*Dementia and Mild Cognitive Impairment in prison care pathway*

1. ***Reception screens***: per prison/healthcare protocol.
2. ***Initial Memory assessment*** for all over 50s using the Montreal Cognitive Assessment (MoCa) (Nasreddine et. al, 2005), taking approximately 20 minutes. This will be carried out by a grade 5 dementia trained nurse 2-4 weeks after reception screening, as deemed appropriate according to the individuals circumstances.

***MoCa negative result*** *(score of 23 or over):* No further action is necessary. 50 and overs will be reassessed using the MoCa annually and 3 months prior to release by the dementia trained nurse.

***MoCa positive result*** *(score of 22 or less):* prompts further assessment (see below)

1. ***Further assessment:*** patient history and current health screen. Screening of patient history will include determining any previous head injuries or stroke, or if there has been a progressive decline in memory. Current mental and physical screen to determine any other diagnoses present. These screenings will be completed within 2-4 weeks of MoCa assessment.
2. ***Referral to external memory assessment services (MAS):***

Completion of Addenbrooke’s Cognitive Examinaton (ACE-III)

***Negative result (score of 88 and over):*** No further action is necessary. Over 50s will be reassessed using the MoCa annually and 3 months prior to release.

***Positive result (score of 83-*87):** referral to memory assessment services to determine Mild Cognitive Impairment.

***Positive result (score of 82 or less)*** referral to memory assessment services to determine dementia diagnosis.

Scans (CT, MRI) completed to determine diagnosis.

***If no diagnosis is given***, review annually using MoCa (dementia trained nurse).

***Diagnosis given:*** medication given dependent on diagnosis, medication will be initially monitored. Patient will be transferred to prison GP for follow up. Referral made to social worker to assess needs, who will signpost to relevant third sector and prison support.

1. **Needs Assessment** made by social worker or an occupational therapist to determine care package. Appropriate referrals made to other services if necessary: eg, Occupational Therapy, Speech and Language Team (SALT), Mental Health teams, learning disability services. Wing location decision to be made and care overseen by dementia trained nurse.
2. ***Accommodation:*** Residents with a diagnosis of dementia or Mild Cognitive Impairment (MCI) can choose to be located on dementia friendly normal location if they are deemed well enough by the dementia trained nurse, those with severe dementia will be located on an adapted specialist wing.

***Dementia friendly normal location:*** Modifications to make a wing dementia friendly include:

* Open plan layouts, and clear signage to assist people with finding their way,
* Label cupboards with pictures of the contents and use of contrasting colours to make everyday items easier to identify.
* Handrails and door handles should be easy to use and comfortable and contrasting in colour with the walls, with clear safety features to indicate where they end.
* Call systems should be fitted and easy to identify in bedroom areas and WC facilities which they may use alone.
* Entrance to reception areas should be bright and well-lit with maximum use of natural light. Corridors should be bright and evenly lit.

Further information on how to make areas dementia-friendly can be found:

* <https://www.dementiaaction.org.uk/resources>
* <http://dementia.stir.ac.uk/design/virtual-environments/virtual-care-home>

***Adapted specialist wing:*** regional, 8-12 bed facility. Receives prisoners with dementia and Activities of Daily Living (ADL) needs on a referral basis. Referrals taken from local group prisons. Staffing is consistent and a flexible regime is in place.

***Alternative environments:*** options for severe dementia:

1. *Release on temporary license:* In order for this to be an option this individual would have severe dementia and there would be no concerns around an individual’s risk of reoffending.
2. *Forensic hospital:* referral made under the Mental Health Act for a forensic hospital bed. Regional unit, complex dementia specialist unit. For those with severe dementia, mental health commodities and associated risk.
3. *Secure nursing home:* There would be no risk associated with this individual, but this person would need support with their activities of daily living (ADLs). Secure nursing homes have not been established in the UK, this option needs exploration of practical and financial implications of implementation.

1. ***Support:*** All individuals are eligible for support, this is dependent on specific needs and assessed by a social worker (step 5).

***People:***

*Dementia trained nurse:* Each prison site should identify/employ a member of staff who will lead the dementia care pathway. This person will have received training in relation to managing dementia in prison. They will manage the screening and referral process, and monitor patients. This centralised role will support both healthcare and the prison in the care and management of prisoners with dementia and mild cognitive impairment.

*For all:*

* *In order to establish a dementia friendly community prison and healthcare staff will be trained in dementia using the DeCIsion study training package and other relevant training depending on the staff member’s needs.*
* If there are no nursing needs and people are able to be placed on normal location, peer carers should be employed. Guidance regarding training, review and close monitoring of peer carers can be found in PSI 17/2015.
* *Support from third sector to support dementia awareness.*

*For those with ADL and nursing needs:*

* Peer carers and healthcare support workers will support daily activities – such as dressing, washing and wheelchair assistance. Peer carer’s will not be responsible for any intimate personal care, please see PSI 17/2015 for further guidance.

*For those in the advanced stages of dementia:*

* In order to maintain open communication amongst staff a named nurse and officer will be allocated to each individual, for a Multi-Disciplinary approach.
* A dementia trained nurse will be allocated to an individual to monitor their health and wellbeing to support.

***Intervention:***

* Psychology based support:
* Therapies such as Cognitive Stimulation Therapy (CST) could be considered where appropriate. Sessions would be delivered by a trained facilitator (support worker, assistant psychologist) in prison. This particular programme is usually delivered over 14 weeks, 45 minutes per session with 5-8 people per group. At the end of this initial block, maintenance blocks can also be delivered. Each session follows the same structure, though the theme changes. Topics might include childhood, food, current affairs and using money. Different activities will be offered around each theme, for example, one week the activities might involve word puzzles or games, another week playing a musical instrument.
* ‘*Post-diagnostic support for people living with dementia’*, page 40 in Clinical Psychology in the Early Stage Dementia Care Pathway (BPS, 2014) provides a useful summary of psychology intervention and support.
* *Medical/Health based support:*
* Tech assisted support, or dosette boxes will be available dependent on needs.
* For all 50s and over, a dementia nurse will reassess once a year using the MoCa.
* For the purposes of information sharing a combined register will be available which will summarise any co-morbidities and other significant information. This will be managed by the dementia nurse with information by other healthcare staff, subject to prisoners providing consent.
* A personalised care plan will also be available developed by the dementia nurse. Both healthcare and prison staff will be able to view subject to prisoners providing consent. This document will include how medication and care times and if applicable to diagnosis, how to effectively communicate (i.e are there any triggers for this person.) It would also highlight any problems with social isolation.

***Social:***

For all:

* Older age day groups should be available offering stimulating activities such as book club, board games, cookery and arts & crafts. These could be provided by Age UK, Alzheimer UK, volunteers, peers or older person’s lead.
* Support groups or sessions will be available to offer advice regarding pensions, housing and legal advice. This could be provided through the third sector, such as RECOOP, Age UK etc.

For those with dementia:

* Services such as Dementia Café’s should be considered where appropriate. These could be held once a month/ once every two months to signpost dementia support in a sociable and stimulating environment.

***End of Life Care:***

*The document ‘Dying Well in Custody Charter’ is a useful resource for supporting those on an end of life pathway in custody.* [*http://endoflifecareambitions.org.uk/wp-content/uploads/2018/06/Dying-Well-in-Custody-Self-Assessment-Tool-June-2018.pdf*](http://endoflifecareambitions.org.uk/wp-content/uploads/2018/06/Dying-Well-in-Custody-Self-Assessment-Tool-June-2018.pdf)

***Staff support and awareness:***

* Staff should submit a referral form to the dementia trained nurse if they have any concerns about a resident.
* Staff should receive dementia awareness training on induction
* Regular information sessions should be held to keep staff informed
* Staff should be made aware of their dementia advisor.

*References*

Dementia Action Alliance. Dementia friendly envrionments. <https://www.dementiaaction.org.uk/>

*Ambitions for Palliative & End of Life Care Partnership. Dying Well in Custody Charter: A National Framework for Local Action. 2018.*

Elamin, M., Holloway, G., Bak, T. H., & Pal, S. (2015). The utility of the Addenbrooke's Cognitive Examination version three in early-onset dementia. Dementia and Geriatric Cognitive Disorders, 41, 9-15. doi: 10.1159/000439248

Hsieh, S., Schubert, S., Hoon, C., Mioshi, E., & Hodges, J. R. (2013). Validation of the Addenbrooke’s Cognitive Examination III in frontotemporal dementia and Alzheimer’s disease. Dementia and Geriatric Cognitive Disorders, 36, 242-250. doi: 10.1159/000351671

Moll, A. (2013), ‘Losing Track of Time’. London: Mental Health Foundation

Nasreddine, Z. S., Phillips, N. A., Bédirian, V., Charbonneau, S., Whitehead, V., Collin, I., Cummings,

J. L. & Chertkow, H. (2005), ‘The Montreal Cognitive Assessment, MoCA: A Brief Screening Tool For

Mild Cognitive Impairment’. Journal of the American Geriatrics Society, 53, 695–699

*NOMS. (2016), ‘PSI 17/2015: Prisoners Assisting Other Prisoners’, London: Ministry of Justice*Spector, A. & Orell, M. a. W. B., 2018. *Cognitive Stimulation Therapy.* [Online]
Available at: http://www.cstdementia.com/[Accessed 24 October 2018].

The University of Striling. *Dementia Services Development Centre.* [Online]
Available at: http://dementia.stir.ac.uk/design/virtual-environments/virtual-care-home
[Accessed 24 October 2018].