

Prison mental health inreach services

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Summary Prison mental health inreach teams have been established nationwide in England and Wales over the past 3 years to identify and treat mental disorders among prisoners. This paper summarises the policy content and what has been achieved thus far, and poses challenges that these teams face if they are to become a clear and effective component in the overall system of forensic mental healthcare.

As many as nine out of every ten prisoners in the UK display evidence of one or more mental disorders (Singleton *et al*, 1998). Despite this, detection of mental illness on reception to prison has been found to be ineffective, with many prisoners' mental disorders left both undetected and untreated (Birmingham, 2003). Better and more accessible services need to be provided to mentally ill prisoners. This is not a new problem (Gunn *et al*, 1978). The standard of prison healthcare has been of concern since the earliest reports on prison welfare, with frequent campaigns for the National Health Service (NHS) to take responsibility for prison healthcare from the Home Office (Royal College of Psychiatrists, 2007). This was the main recommendation of *Patient or Prisoner*, published in 1996, which highlighted the shortcomings in the prison healthcare system; it also argued for equivalence, namely that 'prisoners are entitled to the same level of healthcare as that provided in society at large' (HM Inspectorate of Prisons, 1996). Recommendations made in *The Future Organisation of Prison Health Care* (HM Prison Service & NHS Executive Working Group, 1999) were accepted by the government, which led to the Department of Health and the Home Office sharing responsibility for prison health. In 2003 it was announced that responsibility for the provision of

healthcare would be completely transferred from the Home Office to the Department of Health from April 2006.

IMPACT AND POTENTIAL ADVANTAGES OF PRISON MENTAL HEALTH INREACH TEAMS

At the same time as inreach teams have been introduced, there has been a reduction of 18% in prison suicides for 2004–5 (Howard League for Penal Reform, 2006). It is not clear whether this is due in part to the new inreach teams, as a series of concurrent factors are likely to have contributed to this finding. These include risk-reduction initiatives within prisons, such as the Safer Locals strategy and the implementation of the Assessment, Care in Custody and Teamwork (ACCT) programme. Another probable factor is the 'dilution' effect seen in the USA whereby a rising imprisonment rate means that on average a less unwell or disabled population is sentenced or on remand, and because a larger proportion of the prison population serves long sentences it tends to be more clinically stable (Gore, 1999). In this respect the pattern of imprisonment in the UK is progressively changing to resemble American trends.

Mentally disordered offenders in prison could be managed through the same channels as those in the community, if inreach teams were to form part of a joined-up approach to care in which there were functioning crisis teams and assertive outreach teams in the custodial environment. Secure hospital care could therefore be arranged within the course of fixed sentences through transfers under sections 47 and 48 of the Mental Health Act 1983 (Department of Health, 2006). This would enable the more appropriate use of scarce and valuable secure beds.

THE REMIT AND CHALLENGES OF INREACH TEAMS

Prison inreach teams were intended to be the main vehicle for improvements in mental health services for prisoners, especially those with severe and enduring mental illness. In fact, forms of such teams have existed for several decades at some prisons, for example Belmarsh and Pentonville, and were provided by non-forensic specialists. The current mental health inreach teams are different in that they are intended to provide care to all prisons in England and Wales. The original intention was stated in this way:

'For those persons judged to have the greatest need, the NHS will fund the establishment of multi-disciplinary teams, similar to community mental health teams (CMHTs) offering to prisoners the same sort of specialised care they would have if they were in the community' (Department of Health & HM Prison Service, 2001).

The key point is that, upon joining the NHS, these new inreach teams should bring the mainstream NHS framework to apply equally to prisoners.

Despite nationwide inreach teams being a relatively new initiative, the challenges to such services are already clear. There are already signs of 'mission creep'. The original intention was to restrict inreach services to treating people with severe and enduring mental illness, but already national policy has been broadened to include all those in prison with any mental disorder (Brooker *et al*, 2005). Prisoners often present a complicated clinical picture as they frequently have complex and comorbid problems. Are the general mental health staff in such teams, who do not necessarily have any forensic training, sufficiently expert to provide effective care? In fact a perverse incentive may now operate, in that inreach teams are less likely to want create referrals for themselves. The role of inreach services in relation to people with personality disorders is not yet clear. Now that the evidence base for effective interventions for personality disorder is growing, meeting the treatment needs of people who frequently present with personality rather than illness-driven problems has to be addressed in practice throughout the prison establishment. Should this fall within the remit of an inreach team, be provided in specialist personality disorder units, or should there be a combination of the two? Does the general psychiatric in-patient

sector have the capacity to accept transfers of people identified in prison as requiring hospital assessment and treatment? Are in-reach teams effective for both sentenced and remand prisoners, and can such teams operate rapidly enough to connect the latter successfully, given high turn-around rates and unpredictable court decisions and release dates? To date all these questions about the remit of inreach teams remain unanswered.

Evidence of treatment models that have been found to be effective in the community, such as community mental health and assertive outreach teams, cannot be directly applied to the prison population because issues of criminality can complicate the picture (Brooker *et al*, 2002). Constraints within the prison environment – such as security issues, information sharing and treating prisoners without their consent – have an impact on the translation of community-based treatments into secure settings. Conflicting views on the balance between care and control within a prison environment may also affect the outcome of using these treatment models in prison.

Drug and alcohol misuse and dependency need to be a core focus of such clinical interventions in prison. The greatest health issue (and the real solution to suicide risk) is to address the substance misuse issues of prisoners (Gore, 1999). Yet paradoxically there is relatively little evidence for effective interventions for people with ‘dual diagnosis’, i.e. concurrent substance misuse and severe mental illness. Such patients are often excluded from studies of the general adult psychiatric population, and so caution should be exercised when translating the research findings from the general adult services to the prison population (Brooker *et al*, 2002). Drug and alcohol treatment services in prisons, using the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) system are already well established. Through a more formal collaboration between inreach and CARAT services, some form of dual diagnosis service could be implemented. Drug-free wings might be a therapeutic setting in which to treat prisoners with such comorbidity.

Clinical experience to date suggests that inreach services are operating using limited and idiosyncratic models of care. The average team size, for example, is three members of staff. Official guidance has been deliberately non-prescriptive, and innovative

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commissioning by primary care trusts will therefore be required to sustain the initial momentum to deliver an equivalent standard of care nationwide.

CONCLUSION

Giving the NHS direct responsibility to commission mental healthcare for prisoners allows us to reconsider what services should be provided on the basis of equity and effectiveness. Should home treatment and crisis response teams be as available to prisoners as to everyone else? Should assertive outreach teams, and specialist drug and alcohol treatment teams, similarly supplement generic inreach teams by taking on patients who need such intensive treatment and who happen to be in prison? In other words, should prisoners receive care that is either identical or equivalent to the care that they would receive if they were in the community? Should we continue to insist that prisoners cannot be treated without or against their consent? How best can people with mental illness be assisted to engage with community services after release from prison? In fact, inreach teams are only one element in a complex and rapidly changing landscape, including new arrangements for care pathways (Department of Health & National Institute for Mental Health in England, 2005), treatment of women in prison, and policy changes to expedite transfers to hospital under sections 47 and 48 of the Mental Health Act in less than 1 week by 2008 (Royal College of Psychiatrists, 2007). This new national policy in England has therefore prompted a wholesale renaissance in the treatment of mentally ill prisoners in recent years: the next challenge is to assess the impact of these changes in practice.

DECLARATION OF INTEREST

None.

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