It is widely reported that people with mental health, physical health and substance misuse problems are over-represented in prison populations worldwide, providing both a challenge and an opportunity to undertake individual and public health interventions in a hard-to-engage group.

MENTAL ILLNESS AND SUICIDE RISK IN PRISON
Data from a large-scale epidemiological study conducted in prisons in England and Wales concluded that nine out of ten prisoners had at least one psychiatric diagnosis, with rates of neurotic disorder, personality disorder, hazardous drinking and drug use all significantly higher than in the general population. Rates of serious mental illness (SMI) were also disproportionately high, with between 7% of sentenced men and 14% of women prisoners suffering from psychosis.¹

While these data are now somewhat dated, there is no reason to believe that any significant reduction in the proportion of the prison population that is mentally disordered has occurred during the intervening period.

In addition to elevated levels of mental ill health, offenders have long been recognised as a high-risk group for suicide within governmental suicide prevention strategies. Perhaps this is not too surprising; risk factors for suicide in the general community – for example, being male, young, unemployed and/or having complex personality disorder or substance misuse problems – are commonplace in prison populations.

Rates of mental illness and suicide are significantly higher in prisoners than in the general population. Jane Senior asks why current service provision appears to be inadequate and looks at promising developments for the future.

Offenders have long been recognised as a high-risk group for suicide within governmental suicide prevention strategies.

BLOG
The problem with prison
Should we be reforming the way we penalise miscreants in the UK and elsewhere? Have your say at: www.trendsinmenshealth.com

Jane Senior, BA(Hons), MA, PhD, RMN, Research Fellow, Offender Health Research Network, University of Manchester
Until recently, there had been a consistent downward trend in the rate of completed suicides in prisons in England and Wales, from a peak of 141 per 100,000 prisoners in 1999 to 68 per 100,000 in 2010. However, this downward trend appears to have stalled and the rate may even be starting to rise again. Even this much reduced rate remains significantly greater than the general population rate of 12 deaths per 100,000.

CURRENT SERVICE PROVISION

In spite of high rates of SMI, prison-based mental health services have been criticised historically as ineffective, reflective of neither current best practice nor actual clinical need, delivered by inadequately qualified staff in unsuitable physical environments, yet at a higher cost than services to the wider community. It is only since the turn of the century that the NHS adopted widespread clinical and budgetary responsibility for healthcare provision in public sector prisons following the creation of a formal partnership between the NHS and Her Majesty’s Prison Service.

An examination of their clinical impact showed that inreach teams struggled to target successfully their key client group – those with SMI.

Following the partnership agreement, changes to mental health delivery were rapidly outlined: for example, in 2000 the NHS Plan set a target that, by 2004, 5,000 prisoners at any time should be receiving more comprehensive mental health services in prison. The following year, Changing the outlook was published, outlining a new model whereby NHS community mental health services would inreach into prisons specifically to treat people with SMI, thus providing the mechanism through which to achieve the target set in the NHS Plan.

Limited impact of inreach services

Inreach teams, predominantly consisting of mental health nurses, supported by other professionals, for example psychiatrists and psychologists, are now ubiquitous across the prison estate in England and Wales. Their impact has been examined in a national evaluation study, which found that, while inreach services have generally been welcomed as a useful initiative, they have experienced difficulties adjusting their working practices to facilitate the delivery of modern mental healthcare in the prison environment and establishing clear models of care for those with SMI. The evaluation reported that care delivery was hampered by significant staff recruitment and retention difficulties; insufficient resource allocation; and problems forging effective multi-agency partnerships, stemming from a fundamental culture clash between essentially punitive prison values and modern mental healthcare with an ethos of promoting personal autonomy and choice.

An examination of their clinical impact showed that inreach teams struggled to target successfully their key client group – those with SMI. Senior et al. reported that only a quarter (25%) of people with SMI were assessed by inreach services and only 13% taken onto caseload within the first month of custody. Troublingly, these findings highlighted an almost complete lack of progress from nearly two decades earlier; in 1996, a study with similar methodology reported that only 23% of prisoners with SMI were identified by routine health screening upon reception into custody and that, if not identified at this stage, mental disorder was likely to remain unidentified throughout custody.

A further study identified that both prison-based inreach services and community mental health teams (CMHT) struggled to work together effectively to ensure continuity of care upon release. Of 53 inreach clients released from prison, there was documented evidence of discharge planning in just over half of cases (51%; n=27) and of direct contact between the prison and a particular CMHT in only 38% (n=20) of cases. Follow-up 1 month post-release of these 20 people showed that 16 had failed to make any contact with the CMHT at all and one had made contact to say that he did not want to engage. In total, only three people had made positive contact and had a future appointment.

The reasons for the limited impact to date of inreach services are multifaceted, including continued disparity between the size of the population to be served and the front-line resources available; inadequate health screening and assessment procedures upon initial reception into prison; lack of appropriate treatment options for people with personality disorders; and underdeveloped models of primary mental healthcare services. In particular, in prisons, the concept of mental illness is very expansive and much aberrant or disruptive behaviour that compromises the running of an inflexible regimen may likely be labelled as ‘illness’. Steel et al. used the term ‘mission creep’ to describe the on-the-ground expectation that inreach services should deal with the full range of mental health and behavioural issues presented by prisoners, despite their policy-endorsed delineation of responsibility for only those with SMI.

FUTURE DEVELOPMENTS

Since the evaluation of prison inreach services was completed, there have been several promising developments designed to address the deficits identified. The importance of providing robust primary care mental health services to the high proportion with common mental health problems is now widely understood. As a result, services have proliferated, particularly improved access to psychological therapies (IAPT), offered in the community to facilitate rapid treatment for anxiety and depression. In 2013, the NHS published an updated positive practice guide for those developing IAPT services for offenders and a
nationwide forum for prison-based practitioners has been established.14

Work is also underway to tackle the separation of prison-based mental health services from mainstream community provision, identifying how best to support the transition between prison and community. Innovative models of ‘through the gate’ services are being trialled, designed to promote long-term engagement with community mental health services, increase community tenure and decrease lifestyle chaos and, potentially, reoffending. One such development involves an adoption of critical time intervention (CTI),16 an intervention initially developed to reduce homelessness in people discharged from psychiatric facilities in the USA. In a pilot study in the UK, adapted CTI significantly increased engagement with mental health services post-release, compared to treatment as usual, a finding now being tested in a full randomised controlled trial.16,17

CONCLUSION
Mentally disordered offenders have been described as ‘the unloved, unlovely and unlovable’ of our society.18 They are complex individuals who routinely present with comorbid physical, mental, substance misuse and personality disorders. When in the community their use of non-routine engagement with any type of healthcare service is typically sporadic and crisis-driven. While policy dictates that services for prisoners should be ‘equivalent’ to those provided to the wider community, equivalence cannot simply be taken to mean ‘the same’; responding to the significantly increased levels of all types of mental health morbidity and the elevated suicide rate inevitably requires changes to service modalities and risk formulation.

To meet need effectively, services both in and out of prison need to be responsive, inclusive, flexible and, importantly, holistic, addressing both discrete health issues and wider social care needs. Notably, multiple and complex morbidities have to be accepted as the norm and the indisputable fact that maintaining engagement with chaotic individuals requires commitment, diligence and adequate resourcing needs to be fully embraced.

Declaration of interests: none declared.

The importance of providing robust primary care mental health services to the high proportion with common mental health problems is now widely understood.

REFERENCES