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Implementation of the Care Programme Approach in prison

AIMS AND METHOD

Recent government legislation has highlighted the importance of implementation of the Care Programme Approach (CPA) within prisons, as part of the expectation that prisoners receive equivalent standards of healthcare to those provided by the National Health Service. To effectively plan the service provision at HMP Belmarsh, we retrospectively established the number of prisoners in a one-year period who would have fulfilled the criteria for enhanced CPA.

RESULTS

Of the 91 prisoners found to fulfil the criteria for enhanced CPA, the majority (77%) had a diagnosis of schizophrenia, schizoaffective or delusional disorder, and 58% required transfer to a psychiatric hospital. Of those who required hospital treatment, 75% needed conditions of high- or medium-security.

CLINICAL IMPLICATIONS

Successful implementation of the CPA for all prisoners who meet enhanced CPA criteria is likely to have significant resource implications, both for mental health teams working within prisons and local psychiatric services.

The Care Programme Approach (CPA) was introduced in 1991 to provide a framework for the delivery of mental health care to patients with severe mental illness, using a case management model. At the core of the CPA is an identified keyworker, who coordinates formulation and implementation of an individualised care plan, regular reviews and documentation of discontinuation or transfer of care. Following a review of the CPA by the National Health Service Executive in 1999 (Department of Health, 1999), two levels of care were introduced; standard and enhanced. Enhanced CPA would apply to those with severe and enduring mental health problems who fulfil the criteria for Section 117, have associated complex needs, present a significant risk and require the coordinated care of two or more agencies to prevent and manage social disability and relapse.

The CPA provides a useful, but not incontrovertible, method of coordinating the care of patients with long-term and complex problems and formalises good clinical practice (Burns, 1997; Vaughan & Done, 2000). It has been argued that the model of case management promoted by the CPA has resulted in good standards of practice in the UK, such that it has been difficult to demonstrate any clear advantage for more assertive, community-based case management interventions. Recent government reports state that equivalent standards of health care should be provided to those detained in prison, including implementation of the CPA (HM Prison Service/NHS Executive, 1999).

HMP Belmarsh was the first prison in England and Wales to set up a formal partnership with a local NHS Trust, in December 1998. HMP Belmarsh is a high-security prison in south east London, with a maximum capacity of 900 male prisoners. It serves as a remand prison for Magistrates' Courts and several Crown Courts, including the more recent inclusion of the Central Criminal Court (Old Bailey). It is also a dispersal prison for those prisoners who have received custodial sentences, including a significant proportion who have received life sentences, and await allocation to an appropriate 'lifer' establishment. HMP Belmarsh receives between 4000 and 5500 new prisoners each year.

Currently, a dedicated mental health team work within the prison. Team members are linked with, and have varying service commitments to, a local medium secure unit. At the time of the study, the team consisted of a consultant psychiatrist, two specialist registrar equivalents, one forensic mental health nurse, an occupational therapist and a psychologist.

Referrals come to the mental health team through various routes. Prisoners are screened on reception, at which stage mental health problems might be either disclosed or suspected. Within 24 hours, prisoners are required to undergo a 'wellman check', carried out by nursing staff, which provides a further opportunity to detect serious mental health problems. After this, referrals are accepted from any agency within the prison, including nurses, drug counsellors, prison officers and probation, by completion of a simple referral form. The mental health team also receives self-referrals of prisoners on rare occasions. Excluding those prisoners who are admitted directly to the health care centre (generally those with current severe mental health problems and/or those who are suicidal), the team generally receive between 10 and 20 new referrals per week.

Previous studies (Gunn *et al*, 1991; Birmingham *et al*, 1996; Brooke *et al*, 1996; Singleton *et al*, 1998) have established that between 5% and 10% of the remand population and 2.5% to 7% of the sentenced adult male prison population suffer from severe mental illness. In addition to psychiatric morbidity, the prison population is known to have very high levels of substance misuse, chronic illness and disability (Grounds, 2000).

Aims

The aim of this study was to estimate the number of inmates per year who could be expected to come under

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the provisions of enhanced CPA, as well as making some estimate of how many prisoners with severe mental health problems are currently being missed with current screening and referral methods.

Method

We defined our inclusion criteria for the CPA within HMP Belmarsh based on a local trust document, which in turn had been based on the national guidelines within the NHS Executive document (South London and Maudsley NHS Trust, 2000).

Enhanced CPA should apply to those who: *either* fulfil the criteria for Section 117 after-care, have a diagnosis of any mental disorder, or have a severe and enduring mental illness with multiple and/or complex needs.

The number of prisoners detained at HMP Belmarsh between 1.11.99 and 1.11.00, who would fulfil the criteria for enhanced CPA, was retrospectively established by examination of the inmate medical record for those cases who had been in contact either with the psychiatric team or with the forensic mental health nurse. Data were collected regarding diagnosis, previous contact with psychiatric services, history of substance misuse, nature of index offence and treatment outcome. Inmate medical records generally contained information regarding previous psychiatric history, obtained by the mental health team at HMP Belmarsh from patients' community mental health teams. Information regarding the index offence was confirmed using the prison's inmate database. For those prisoners who needed transfer to hospital, final care pathways were available regarding the level of security required.

The study was limited in that it was a retrospective case note study on those who were known to have had contact with the mental health team. Inmates who may have been identified as having a history of severe mental health problems by prison staff, but were never referred to the team, would therefore have been missed.

Results

A total of 91 prisoners were identified who fulfilled our criteria for enhanced CPA. Table 1 shows breakdown by primary diagnosis, as defined by the patient's own community mental health team, or the prison mental health team for those who had not had previous contact with services. The 91 prisoners were convicted of, or on remand for, a total of 96 offences. Fifty (52%) were violent offences (including homicide), 16 (17%) sexual offences, 2 (2%) arson and 28 (29%) other offences.

Of the 91 prisoners, 73 (80%) were previously known to psychiatric services and the remaining 18 (20%) were first diagnosed as mentally ill during their present period in custody. These prisoners were usually identified as 'odd' on reception, were frankly psychotic, or were admitted to health care because of the serious or high-profile nature of their offences and found to be mentally ill on assessment by the psychiatric team.

Table 1. Primary diagnosis of those meeting enhanced CPA criteria

Diagnosis	Number of prisoners N=91 (% of total)
Schizophrenia/schizoaffective disorder/ persistent delusional disorder	70 (77%)
Bipolar affective disorder	5 (5.5%)
Psychotic episodes	4 (4.5%)
Severe affective disorder	4 (4.5%)
Personality disorder subject to Section 117	4 (4.5%)
Complex PTSD	3 (3%)
Diagnosis unclear	1 (1%)

CPA, Care Programme Approach; PTSD, post-traumatic stress disorder.

Table 2. Final care pathway

Final care pathway	Number (% of total)
Transfer to psychiatric hospital	53 (58%)
High-security	8 (15%)
Medium-security	32 (60%)
PICU/open ward	13 (25%)
Community care package within prison	38 (42%)

PICU, psychiatric intensive care unit.

Data on history of substance misuse were available from the inmate medical record on 68 (75%) prisoners. Of these, 30 (44%) had a history of alcohol abuse or dependence and 50 (74%) had a history of drug abuse or dependence.

Table 2 outlines final care pathways. The level of security required for those needing transfer to hospital was determined by the usual factors of nature of the index offence and current level of behavioural disturbance.

Accurate figures for the proportion of remand and sentenced prisoners at HMP Belmarsh for the year studied were not available. However, based on rates of severe mental disorder in prison samples from previous studies, it could be expected that between 2.5–7% of new prisoners per year would fulfil criteria for enhanced CPA. This would suggest that at least double the number of prisoners actually identified in the present study would be expected to meet our criteria for enhanced CPA in any one year, if all cases were identified.

Discussion

This retrospective study identified 91 prisoners in a one-year period who met our criteria for enhanced CPA. The vast majority of these suffered with schizophrenia or schizoaffective disorder and were previously known to psychiatric services, although a significant proportion were first identified as having serious mental health problems in prison. The majority of these prisoners had

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histories of drug or alcohol abuse or dependence. Over two-thirds of those identified were in custody for serious violent and sexual offences, which reflects the special status of HMP Belmarsh as a maximum-security prison. Just over half the prisoners identified required transfer to a psychiatric hospital. Of these, 75% required treatment in conditions of medium- or high-security, again reflecting the large proportion of prisoners in custody for serious offences.

Why implement the CPA within prisons?

The Joint Prison Service and National Health Service Executive Working Group, in its paper *The Future Organisation of Prison Healthcare* (HM Prison Service/NHS Executive, 1999), highlighted the failures in delivery of prison health care and endorsed the idea that prisoners should receive an equivalent standard of care to that which could be expected within the National Health Service. It also made specific recommendations with regard to mentally ill prisoners, including the recommendation that mechanisms should be put in place to ensure the satisfactory functioning of the CPA within prisons.

Advantages of introduction of the CPA are that it will:

- Clearly identify a prisoner's health and social needs;
- Enable the integration of care planning with sentence planning;
- Help define clear lines of responsibility and accountability;
- Provide a forum for communication and sharing of information between agencies;
- Inform risk assessment by identification and documentation of previous offences as well as current risk behaviours;
- Provide a forum for coordinated input for those awaiting transfer to, or returning from, assessments in specialist mental health units.

Problems of implementing CPA in prison

The very nature of the prison population, with its inherent fluidity, makes implementation and effective coordination of CPA difficult (Telfer, 2000). The initial hurdle is identifying those potentially subject to CPA. Previous studies have highlighted the inadequacies of the reception screening process (Birmingham *et al*, 1997). There continues to be a lack of coordinated strategies to identify the inmates who we are attempting to target, and conflicts of expectation remain between the prison staff and the mental health team. Prison staff are more likely to refer those who are particularly vociferous or causing them problems (Telfer, 2000). A further hurdle exists in trying to access prisoners prior to transfer or release. With 4000–5500 new prisoners per year entering HMP Belmarsh, coordinated care remains a major challenge.

Effective working of the CPA is likely to have resource implications. Our study has shown that we could expect to place over 90 inmates per year on CPA, and as methods for identification of those with severe mental illness hopefully improve as a result of new screening methods being piloted, this figure could be expected to rise rapidly. There are often difficulties with local services attending prisons, in terms of their own service pressures as well as potential difficulties in gaining access to the high-security prisons. Within our own service at HMP Belmarsh, the consultant psychiatrist fulfils the duty of care for the prisoner, taking responsibility for their management within the prison establishment. In reality, the care is shared with catchment area services, who have responsibility for providing in-patient or community care, although standards for shared care are not yet formalised. Similarly, for those who are already included on the CPA, the mental health liaison nurse has acted as care coordinator, sharing responsibility with community mental health teams. However, the provision within HMP Belmarsh, with its large, established mental health team and Beacon status, will not reflect the provision within the majority of prisons, where in-reach community psychiatric nurses from community mental health teams are more likely to assume the role of care coordinator and the medical responsibility is retained by the patient's community consultant.

We see implementation of the CPA as a service priority and aim for involvement of the local services at the earliest stage, so that progress can be monitored and transfers to hospital expedited. For the foreseeable future, implementation of CPA will remain largely restricted to those subject to the provisions of enhanced CPA.

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