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SARA SMITH, VINCENT BAXTER AND MARTIN HUMPHREYS

The interface between general and prison psychiatry – the consultant's perception

AIMS AND METHOD

A postal questionnaire was sent to 100 Section 12 (2) approved consultant psychiatrists in the West Midlands to ascertain their perceptions of the role of general psychiatric services in the care of imprisoned patients with mental disorder previously cared for by generic services.

RESULTS

Of 59 respondents 90% believed they could contribute to the care of imprisoned patients with mental disorders. Ten per cent would delegate total responsibility to specialist forensic services. Lack of awareness of imprisonment of patients was a common problem.

CLINICAL IMPLICATIONS

Insufficient liaison between prison and general psychiatric services may impede the provision of psychiatric care in prison and prevent discharge planning in line with the Care Programme Approach and current Government guidelines.

On 27 July 2000 the NHS Executive published guidelines that explicitly required NHS mental health services to maintain links with mentally disordered offenders (MDOs) during imprisonment if previously subject to the Care Programme Approach (CPA; Adam, 2000). The involvement of NHS mental health services in 'sound discharge planning' for prisoners about to be released from prison was also required.

The *Review of Health and Social Services for Mentally Disordered Offenders and Others Requiring Similar Services* (Reed, 1992) recommended the diversion of prisoners with mental illness to health or social services facilities wherever possible. Although high rates of psychiatric morbidity among prisoners have long been established (Gunn *et al*, 1991; Davidson *et al*, 1995; Brooke *et al*, 1996), many prisoners are insufficiently ill to require diversion from custody (Lart, 1997) but continue to require ongoing psychiatric treatment during their period of incarceration. Historically, psychiatrists have had limited involvement with local prisons in many areas of the country, leaving prison health care staff to manage all but those with most severe mental illness within the confines of the custodial system and with little additional specialist psychiatric input.

The NHS Executive guidelines (Adam, 2000) highlighted the shared responsibilities of prison and NHS mental health services in ensuring appropriate liaison in the care of MDOs. Pre-existing health care arrangements have done little to facilitate this approach and have at times led to confusion regarding the responsibilities of psychiatric services to patients, both in prison and on release.

We are unaware of any previous study evaluating the role of the consultant psychiatrist in the on-going care of previously known patients serving custodial sentences and we undertook this study to gain an impression of contemporary practice prior to the publication of the NHS Executive Directive.

The study aimed to estimate the level of liaison between prisons and consultant psychiatrists in general psychiatric services and to assess the consultants' perceptions of their role in the care of patients in prison.

Method

A questionnaire was sent to 100 randomly selected consultant psychiatrists in the West Midlands approved under Section 12(2) of the Mental Health Act 1983. Those in substantive posts, listed without sub-specialities in the Section 12(2) approved register, were contacted. There were four questions:

(1) If one of your patients was in prison, how often would you ever be made aware of this?
(2) If you were aware that your patient was in prison, what responsibility would you feel you had?
(3) If your patient was released from prison, what follow-up would you suggest?

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(4) If you were contacted by prison diversion services or prison health care staff regarding serious concerns over the mental health of a prisoner previously unknown to you but about to be released, how would you respond?

Multiple responses are additional comments were invited. The survey was undertaken prior to the release of the NHS Executive guidelines.

Results

Fifty-nine consultants replied. Most (73%) felt that information regarding imprisoned patients was infrequently communicated. Twenty-five per cent (15) had never been made aware of a patient of theirs in prison. A further 42% (24) estimated they were informed less than half of the time. When asked about responsibility for imprisoned patients 10 consultants (17%) believed they had no responsibility in this situation. Sixty-one per cent (36) said they would offer information or advice to prison staff. Twenty-six per cent (15) would make contact with the patient in prison.

Table 1 shows choice of follow-up for (a) a known patient and (b) an individual with severe mental illness imminently due for release from prison. Some consultants stated that they would offer no direct input, four stating they believed the mental health needs of imprisoned patients with mental disorder were the remit of specialist forensic and prison health care services.

Comment

The results of this study suggest that liaison between prison and mental health services may be suboptimal: notification of imprisonment of patients with mental disorder generally being infrequent. The majority of consultants who responded did feel obliged to continue involvement in the care of known patients if notified of their imprisonment, but would take a case-by-case approach, seeking relevant information to determine the most appropriate course of action. A significant proportion of consultants believed that their responsibility to patients ended completely when a period of incarceration began, rejecting even involvement on a liaison/information-sharing basis. The scenarios upon which the survey questions were based are common and prison psychiatric liaison services may experience some resistance from general psychiatric services when patients are re-referred.

In most cases there is acknowledgement by consultant psychiatrists that general psychiatric services can play a useful part in the on-going care of MDOs in prison, but that the opportunity to do so may be limited by poor communication. In some cases a change in awareness of responsibilities may be required: by both NHS mental health care professionals and prison staff.

For the NHS Executive Directive to be implemented, a minimum requirement would be that CPA coordinators 'remain in contact with the care and treatment of individuals receiving CPA who enter the prison system' (Adam, 2000), being aware of their location and likely release date. Prison services must cooperate in the provision of appropriate mental health screening of prisoners and the communication of relevant information to appropriate agencies to ensure continuity of care and to facilitate discharge planning with the full involvement of the mental health care coordinator. A balance must be achieved to ensure that a multi-agency approach is practised rather than a shifting of duty of care between NHS and prison services.

High rates of psychiatric morbidity (Office for National Statistics, 1998) and poor health care arrangements in prisons (Reed & Lyne, 1997) have been widely acknowledged, long-standing and persistent (Reed & Lyne, 2000). Non-NHS provision of prison health care has encouraged neither a multi-disciplinary approach nor a working alliance with NHS services. This compounds the problems associated with the management of MDOs who are often difficult to engage in treatment. Existing arrangements for linking prisoners into community services on release are limited (National Association for the Care and Resettlement of Offenders, 1993) and the risk of patients with severe and enduring mental illness being lost to follow-up is high. The development of a closer partnership between prison and the NHS, and the extension of the CPA into prisons aims to limit this (HM Prison Service & NHS Executive, 1999).

Increasingly prompt, accurate, efficient communication between prison and psychiatric services is necessary in the transition to a seamless, multi-agency approach to the care of imprisoned MDOs.

Inevitably there will be implications for service provision, funding and organisational structure. In the long term the aim should be to improve care of people with mental illness both in prison and in the community and for effective treatment and management opportunities to be maximised.

Table 1. Summary of preferred follow-up arrangements of prisoners with mental disorder

Follow-up	Percentage
Known patient	
None	18.6
Refer to GP	5.0
Refer to MDT	22.0
Routine OPA	45.8
Urgent OPA	28.9
Other	25.4
Unknown patient with SMI	
Await GP referral	8.5
Contact GP	5.1
MDT to visit	27.1
Routine OPA	8.5
Urgent OPA	33.9
Other	23.7
Visit to access	45.8

GP, general practitioner; MDT, multi-disciplinary team; OPA, out-patient appointment; SMI, severe mental illness.

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JOE HERZBERG AND ELISABETH PAICE

Psychiatric training revisited – better, worse or the same?

AIMS AND METHOD

To evaluate psychiatric training in one deanery following a programme of site visits, interviews with trainers and trainees, reports, and recommendations. To assess the findings in the context of NHS training requirements. Information was collected by semi-structured interviews and questionnaire surveys.

RESULTS

Forty-three sites were visited, training is generally of a high standard and most trainees are satisfied with their posts. There are significant problems in delivering sufficient community experience to general practice trainees and deficits in availability of multi-professional training programmes.

CLINICAL IMPLICATIONS

College tutors should work to ensure that trainees have access to shared learning occasions with non-medical health professionals to meet the NHS training agenda.

The postgraduate deans commission training to speciality standards set by the Medical Royal Colleges. The Royal College of Psychiatrists has published clear guidance on the standards expected for basic and higher professional training (Royal College of Psychiatrists, 1998, 1999), and these guidelines are updated regularly. Additionally, in the NHS professionals are re-defining and extending their traditional roles, and this has major implications for workforce development, which will need to be supported by multi-professional training (Department of Health, 2000).

At the time of the study, the North Thames deanery was responsible for training approximately a sixth of the psychiatric trainees in the UK. We reviewed psychiatric training on all sites in North Thames in 1996–1997 (Herzberg *et al*, 1999) and found that, despite a high level of satisfaction expressed by trainees, deficiencies in educational and safety standards were found. Trusts and trainers were made aware of these deficiencies by immediate feedback and a written report. A subsequent cycle of visits was carried out in 1999–2000 to see whether improvement had occurred.

Method

Training sites visited in the first survey were revisited. College tutors provided information on a structured questionnaire about the staffing levels, general characteristics of their NHS trusts and their training programmes. The questionnaire was identical to that used in the previous cycle of visits in 1996–1997. Additionally, structured interviews were carried out with senior house officers (SHOs) and specialist registrars (SpRs) on each site. The interviews lasted approximately half an hour per group and the responses were entered onto a form.

Results

All 43 psychiatric training sites in North Thames were revisited. Of 374 SHOs on the deans' database, 237 (63%) were interviewed, and of 161 SpRs 101 (63%) were interviewed. Our experience is that the number of trainees available for interview at any time is approximately 12–15% less than the full establishment, because of leave or vacancies (Paice *et al*, 1997, 2000). The true response rate was therefore over 75% for each group. Tables 1 and 2 compare key findings on the 1996–1997 visits with those of the 1999–2000 visits.

General practitioner vocational training scheme posts

The percentage of general practitioner (GP) vocational training scheme posts without community sessions

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