

In Brazil, which incarcerates an exceptionally high proportion of its population, there are serious problems due to overcrowding and little support for prisoners with mental disorders, as discussed by Sergio Baxter Andreoli and fellow authors. Their recent research has shown that the prevalence of mental disorder is very high among prisoners, up to ten times greater than that in the general population. Most prison psychiatric hospitals lack mental health teams to run them. The authors question the logic by which individuals with a serious mental illness, whose offence was linked to their disorder, may end up in conventional prisons in Brazil, where they receive no adequate treatment. On their release, their chances of rehabilitation are seriously compromised as a consequence of the failure of the law to take appropriate account of their condition.

Finally, we have a fascinating study from Somaliland, where a novel in-reach service has been developed. The authors, Jibril Handuleh and Ronan McIvor, invite us to consider the project as providing a model for the development of in-reach services in other low-income countries. Their study was built on long-standing foundations, in terms of a collaborative venture between King's College London, the Tropical Health and Education Trust, and Somaliland partners. Training was provided to prison guards and police officers in Borama Prison, working jointly with a local university. Benefits included a direct ban on khat use by prisoners, as well as an indirect influence on the awareness of mental illness among local judicial and governmental authorities. Given the country has no resident psychiatrists and no mental health legislation, this is a remarkable result.

MANAGING THE MENTAL HEALTH OF PRISONERS

The management of mental health problems among prisoners in England and Wales

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This paper reviews the major organisational changes made to the delivery of mental healthcare in prisons in England and Wales since the turn of the century. These changes have included the introduction of 'in-reach' services for prisoners with serious mental illness, replicating the work of community mental health teams. In addition, healthcare budgets and commissioning responsibilities have been transferred to the National Health Service. Measures to reduce the rate of suicide in prisons are also considered.

The overrepresentation of people with mental illness is a feature of prison systems and a challenge to governments, prison administrators and healthcare providers across the globe. Data from large-scale epidemiological studies of psychiatric morbidity are reported fully elsewhere (e.g. Singleton *et al.*, 1998; Fazel & Danesh, 2002) and, while somewhat dated, such surveys show that all types of mental illness, personality disorder and substance misuse, commonly coexisting, are

significantly more common in prison populations than in the wider community.

Since the turn of the century there have been major organisational changes to the delivery of healthcare in prisons in England and Wales. In 1999, the National Health Service (NHS) entered into a clinical improvement partnership with Her Majesty's Prison Service (HMPS), designed to achieve equivalence in the range and quality of prison-based services to those provided to the wider community (HMPS & NHS Executive, 1999). As part of this, changes to mental healthcare delivery, notably the introduction of 'in-reach' services for prisoners with serious mental illness (SMI), replicating the work of community mental health teams (CMHTs), were introduced (Department of Health, 2001) and healthcare budgets and commissioning responsibilities were transferred to the NHS.

Current issues in prison mental healthcare in England and Wales

In 2002, Martin Narey, then Director General of HMPS, described in-reach team staff as 'the

cavalry coming over the hill ... from the NHS'; however, this optimistic tone was tempered immediately by his candid acknowledgement that the problem faced was 'near overwhelming' (Narey, 2002).

After nearly 10 years of operation, a national evaluation of mental health in-reach services was conducted. The study, undertaken in six prisons in England and that included 3492 male and female adult prisoners, concluded that only 25% of those with an SMI, defined as major depressive disorder, bipolar disorder and/or any form of psychosis, were assessed by in-reach services within a month of reception into custody. Furthermore, only 13% were actually accepted onto in-reach team case-loads for ongoing treatment (Senior *et al.*, 2013). A much earlier 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 a person's time in custody (Birmingham *et al.*, 1996). Thus, with more than a decade and a half between the two studies, during which a nationwide policy initiative specifically designed to improve care for this vulnerable group was championed, rates of identification and treatment of prisoners with SMI appear unchanged. How did this happen, and what are the lessons to be learnt?

In-reach services were introduced to treat those with SMI, but were immediately hampered in that task by the relentless referral of those experiencing a wide range of mental distress, including common mental health problems, personality disorders and people simply experiencing distressing, but arguably normal, reactions to their incarceration. In prison, the concept of mental illness is very expansive and many aberrant or disruptive behaviours which compromise the running of an inflexible regime may be labelled 'illness'. Steel *et al.* (2007) used the term 'mission creep' to describe the on-the-ground expectation that in-reach services should deal with the full range of mental health issues presented by prisoners, despite any policy-endorsed delineation of responsibility. It therefore rapidly became evident that, by sticking to a core remit of dealing with people with SMI, the introduction of in-reach as a single-tier mental health service did not address the majority of clinical problems that prison staff wanted most help with: personality disorder and multiple comorbidities.

Since the evaluation of prison in-reach services was completed, there have been several promising developments designed to address the deficits identified. The importance of providing robust primary 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 (NHS, 2013).

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 adaptation of 'critical time intervention' (CTI; Susser *et al.*, 1997), an intervention initially developed to reduce homelessness in people discharged from psychiatric facilities in the USA. In a pilot study, adapted CTI in the UK was found to significantly increase engagement with mental health services after release, compared with treatment as usual, a finding now being tested in a full randomised controlled trial.

Suicide in prison

Offenders have long been recognised to be a high-risk group for suicide within governmental suicide prevention strategies. 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 (Shaw *et al.*, 2013). 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 (Office for National Statistics, 2013). Perhaps this is not too surprising; risk factors for suicide in the general community, for example being male, young, unemployed and with complex personality disorder or substance misuse problems, are common in prison populations.

During the decade when prison suicide rates fell, suicide and self-harm management procedures were overhauled in prisons in England and Wales. Those considered to be at especial risk are cared for using the Assessment, Care in Custody and Teamwork (ACCT) procedures. Any member of prison staff can initiate ACCT processes for any prisoners under their care whom they consider to be of particular concern. Under ACCT, a prisoner should be offered an individual assessment of needs and risks, followed by the formulation of a care plan, known as a CAREMAP, which guides intervention from the multidisciplinary team and provides a mechanism for ongoing reviews of progress. CAREMAPs are drawn up and agreed by a core group of multidisciplinary staff involved with the at-risk individual, and guidance states that there should be an identified key worker and that the prisoners should be actively involved in all stages of their care. ACCT recognises that identifying those at risk of suicide is a prison-wide responsibility in which all staff are expected to play an active role. In many prisons, peer schemes comprising prisoners known as listeners, trained

by the Samaritans, also offer support. Changes to the physical environment have also taken place, notably the creation of 'safer cells' with no ligature points and the creation of first-night centres to offer closer supervision in the early, particularly risky, days of custody.

These physical and procedural changes are only part of the story, however. The training that prison officers, the largest single occupational group with the most hands-on contact with prisoners, receive in the management of suicide and self-harm risk is limited and generally confined to their initial induction period, with no requirement for mandatory updates throughout their career. This lack of training likely contributes to the faulty identification of those at risk of suicide; a recently published review found that 79% of 280 prisoners investigated by the Prison and Probation Ombudsman (PPO) between 2008 and 2012 were not being cared for under ACCT procedures at the time of their apparently self-inflicted death (PPO, 2014). Of course, this also means that one in five people who died by suicide actually had been identified as being at risk, yet the care put in place had, ultimately, been insufficient to keep them safe.

Both the PPO and independent researchers have identified issues with the operation of the CAREMAPs, with over one in four of the CAREMAPs relating to the deaths investigated by the PPO (2014) found to be inadequate, including insufficient support being offered to help prisoners achieve specified goals. In line with our own research, the PPO also recommended that individual staff be allocated responsibility for specific CAREMAP actions, to increase the chances of their completion.

Risk of suicide is not restricted to those in prison; those recently released are also at elevated risk, particularly in the first month. Pratt *et al* (2006) concluded that the overall age-standardised mortality ratio for recently released prisoners was 8.3 for men and 35.8 for women compared with the general population. This finding strengthens the need for mental health services to engage in proactive, 'through the gate' support.

Conclusion

Offenders with mental disorders have been described as 'the unloved, unlovely and unlovable' of our society (Prins, 1993). 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 care, such as accident and emergency and ambulance services, is high and engagement with any type of health 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 suicide rate inevitably requires changes to service modalities and risk formulation.

To meet their needs 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. Risk is best managed by working in partnership with other agencies, including a range of health services, wider criminal justice organisations and third-sector providers. Services have to fully understand and respond in a timely manner to the issues being presented. Notably, multiple and complex morbidities have to be accepted as the norm; commissioners, service managers and practitioners need to honestly embrace the indisputable fact that maintaining engagement with chaotic individuals requires commitment and diligence, as well as adequate resourcing; and special care is required at risky points of transition between prison and the community.

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