU WORRIED ABOUT INFECTIOUS DISEASES** (eg HIV, hepatitis)?
   - No [ ] Yes [ ]

   **CONSIDER REFERRAL TO HIV COORDINATOR**

3. **WOULD YOU LIKE TO BE VACCINATED AGAINST HEPATITIS B?**
   - No [ ]
   - Already vaccinated [ ]
   - Yes [ ] Refer to Hep B Clinic

4. **DO YOU SMOKE?**
   - No [ ] Yes [ ]

   Would you like help to give up?
   - No [ ] Yes [ ]

   **REFER TO SMOKING CESSATION CLINIC**
5. DATE OF LAST MENSTRUAL PERIOD? ___________ Offer Pregnancy Test (if more than a month ago)

6. WHEN WAS YOUR LAST SMEAR TEST? ___________ Results? ___________

**IF REQUIRED, REFER TO CYTOLOGY NURSE**

7. HAVE YOU HAD, OR DO YOU CURRENTLY HAVE, ANY GYNAECOLOGICAL PROBLEMS? 
   No [ ] Yes [ ]

8. HAVE YOU ANY OTHER WORRIES REGARDING YOUR HEALTH? 
   No [ ] Yes [ ]

9. WOULD YOU LIKE FURTHER INFORMATION ON ANY ASPECTS OF HEALTH PROMOTION? 
   No [ ] Yes [ ]

10. DO YOU HAVE ANY DISABILITIES THAT YOU CONSIDER TO BE A PROBLEM? 
    No [ ] Yes [ ]

   What and how do they affect you?

11. ARE YOU WORRIED ABOUT ANY DEPENDENTS OUTSIDE? No [ ] Yes [ ]

**PLANNED ACTION**

NO FURTHER ACTION REQUIRED ___________

ADVICE GIVEN ___________

REFER TO HIV COORDINATOR ___________

REFER TO HEPATITIS B CLINIC ___________

REFER TO SMOKING CESSATION CLINIC ___________

REFER TO DOCTOR ___________

REFER TO CYTOLOGY NURSE ___________

OTHER REFERRAL ___________

Health Care Worker ____________________________ Date ___________

Print Name ____________________________
MODIFIED FIRST RECEPTION HEALTH SCREEN TO BE USED IN YOUNG OFFENDER INSTITUTIONS

SURNAME: ___________________  PRISON NUMBER: ____

FIRST NAMES: ___________________  DATE: ________

DATE OF BIRTH: ________

HOME ADDRESS: ___________________

                        ___________________

                        ___________________

POSTCODE: ___________________

GP NAME: ___________________

GP ADDRESS: ___________________

                        ___________________

CURRENT CHARGE: ___________________

PRISONER STATUS: Remand □ until .................

Detainee □

Convicted - not sentenced □

Convicted - sentenced □ length ..................

MEDICAL/PSYCHIATRIC REPORT REQUIRED: No □ Yes □

HEALTH INFORMATION RECEIVED FROM OUTSIDE SOURCE: No □ Yes □

If so, what and from who?

HAVE YOU BEEN HOMELESS IN THE LAST YEAR?: No □ Yes □

HAVE YOU BEEN IN PRISON BEFORE?: No □ Yes □

If yes, where and when were you last in?

IF CHARGED WITH HOMICIDE, REFER TO MENTAL HEALTH NURSE

46
PHYSICAL HEALTH

1. IN THE LAST FEW MONTHS HAVE YOU SEEN A DOCTOR?  
   No □  Yes □  
   If so, why?

   Do you have any outstanding hospital or doctor's appointment?  
   When?  
   With whom?

2. ARE YOU RECEIVING ANY PRESCRIBED MEDICATION?  
   No □  Yes □  
   What type of treatment?

3. HAVE YOU RECEIVED ANY PHYSICAL INJURIES OVER THE PAST FEW DAYS?  
   No □  Yes □  
   If yes, when and what injuries, what treatment received?

4. DO YOU HAVE PROBLEMS WITH:
   ASTHMA  No □  Yes □  
   DIABETES  No □  Yes □  
   EPILEPSY OR FITS  No □  Yes □  
   CHEST PAIN  No □  Yes □  
   TUBERCULOSIS  No □  Yes □  
   SICKLE CELL DISEASE  No □  Yes □  
   ALLERGIES  No □  Yes □

5. DO YOU HAVE ANY (OTHER) CONCERNS ABOUT YOUR PHYSICAL HEALTH?  
   No □  Yes □
Record any health related observations about the prisoner's physical appearance. IF NIL OF NOTE, PLEASE DOCUMENT.

*IF "YES" RECORDED TO ANY OF QUESTIONS 2 - 5 REFER TO DOCTOR OR RELEVANT CLINIC.*

**SUBSTANCE USE**

6. **DO YOU DRINK ALCOHOL?**
   - No [ ] Yes [ ]
   If yes, how much do you usually drink?

   In the week before coming into custody, how much were you drinking?

*IF MORE THAN ABOUT 20 UNITS DAILY OR SHOWING SIGNS OF WITHDRAWAL, REFER TO DOCTOR*

7. **IN THE PAST MONTH HAVE YOU USED:**
   - None [ ]

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DO YOU ANY OF THESE INTRAVENOUSLY?  No [ ] Yes [ ]

*IF USING MORE THAN ONCE PER WEEK OR POSITIVE URINE TEST, REFER TO DOCTOR AND NURSE LED DRUGS SERVICE.*

8. **DO YOU USE ANY OTHER DRUGS?**
   - No [ ] Yes [ ]
   If so, what and how much?
MENTAL HEALTH

9. HAVE YOU EVER SEEN A PSYCHIATRIST OUTSIDE PRISON?  
   No ☐ Yes ☐

   If yes, what was the nature of the problem?

   Have you ever stayed in a psychiatric hospital?  
   (Detail most recent discharge date and name of hospital/consultant)

   Do you have a psychiatric nurse or care worker in the community?  
   Who, and where?

10. HAVE YOU EVER RECEIVED MEDICATION FOR ANY MENTAL HEALTH PROBLEMS?  
    No ☐ Yes ☐

    (Answer yes if antidepressants or antipsychotics)

    If yes, when and what?

    If current, what dose?

11. HAVE YOU EVER TRIED TO HARM YOURSELF?  
    No ☐ Yes (in prison) ☐ Yes (outside prison) ☐

    Refer to Mental Health Nurse

    Details of most serious and most recent

12. HAVE YOU SUFFERED A RECENT LOSS (FAMILY OR CLOSE FRIEND)?  
    No ☐ Yes ☐

13. FOR SOME PEOPLE COMING INTO PRISON CAN BE DIFFICULT, AND A FEW FIND IT SO HARD THAT THEY MAY CONSIDER HARMING THEMSELVES. DO YOU FEEL LIKE THAT?  
    No ☐ Yes ☐

IF YES TO QUESTIONS 11 OR 13 CONSIDER OPENING A F2052SH.

RECORD YOUR IMPRESSION OF THE PRISONER'S BEHAVIOUR AND MENTAL STATE. (If nil of note, please document.)

IF YES TO QUESTIONS 9-11 REFER TO MENTAL HEALTH NURSE FOR PSYCHIATRIC ASSESSMENT

I do not have any more specific questions. Is there anything you would like to ask me, or anything about your health that you think I should know?

IF NO INDICATIONS FOR MEDICAL REFERRAL:
DO YOU THINK THERE IS ANY REASON WHY YOU MIGHT NEED TO SEE A DOCTOR?  
   No ☐ Yes ☐
PLANNED ACTION

HEALTHCARE SERVICES INFORMATION LEAFLET GIVEN

NO IMMEDIATE ACTION REQUIRED

REFER TO DOCTOR (DR ________)

  PHYSICAL HEALTH

  SUBSTANCE USE

REFER TO NURSE LED DRUGS SERVICE

REFER TO MENTAL HEALTH NURSE

OPEN F2052SH

OTHER REFERRAL ..........................

FIT FOR NORMAL LOCATION, WORK AND ANY CELL OCCUPANCY

  YES

  REFERRED TO DOCTOR

Health Care Worker _____________________  Date __________

PRINT NAME ___________________________
PROTOCOLS FOLLOWING RECEPTION HEALTH SCREENING

1. If the screen is entirely negative, the inmate is offered the opportunity to see the doctor. If they decline they are advised how to contact health services in the future and no further action is taken.

2. If the inmate does not require referral to a doctor, the nurse can indicate that the inmate is fit for work, kitchens and normal location. Otherwise the decision will follow a doctor’s assessment.

3. If the screen is positive for physical health problems a referral is made to the doctor for further assessment.

4. If the screen is positive for mental health problems a referral is made to a mental health nurse for further psychiatric assessment.

5. If the screen indicates a risk of deliberate self harm, an F2052SH is opened.

6. If the screen indicates a risk of withdrawal from alcohol or drugs, a referral is made to the doctor for treatment or chemical detoxification. The inmate is also referred to the nurse led drugs service.
**GENERAL HEALTH ASSESSMENT**

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**HEIGHT:** __________  **WEIGHT:** __________

1. **IS THERE A HISTORY OF ANY SERIOUS ILLNESS IN YOUR FAMILY (eg heart disease, diabetes, epilepsy)?**
   
   No [ ] Yes [ ]

   If so, what?

   **IF YES, OFFER ADVICE AND APPROPRIATE INVESTIGATIONS.**

2. **ARE YOU WORRIED ABOUT INFECTIOUS DISEASES (eg HIV, hepatitis)?**
   
   No [ ] Yes [ ]

   **CONSIDER REFERRAL TO HIV COORDINATOR**

3. **WOULD YOU LIKE TO BE VACCINATED AGAINST HEPATITIS B?**
   
   No [ ]
   Already vaccinated [ ]
   Yes [ ] Refer to Hep B Clinic

4. **DO YOU SMOKE?**
   
   No [ ] Yes [ ]

   Would you like help to give up?
   
   No [ ] Yes [ ]

   **REFER TO SMOKING CESSATION CLINIC**
5. ARE YOU AWARE OF THE NEED TO DO TESTICULAR SELF-EXAMINATION?

Would you like more information?  No [ ] Yes [ ]

6. HAVE YOU ANY OTHER WORRIES REGARDING YOUR HEALTH?

No [ ] Yes [ ]

7. WOULD YOU LIKE FURTHER INFORMATION ON ANY ASPECTS OF HEALTH PROMOTION?

No [ ] Yes [ ]

8. DO YOU HAVE ANY DISABILITIES THAT YOU CONSIDER TO BE A PROBLEM?

No [ ] Yes [ ]

What and how do they affect you?

PLANNED ACTION

NO FURTHER ACTION REQUIRED [ ]

ADVICE GIVEN [ ]

REFER TO HIV COORDINATOR [ ]

REFER TO HEPATITIS B CLINIC [ ]

REFER TO SMOKING CESSATION CLINIC [ ]

REFER TO DOCTOR [ ]

REFER TO CYTOLOGY NURSE [ ]

OTHER REFERRAL ____________________________ [ ]

Health Care Worker ____________________________  Date __________

Print Name ____________________________
References


