What will the future bring? Prison mental health care in England

Dina Gojkovic is pessimistic about the future of mental health services in prisons unless greater attention is given to budgetary constraints and service delivery.

Evidence suggests that, compared to the population as a whole, offenders are considerably more likely to suffer from mental health problems (especially from severe/multiple mental health problems). Some authors estimate that the proportion of people with mental health problems in prisons is as high as 90 per cent (e.g. Roberts and Cobb, 2008). Recent research published in cjm advocates putting more robust court diversion mechanisms in place which would ensure that offenders with mental illness are directed into mental health services (Roberts and Cobb, 2008). What happens however, when these mechanisms are not in place or do not perform as expected, and offenders with mental health problems end up in prisons?

The Prison Modernisation Agenda, which was launched in 1999, recommended that offenders be met by a range of specialised and dedicated prison services which would treat and prepare them for reintegration into the community at the end of the sentence. These services include: in-reach service teams, to work with offenders with severe mental illness; a variety of drug and alcohol services; dual diagnosis services (in cases of both mental illness and substance misuse); and dangerous and severe personality disorder services. However, recent research suggests that these services are facing a number of organisational problems which can considerably affect the nature and quality of service delivery – particularly in the case of services to offenders with severe mental illness or with multiple and complex problems. One of the most chronic issues for the Prison Service, as reported by Brooker and Ullmann (2008) in their report for Policy Exchange, is the problem of underfunding for prison mental health care. The portion of healthcare funds spent on mental health is 15 per cent in the community, whereas in prisons this figure is as low as 11 per cent. This means that prison mental health on average gets approximately 25 per cent less funding, proportionate to the expenditure on physical health, than its community counterpart. The authors argue that not only are prison mental health budgets insufficient, but they are also inefficient. Brooker and Gojkovic (2009) revealed that over 70 per cent of secondary mental health teams across the country report that they had at least one unfilled post in 2007. Additionally, Brooker and Ullmann (2008) noted: a degree of confusion over the role of mental health teams in prisons; spill-over of caseload between teams; and inappropriate referrals. These together amounted to £8.6 million being spent inefficiently – approximately a third of the overall budget.

The situation gets somewhat more complicated in relation to services for offenders with multiple mental health problems, who make up over 70 per cent of the offender population (Roberts and Cobb, 2008). Gojkovic (2009) looked at the experiences of mental health workers, working in prisons, who co-ordinate with other services in providing care for offenders. Save for a few notable exceptions, the study found that care was often disjointed due to poor communication between services, excessive caseload volume, the restrictive nature of the prison environment, and different services being commissioned by different agencies (some by the NHS, some by the Ministry of Justice, and some by the private and voluntary sectors). All of these problems also had implications for the continuity of care for offenders at the end of the sentence. Many prison mental health workers reported that they had insufficient time to make the links between offenders and community services before release. They also struggled to overcome a degree of reluctance among the community mental health team to take on ex-offenders.

All of the previously discussed problems are aggravated by several additional factors: inadequate and insufficient training for prison mental health staff; a lack of comprehensive policy guidance on collaboration between services and joint caseload management; poor-quality triage of patients, often resulting in inappropriate referrals; a lack of overarching management structure for mental health services and substance misuse services in prisons; an inadequate number of experts in the field of commissioning of prison mental health services; and a frequent lack of suitable clinical supervision for prison mental health staff. When all of these factors are taken into account, it is no surprise that authors such as Brooker and Ullmann (2008) recommend that investment in prison mental health care be trebled from the current level (approx. £24 million) in order to raise the standards of prison care to the level available in the community.

What was the response to these findings?

In a much awaited review of prison mental health care services, Lord Bradley (2009) formally acknowledged that prison mental

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health care provision to offenders was on the whole less than adequate. A range of recommendations were made; however, some of the issues were arguably not voiced as clearly as they should have been. One of these is World Class Commissioning, which has been introduced into the community since 2008 to raise the standards of health care services by using a strategic approach to commissioning and long-term planning of services (Department of Health, 2009). The recommendations to introduce the same principle in prisons are somewhat anodyne, and do not address the problems which were revealed in some of the previously presented research, such as lack of specialist commissioning and even a lack of motivation by investors to introduce novel approaches in prison mental health care (Brooker et al., 2009). Additionally, Lord Bradley's recommendations pertaining to the resettlement of offenders focused more on the social aspects of rehabilitation (e.g. housing and employment) than the mental health interventions. However, research shows that the first two weeks after an offender's release from prison are an especially dangerous time, with standardised mortality rates that are 12.7 times higher than the general population (Brooker et al., 2009). This means that making links with a mental health professional on release may be of vital importance for an offender with a mental health problem.

Lord Bradley's review, on the whole, takes a rather broad approach to treating prison mental health care, and the fundamental principles that underpin his recommendations for offender care are unclear. The reader is uncertain whether the recommendations are in line with the improvement-of-care agenda, the reducing-re-offending agenda, the promoting-clinically-effective-practice agenda, or the integration-into-mainstream-mental-health-services agenda. Yet it is on the principles in these agendas, as Brooker et al. (2009) argue, that the foundations of any new model of care should lie. The motivation and dedication of the prison mental health care commissioners also arguably depend on these principles.

The recently published Offender Health Strategy (Department of Health, 2009) incorporated the findings of Lord Bradley's Review (2009) and presented a case for reform of offender mental health care. World Class Commissioning was advocated as the best approach to improve offender care. The clarification of mental health service remits was requested, in order to avoid inappropriate referrals, and the development of in-depth mental health and personality disorder awareness training for the workforce was promoted. It was also pointed out that the focus of the reform would be on using the existing resources more efficiently, rather than providing new resources. How the numerous recommendations for improvements to the old services, as well as to a number of new interventions and trainings made in the strategy, fit into this funding scheme is however somewhat unclear. This is left to be decided by the Department of Health, following a detailed cost analysis to be carried out in the next 12 months. This is however but one in an array of questions which arise in relation to the future of prison mental health care. For example, once the remits of different services are clarified, where will this leave offenders with complex and multiple needs who may fall between providers, especially if no funds are dedicated to the formation of new services which would work with this group? Is there a plan to improve primary mental health care service provision, which would reduce the pressure on more specialised services? Is there an intention to form an overarching management structure for all mental health and substance misuse services in prisons which would ensure smooth and uninterrupted care provision to offenders? How will World Class Commissioning competencies be introduced in prisons, with the existing limited resources and, as research has shown, limited supervision? Is there a plan to introduce specialists on the ground to monitor and evaluate the commissioning of these specialist services? Will the inefficiencies in funding identified in research be addressed in the future plans? Is there a plan to improve recruitment of mental health specialists in prisons?

These are some of the specific questions that will arguably need to be answered before any major improvements can take place. The manner in which they are answered will set the course of prison mental health service development for the following period. One thing is certain however: the times that lie ahead will be challenging for service commissioners, providers, and users alike. ■

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