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Title: Including the Excluded: Developing mental health in-reach in the South West

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Introduction

Recent attention to the health of prisoners has seen significant shifts in service delivery to this population. One strand of these service developments has been the focus upon the mental health of prisoners. This paper describes the components of the prison mental health in-reach services in the South West region of England provided by staff of Avon and Wiltshire Mental Health Partnership Trust.

Sentenced and remand prisoners have been found to have higher rates of mental illness than the general population. As many as 90% of prisoners have a diagnosable mental health problem, substance abuse problem or both (ONS 1998). The criminal justice system has been restricted in its ability to care for these prisoners not least because the prime function of these services does not include health care (Reed and Lyne 2000). However, government policy in the form of the NHS Plan (DoH 2000) and Changing the Outlook (DoH 2001) have placed an onus upon health service and criminal justice systems to identify the health needs of prisoners and respond to them with health care which is equitable with that delivered by the NHS to the general public.

The experience of prisoners and ex-prisoners is one characterised by exclusion. When incarcerated, prisoners are excluded from the wider community as well as access to health care of their choice. Additionally, the prisoner population are more likely to have experienced a complex history of lifelong social exclusion. Specifically, they are more likely than the general public to have experienced long periods of unemployment, have poor numeracy, literacy and coping skills and to have been in care as a child. Additionally, it is well known that mental health problems can
exacerbate and compound these problems so that social exclusion is cemented in place. A central principle of prison health services is to ensure that prisoners should not be excluded from receiving the same standard of care that pertains to the general public. The governments’ modernisation agenda through the National Service Frameworks are as relevant to prisoners as they are to the general public. Indeed the English National Service Framework for Mental health (DoH 1999) makes specific recommendations relevant to prisoners. The National Service Framework highlights the need to address prisoner’s mental health issues in order to remove one obstacle to prisoners returning to more integrated community living.

One of the key strategies for achieving improvement in mental health outcomes in the prison service has been through the use of mental health in-reach teams. Changing the Outlook (DoH 2001) identified the need to create a Prison Mental Health In-reach Collaborative (DoH/HM Prison Service 2002) and this was achieved in collaboration with NIMHE. To support In Reach development aims and objectives of the collaborative have been outlined (box 1.)
Aim: to improve the mental health care provided to prisoners who need it and to help in providing the correct amount of appropriately trained and skilled staff

Objectives:
Establish a process for the integrated Care Programme Approach in Prisons
Implement the Mental Health Promotion component of the Health Promotion Strategy in prisons
Improve transfers between prison and NHS units
Identify and provide the training needs

(Box 1. Aims and Objectives of Prison Mental Health In-reach Collaborative)

Local Context of services
The South West region covers Dorset, Devon, Cornwall, Somerset, Gloucester, Avon and Wiltshire. There are 13 prisons and 2 young offenders’ institutions in this area with a total maximum prison population of 6322 prisoners at any one time. Mental health needs assessments have guided the particular service response for each prison. Each Strategic Health Authority Area has developed in-reach services which have been planned, commissioned and employed locally but with a strategic overview. Local Mental Health Trusts employ the team members. The teams have established links with each other to ensure best practice is shared and to offer continuity of service. Data collection and outcomes are set to reflect national guidelines. Local priorities and operational policies have been developed and put in place.

Teams typically consist of a social worker and mental health nurses. General psychiatry sessions are available in some prisons to support in-reach services and further medical input is planned. This is a developing model of service provision with
the objective of offering primary, secondary and tertiary mental health services to all prisoners, see Box 2. for an example,
Outline of developments at HMP Bristol

- General Consultant Psychiatric sessions.
- Weekly multi-agency lunch-time review/briefing meetings to share knowledge.
- Multidisciplinary and multi-agency involvement for example General Practitioner’s, in-reach, in-patient staff, prison Mental Health staff, and forensic medical staff attend.
- Notes are recorded for review the following week.
- Primary/secondary/tertiary referral and assessment
- Staff feedback is positive and individuals & professional groups say they feel supported, well informed and able to raise issues which may have been difficult to resolve previously. It ‘feels’ ‘joined up’.

Box. 2. A developing model of mental health in-reach provision at HMP Bristol

What do in-reach services do?

Mental health in-reach teams function in many ways similar to community mental health teams. In some cases these teams see their explicit purpose as identifying all people with a diagnosable mental illness in prison and providing them with continuing care up until transfer or release from prison (Armitage et al 2003). In the initial stages of service development this was of prime importance for in many cases no mental health service input existed in many prisons (NHS Executive 1999). The development of comprehensive mental health services in-reach teams are now one part of an expanding focus on mental health in prisons. As such these teams form the secondary mental health service and have an important role in linking, communicating and consultation with primary, tertiary and prison staff. See case scenarios (box 3)

Process

Referrals are accepted from a number of sources including;

- the primary health team
- prison inpatient unit,
- from reception screening especially if it is known that a prisoner is on standard or enhanced CPA prior to prison,
- wing-based staff or assessment team following risk assessment of self-harm or suicide risk,
- detoxification services, and
- safer custody

Once referrals are received and allocated, a member of the team will arrange to complete an individual assessment of the person to determine their mental health needs and behavioural risks. Outcomes of assessment will be varied and may include, referral back to primary care or prison in-patient units with advice and support to develop a care plan. The prisoner will be placed on standard or enhanced CPA following a multidisciplinary care management process with the in-reach team initiating a care plan of interventions and acting as care co-ordinator during the prison sentence. The in-reach team will also establish links with the wider mental health community in order to implement effective Care Pathways. Liaison with local community care co-ordinators is an important aspect of the role of the in-reach teams. The team also responds to crises and delivers specific psychological interventions when indicated. Referral to the NHS for specialised inpatient care may sometimes be necessary and the in-reach team will facilitate this through their linking role between prison mental health care and the local services.

The main priorities for in-reach services are to provide a multidisciplinary specialist assessment and treatment service similar to that provided by community mental health teams and in line with the National Service Framework for mental health (DoH 1999).
Priority groups of prisoners include those with severe, complex and enduring mental health problems. This includes those with

- Functional psychoses
- Severe depression
- Personality disorder
- Prisoners requiring interventions under the Mental Health Act
- Integrated care of co-morbidity e.g. substance misuse and mental disorders

Once the team conclude from the assessment that their services are appropriate to meet the individuals’ needs a prisoner will have a care plan drawn up and an allocated worker identified. The in-reach worker prompts regular multi-disciplinary reviews of medication, liaises with Care Co-ordinators regarding the ongoing management of the prisoner, facilitates early NHS transfers, liaises with NHS staff regarding the continuity of care for prisoners being discharged back to the prison, liaises with all key external agencies regarding pre-release planning and provides support to families. Direct therapeutic intervention and support of prisoners by the in-reach team can help to reduce the need to transfer prisoners onto the prison in-patient units by supporting them and prison staff on the wing. A combination of psychological and social support for example, providing help with relapse awareness and ensuring that meaningful activities are available such as day care, can help to maintain prisoners in their normal residential setting.
1. Mr J came into prison, initially on remand and charged with arson. In reach assessment indicated a severe depressive type illness. The intervention of the In Reach team resulted in Mr J being promptly assessed by a visiting Psychiatrist who confirmed and treated the suspected depression. The next hurdle was to get a CMHT to offer Mr J follow up. Luckily he had remained registered with a GP, and the CMHT for that practice took referrals based on GP registration rather than address, as Mr J was now NFA. The CMHT were reluctant to accept responsibility for Mr J on the basis that he may not reside in their area on release but In Reach were able to advocate for him, and secure an allocated care co-ordinator prior to his release. Mr J was then able to meet his care co-ordinator and community psychiatrist prior to release and an enhanced care plan was formulated.

2. Mr B had a well documented history of bi polar effective disorder. He had been on lithium for many years but as the medication was starting to have an adverse effect on him physically his medication had been stopped. During this period he had become unwell and had ended up in prison on remand for numerous petty offences. In prison he was resistant to taking medication and was becoming unpopular with prison staff due to his irrational behaviour. In Reach was able to educate wing staff about the nature of his illness so they were more understanding and less punitive with regard to his behaviours. In Reach also worked hard to form a relationship with Mr B, and persuade him to take medication. Liaison with his CMHT helped to determine the best treatment for him. Mr B then became extremely anxious about the debts accrued while unwell. The anxiety threatened to jeopardise his recovery and so, with his consent, In Reach wrote to all creditors explaining the position and requesting further interest charges were put on hold until Mr B was well enough to countenance repayment. This reassured Mr B and he was able to focus on his recovery. This work was handed over to his local Debt Advice Service once he was transferred into a psychiatric hospital.

Fiona Banes, In-reach worker, AWP (Avon and Wiltshire Mental Health Partnership Trust) Prison Mental Health In Reach Team

Box 3. Case scenarios of typical in-reach interventions

Wing-based prison staff are being helped to recognise and respond to mental health issues as part of the overall strategy to improve knowledge and understanding about mental health issues. As such in-reach nurses provide advice, support and training on
the management of mental health problems to all relevant prison areas and prison staff
disciplines. This educative function of the in-reach service is aiming to improve
awareness, detection and responsiveness to mental health issues within the prison
environment. Ultimately it is hoped that it will have a direct impact on levels of
deliberate self harming behaviours and reduce suicides among prisoners.

Care pathways
A Care Pathway is a planned patient/prisoner journey through appropriate stages of
input by a range of service providers and is a means of assisting and managing
clinical improvements within services. Standards for these stages are currently being
agreed in a national care pathway document. Care pathways are minimum standards
for action by key prison and health personnel in relation to the mental health of
prisoners during key stages of their incarceration. As part of the development of
prison mental health services a number of established care pathways have been
developed to address prominent stress points in the prisoners’ sentence experience.
For example it has been suggested that 43% of all suicides in prison occur within the
first month of detention (DoH 2001). Detailed work is currently taking place to bring
together Prison Health Care and Safer Custody initiatives with the National Suicide
Prevention Strategy (DoH 2000). Care pathways are being designed to address issues
such as screening for mental health problems on reception to prison and to ensure the
assessment, care and safety of prisoners during the earliest stages of their sentence. A
further critical point in the sentence is leading up to release and care pathways are
being developed to ensure that adequate pre-release planning is in place to ensure
continuity of care once the prisoner has returned to community living.
Service user involvement

The focus on service user involvement is now an established feature of mental health services although a disparity between rhetoric and practice has been acknowledged (Campbell 2003). The challenge for mental health services in prison is to achieve the greatest amount of service user involvement possible within the confines of the necessary security limitations. As a general principle in-reach services should be designed, provided and evaluated with the involvement of those in receipt of services. One route that has been taken is the involvement of prisoners in assessment of their health care needs. For instance Lester et al, (2003) found that prisoners in one sample had used illegal drugs (68%), smoked cigarettes (84%), ate less than 3 portions of fruit and vegetables per day (62%) and had scores outside the normal range for anxiety and depression (75%). The authors concluded that targeting these determinants of health would improve health and may even lead to reduced recidivism. Additionally as services are aiming to achieve equivalence with NHS provision, recipients of in-reach services should have access to standard patient advice and information on services and their condition as well as redress through a complaints procedure. The implementation of the Patient and Public Involvement Agenda is now being planned in prisons across the south-west. Serving prisoners have also attended planning meetings and have received payment for their services. Carers comments and user participation is regularly sought although this is often a complicated and lengthy process due to security restrictions.

Conclusions

Mainstreaming mental health is our aspiration and we can now build on the work achieved during the first two years of development. The task remains challenging but
we are taking the first small steps on a long journey. Significant change is possible if the end goal is identifiable and perceived by all to be a benefit for all. Providing in-reach mental health services to the prison population of the south west is one route to ensuring that appropriate health care provision is available to this very vulnerable group.
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