

A lifetime of exclusion?

Geoff Shepherd on the demand for and availability of mental health services in prison

Prisons are full of socially excluded people with mental health problems. They are also caught between demands for public safety and the ambition to 'rehabilitate' offenders. If psychologists are going to work effectively in this kind of environment, they need to think how best to target their skills on those most in need, to impart their skills to others and to contribute to long-term interventions that might help reduce re-offending in the future.

There is a shocking imbalance between the scale of demand for mental health services in prison and the availability of specialist resources to meet it. Prevalence levels of mental health problems among prison populations are anything between five and 15 times greater than that found in the general population (SCMH, 2007). They are even higher among those on remand, women prisoners and prisoners from black and minority ethnic groups (Singleton et al., 1998). In contrast, the 'average' prison mental health inreach team has approximately a quarter of the resources available to the 'average' CMHT (Brooker et al., 2008). This is likely to include only a few sessions (if any) from a qualified clinical psychologist, and similar input from a psychiatrist.

In these circumstances, perhaps it is surprising that the level of service is not worse than it is. The recent review of the mental health of prisoners by Her Majesty's Inspectorate of Prisons noted that, in the last 10 years, 'There can be no doubt that the quality and extent of treatment available to mentally ill prisoners has improved...' [but] 'In a sense, this infusion of skilled personnel has acted as a marker establishing beyond doubt not only the scale, but also the complexity, of the need'



Prisoners are 13 times more likely to have been in care as a child

(HMI Prisons, 2007, p.5). The report also commented that many of the mental health inreach teams appeared to be working in isolation from colleagues in the general healthcare teams (analogous to primary care) and staff engaged in specialist drug and alcohol or sex-offending treatment programmes. It was further noted that reception screening often failed to pick up serious mental problems on entry; this was particularly the case for prisoners with learning disabilities, who were entering the system largely undetected.

So, what can psychologists do?

Firstly, the mental health team in the prison needs to target those most in need. Just as in the community, this means trying to filter out those with 'common mental health problems' from those with more severe and enduring difficulties. The former should be the responsibility of primary healthcare teams in the prison, whereas the latter clearly require more specialist staff. Our experience in managing the 'interface' between primary and secondary care in the community suggests that this process requires not only clear, agreed, referral criteria, but

also regular, face-to-face discussion and negotiation to ensure that these criteria are consistently applied. It may also require some training and supervision from specialist practitioners to enable the healthcare teams to offer 'low-intensity' psychological interventions. This process would be helped if the prison healthcare teams contained at least one mental health professional.

Alongside this, they need to try to develop the same kind of 'stepped care' models for the delivery of psychological treatments that have been successfully developed in the community.

question

To what extent are key developments in the organisation and practice of clinical psychologists in the community relevant to the problems of delivering effective mental health services in prison?

resources

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These are reflected in the 'New Ways of Working' (see www.bps.org.uk/nwow) and form the basis for the current 'Improving Access to Psychological Therapies' initiative.

Given the high levels of unmet need in the prisons, clinical psychologists also need to try to be involved with others in the screening processes used on reception and induction. Because of the high numbers of new receptions in many prisons, screening tends to be extremely brief (usually a maximum of 10 minutes) and the mental health component is cursory. Assessment on the induction wings offers more potential and might involve working with the healthcare teams and officers using simple observational instruments (e.g. Birmingham & Mullee, 2005).

Psychologists should also try to devote more time generally to training prison staff in the detection and management of psychological problems. This is more difficult than it sounds because of the decentralised nature of prison officer training: it is the responsibility of individual prison governors, and national standards are seldom enforced. In addition psychologists will be caught between the need to deliver a service and the need to train others. This is a difficult balance to get right. Officers are also caught in a conflict between their roles in relation to security, which invariably take precedence over their contribution to 'rehabilitation' (Braggins & Talbot, 2005). Budgetary restrictions and staffing reductions make it difficult for officers to attend pre-planned training sessions, so it may therefore be necessary to take training out to the wings.

Finally, psychologists in prison should consider what they might do in terms of improving prisoners' chances of 'social inclusion' on release (see below).

Social exclusion

Most prisoners have experienced a lifetime of social exclusion. Compared with the general population, prisoners are 13 times more likely to have been in care

as a child; 10 times more likely to have a history of regular truanting; and 20 times more likely to have been excluded from school. 50 per cent of prisoners have reading skills at or below Level 1 (vs. 23 per cent in the general population). Sixty-six per cent are unemployed at the time of imprisonment (vs. 5 per cent in the general population), and 75 per cent say they do not have paid employment to go to on release. The situation is particularly bad among young people (aged under 20) where basic skills, unemployment rates and school exclusion histories are over a third worse than those for older prisoners.

With these kinds of figures and, given the pressures on staff to meet very basic standards for assessment and treatment of symptoms, it is difficult to think what can realistically be done by psychologists to prepare prisoners more effectively for release and to reduce the likelihood of further social exclusion. Much valuable work is already undertaken within prison by staff from organisations such as NACRO, Jobcentre Plus and independent sector work and employment providers (e.g. Apex) to assess housing and employment needs, but there is almost no follow-up (and no transfer of this information) when the prisoner leaves.

This is compounded by the fact that due to the high rates of movement in the prison estate overall, most prisoners complete their sentences in prisons in a very different area from that which they will go to on release. This makes continuity with probation offices, housing and employment services – and local mental health teams – very difficult. A significant proportion of prisoners effectively receive no 'aftercare' except a small amount of money (less than £50) on which they are supposed to exist until they find a job, or sort out their benefits. The consequences in terms of reoffending are predictable.

Specifically in terms of employment, it has been estimated that reoffending rates could be cut by between 33 and 50 per cent if prisoners were engaged in (legal) paid employment post-release (SEU, 2002). However, there is very little use of the evidence-based approaches (e.g. 'Individual Placement and Support', see Becker et al., 1994; Bond, 2004) that have been so successful with people with severe

Commentary

Sheena Foster, Member of the DCP Service User and Carer Liaison Committee, and a carer whose son has been involved in the criminal justice system.

I found this a depressing read, which clearly identified the problems for those with a mental health problem in prisons. The lack of a whole-system approach, the failure to adequately screen people on reception, lack of staff training and the constant movement of prisoners with no agency prepared to follow through with any individual.

My own experience was a total lack of coordination with the local authority, who failed to recognise their duty to perform a Mental Health Assessment. My son's Care Programme Approach, which should be the tool that enables care to be continuous, was done without my involvement and any agreement reached was ignored.

If individuals are to be socially included a more radical and far-sighted approach is needed. Proposals to the PCT need evidence of the cost-effectiveness of rehabilitation and the failure to reduce re-offending. Outreach work should be considered with family support groups being developed, 'buddy' systems in place and a Social Enterprise that fulfils the need for daytime occupation on release. We may look to the prisons to improve their understanding of mental illness, but it's what happens on the outside that will make a difference.

mental health problems outside prison (Boardman et al., 2003; Burns et al., 2007). At the very least, we should ensure that social care objectives like housing and employment figure prominently in Care Programme Approach care plans.

This brief review highlights just how far we are currently from achieving anything like 'equivalence' for mental health services within the prison, compared with outside it. This supposedly remains the cornerstone of the government's strategy for prison health services (HM Prison Service & NHS Executive, 1999). As we have seen, it still provides considerable challenges for psychologists, both in terms of symptom relief and social inclusion. Some of these challenges can only be addressed by increased resources, but some progress might be possible by changing ways of working and concentrating more on 'systems' issues, rather than individual care. This is an invidious choice.



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