

## Introduction

Up to 200,000 people flow in and out of prison each year, many staying only a few months. Prisoners have both an extremely high prevalence and complexity of mental disorders, often combining vulnerability factors (such as homelessness or a history of abuse) with multiple disorders and substance abuse. They include some of the most disturbed, disturbing and socially excluded members of our society. They present a tremendous challenge to those charged with their care.

As in the community, most care for mental-health problems in prisons is provided by doctors, nurses and others who are not mental-health specialists. This book has been written to help the generalists carry out the mental health aspects of their role and to help those in Primary Care Trusts and Health Authorities who are their partners. It assumes that generalist staff will have access to specialist advice and treatment and does not attempt to be a guide to secondary- or tertiary-level psychiatry. Nevertheless, it recognises that the role of primary care within prisons is a particularly demanding one.

What is in the Guide?

This book is divided into five main sections:

- Section 1 contains information about the diagnosis and management of specific mental disorders, in adults, young people and women who are mothers. The primary-care management of people with personality disorder forms part of this section.
- Section 2 focuses on core management issues and skills that are relevant to a number of mental disorders — for example, assessment, referral, resettlement, managing patients who are at risk of suicide and those who have self-harmed.
- Section 3 contains information about the mental-health needs of particular groups of prisoners (eg detained asylum seekers and those with Learning Disability). It also gives advice about how to respond to the needs of prisoners who have had particular life experiences (such as sexual assault, abuse in childhood or domestic violence) that put them at increased risk of developing a mental disorder.
- Section 4 looks at possible responses to prisoners who behave in ways that are difficult to manage, such as those who are aggressive or who refuse food. Many of these prisoners will not have a mental disorder, but mental disorder is a factor that must be considered.
- Section 5 considers important related matters, such as legal and ethical issues and working with voluntary organisations.

What is the role of primary-care staff in mental health in prison?

Prison healthcare staff and governors are now working in collaboration with Primary Care Trusts and Health Authorities to jointly provide health services of an equivalent standard to services outside prison. In mental health, this means working to meet the standards set out in the National Service Framework. Thus, the role of primary-care staff in prisons can be summarised as:

- Supporting the governor and other staff to develop an environment that supports mental health and well-being (Standard 1).
- Identifying prisoners with mental and substance abuse disorders (Standard 2).
- Managing prisoners with common mental disorders eg depression (Standard 2).
- Referring appropriately for assessment, advice or treatment (Standard 2).
- Working with diverse groups of patients from many different cultures.
- Providing information and guidance for those who provide regular and substantial care for prisoners with mental-health problems — in prison, often staff as well as family members (Standard 6).
- Contributing to the multidisciplinary work to prevent suicide (Standard 7).

The Guide provides information that supports all the activities listed above.

However, health services in prisons are currently in transition. This is reflected in the Guide which includes information:

- about psychological therapies that have been shown to be effective for certain conditions, even though some (perhaps many) prison healthcare staff may not have access to these at the moment
- for generalists to help them in roles that go beyond those expected of primary-care staff outside prisons — for example, advice for generalist nurses working with acutely mentally ill patients in an in-patient setting. We have not, however,

included information about running an in-patient Mental Health Unit, even though there are, at the moment, still some such units in prisons that are managed on a day-to-day basis by generalist healthcare staff.

What sort of Guide is it?

Advice and information for individual clinicians

This Guide is aimed at individual clinicians — nurses, doctors or healthcare officers in the prison health centre. It is not a guide for managers about service development, nor should its advice and suggestions be viewed as mandatory Prison Service policy. However, as we recognise that services are at different stages of development in different establishments, we have included, where appropriate, brief suggestions for how services for particular conditions might be further developed.

Multidisciplinary — including disciplines other than health

The Guide emphasises throughout the contribution that staff from disciplines other than health can and do make to the management of patients with mental disorders. The management advice for each condition includes information and advice for healthcare workers to give, with patient permission, to prison officers and other staff involved in the care of the prisoner. The purpose is to ensure that the management of the patient supports rather than undermines recovery, whether the patient is on the wings, in education or workshops. The related information sheets for other staff are also aimed at that goal. Of course, on occasion patients may withhold permission for information to be shared. However, many will agree if asked, to at least certain information being shared in order that they may receive the most appropriate treatment on ordinary location.

This multidisciplinary approach is in line with standard 6 of the National Service Framework for Mental Health, which requires that healthcare workers provide information and guidance for those who provide regular and substantial care for people with mental-health problems. In the prison context, 'those who provide regular and substantial care' will vary. This is reflected in the wording used in the Guide. In the Guide for primary-care workers in the community, we use the phrase 'Essential Information for the Patient and Family'. In this Guide, we have substituted the phrase 'Essential Information for the Patient and Primary Support Group'. The primary support group might include family members, residential staff, workshop supervisors, chaplains or others as appropriate. Informing and supporting those who care for the patient, whether family members or prison officers, has to be done with patient permission (except where there is a risk of serious harm to the patient or others).

Voluntary and community agencies

The Guide emphasises throughout the contribution that can be made by self-help, voluntary and community agencies. These agencies can help augment and support healthcare treatment, addressing the practical and social problems that cause or exacerbate illness and which healthcare professionals may be untrained or too busy to deal with. Poor access to such forms of community support makes the life of both prisoners and primary healthcare staff much more difficult.

Comorbidity

The Guide attempts, as much as is possible, to give advice about dealing with the huge comorbidity which is the norm in prisons. Clinicians need to be aware of comorbidity of all kinds — between behavioural disorders, mental disorders and substance misuse disorders. Dichotomous thinking has no place in prison healthcare, eg that an inmate is either ill or dependent on substances, or that an inmate is either genuinely mentally ill or personality-disordered. It is essential to think multi-axially — to be aware of physical, social and psychological dimensions and also to be aware of multimorbidity.

Broader prison environment

Although this book is aimed at the individual clinician, it is important to recognise the crucial importance of the broader institutional context within which healthcare takes place. Mental health, in particular, is affected by environmental factors such as access to exercise, fresh air, constructive activities, time out of cell and contact with family and friends outside the prison. It is important for healthcare staff to actively promote health, including mental health, at both the individual and establishment level. How this may be done is set out in the World Health Organization (Regional Office for Europe) Health in Prisons Project Consensus Statement on Mental Health Promotion in Prisons ([www.hipp-europe.org](http://www.hipp-europe.org)). This highlights the following practical and effective ways of enhancing mental health and reducing mental ill-health:

- regular physical exercise
- access to the arts

- antibullying strategies
- depression prevention:
  - cognitive-behavioural therapies
  - spiritual reflection, eg religion, meditation or yoga
- skills acquisition
- utilising prisoners' resources, eg for peer support.

A Management Checklist of prison procedures which can promote mental health within the prison is contained in the Consensus Statement (it is provided on the disk ).

#### How the Guide was developed

The World Health Organisation (WHO) developed a state of the art classification of mental disorders for use in clinical practice and research: the 'Tenth Revision of the International Classification of Diseases (ICD-10). To extend this development into primary care, it published in 1996 the 'Diagnostic and Management Guidelines for Mental Disorders in Primary Care (ICD-10 Chapter V, Primary Care Version). These guidelines were developed by an international group of general practitioners, family physicians, mental-health workers, public health experts, social workers, psychiatrists and psychologists with a special interest in mental-health problems in primary care, using a consensus approach. The WHO guidelines were extensively field-tested in over 40 countries by 500 primary-care physicians to assess their relevance, ease of use and reliability.<sup>1,2</sup>

These guidelines and other WHO primary-care resources were adapted for the UK by a national editorial team, coordinated by the WHO Collaborating Centre at the Institute of Psychiatry. The evidence base was reviewed, information on psychological therapies added, the views of primary-care nurses, counsellors and patient groups were consulted and the text agreed, following several rounds of consensus and a conference. This UK version 'The WHO Guide to Mental Health in Primary Care' was published in 2000.

This subsequent version for prison staff was developed following a survey of prison healthcare staff about whether a version tailored specifically to their needs would be useful, and if so, what should be in it. This has resulted in a guide covering a considerably broader range of topics and including material specifically written for prison nurses and healthcare officers as well as doctors; and with information sheets for prison officers as well as patients. The process followed was a consensus one similar to that followed for the community primary-care guide. The number and range of different professions and groups involved was larger — a reflection of the complexity of the prison environment. A list of all involved can be found in the Acknowledgements section page 351.

#### Evidence on which the specific mental disorder guidelines are based

The diagnosis sections are based on the ICD-10 classification of mental disorders. ICD-10 is itself a consensus document, tested for reliability. The ICD-10 diagnostic criteria presented here have been tested among primary-care professionals to check for face validity and usefulness.

References supporting evidence have been given in line with the principles set out below.

#### Treatments (medication and psychotherapies)

The recommendations about medication are all in line with the *British National Formulary (BNF)*. Where recommendations about medication are unexceptional and in line with both the *BNF* and established practice for many years, references have not been given.

References have been reserved for key statements about medication and about particular psychotherapies or for statements about which evidence and opinion are divided. Where possible, evidence has been given from Cochrane reviews, high quality published reviews and meta-analyses or randomised controlled trials (RCTs). Discussions have been held with experts and authors of key areas of research. The evidence has been graded as follows:

#### **Strength of the evidence supporting the recommendation**

A = Good evidence to support

B = Fair evidence to support

C = Preliminary evidence to support

#### **Quality of the evidence supporting the statement**

I = Evidence obtained from a meta-analysis of trials, including one or more well-designed RCTs

II = Evidence obtained from one well-designed RCT

III = Evidence obtained from one or more controlled trials, without randomisation

IV = Evidence obtained from one or more uncontrolled studies

V = Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.

Occasionally the 'respected authorities' comprise collective patient experience. Where this is the case, it is clearly stated.

Where a qualitative review of previously published literature without a quantitative synthesis of the data is referenced, it has been graded in accordance with the type of studies the review includes. Where a reference is marked 'N', this means that the note contains additional information or a discussion of the issues, as well as the reference.

#### Information and advice

The sections on 'Essential information for the patient and primary support group' and 'Advice and support for the patient and primary support group' are primarily the result of consensus. There are no trials comparing the outcome of patients given different sorts of advice by their general practitioner. The advice itself is based on a mixture of evidence and consensus of professionals and patients.

#### Referral

The referral recommendations are based on consensus and will vary from place to place, depending on services available in all care sectors.

## References

- 1 Goldberg D, Sharp D, Nanayakkara K. The field trial of the mental disorders section of ICD-10 designed for primary care (ICD-10-PHC) in England. *Family Practice* 1995; 12(4).
- 2 Ustun B, Goldberg D, Cooper J, Simon G, Sartorius N. A new classification of mental disorders based on management for use in primary care (ICD-10-PHC). *British Journal of General Practice* 1995; 45: 211–215.

## Prevalence of mental and personality disorders in prisoners

### Prevalence of psychiatric disorder and self-harm in sentenced prisoners

Study 1: Gunn J, Maden A, Swinton M. Treatment needs of prisoners with psychiatric disorders. *British Medical Journal* 1991; 303: 338–341  
Aimed to identify those prisoners with psychiatric disorders needing treatment

Disorder or condition	Population	Prevalence of men (%)
<b>Psychosis (including schizophrenia)</b>		2.4
<b>Affective psychosis</b>		0.5
<b>Neurotic disorders</b>		5.2
<b>Personality disorder</b>		7.3
<b>Alcohol dependence</b>		8.6
<b>Drug dependence</b>		10.1

Study 2: Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. *Psychiatric Morbidity of Prisoners in England and Wales*. London: ONS, 1998  
Aimed to provide baseline information about the prevalence of psychiatric disorders in prisons in order to inform policy decisions about services

Disorder or condition	Population	Prevalence of men (%)	Prevalence of women (%) <sup>b</sup>
<b>Any schizophrenic or delusional disorder</b>		6	13
<b>Affective psychosis</b>		1	2
<b>Neurotic disorders</b>		40	63
<b>Personality disorder</b>		64	50
<b>Alcohol dependence<sup>a</sup></b>		30	19
<b>Drug dependence (opiates, stimulants or both)</b>		34	36
<b>Suicide attempt in the last year</b>		7	16
<b>Self-harm (not a suicide attempt) in the current prison term</b>		7	10

<sup>a</sup>Measured as AUDIT = 30.

<sup>b</sup>Prevalence of schizophrenic or delusional disorders, affective psychosis and personality disorder was made from a combined sentenced and remand female sample.

Prevalence of psychiatric disorder and self-harm in remand prisoners

Study 1: Maden A, Taylor CJA, Brooke D, Gunn J. *Mental Disorders in Remand Prisoners*. London: Department of Forensic Psychiatry, Institute of Psychiatry, 1995

<b>Disorder or condition</b>	<b>Population</b>	<b>Prevalence of men and women combined (%)</b>
<b>Schizophrenia, psychosis or a delusional disorder</b>		5.5
<b>Neurotic disorder</b>		19.1
<b>Personality disorder</b>		11.0
<b>Substance misuse</b>		39.0

Study 2: Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. *Psychiatric Morbidity of Prisoners in England and Wales*. London: ONS, 1998

<b>Disorder or condition</b>	<b>Population</b>	<b>Prevalence of men (%)</b>	<b>Prevalence of women (%)<sup>b</sup></b>
<b>Any schizophrenic or delusional disorder</b>		9	13
<b>Affective psychosis</b>		2	2
<b>Neurotic disorder</b>		59	76
<b>Personality disorder</b>		78	50
<b>Alcohol dependence<sup>a</sup></b>		30	20
<b>Drug dependence (opiates, stimulants or both)</b>		43	52
<b>Suicide attempt in the last year</b>		15	27
<b>Self-harm (not a suicide attempt) in the current prison term</b>		5	9

<sup>a</sup>. Measured as AUDIT = 30.

<sup>b</sup>. Prevalence of schizophrenic or delusional disorders, affective psychosis and personality disorder was made from a combined sentenced and remand female sample.

Prevalence of selected risk factors for mental disorder:  
Singleton et al. 1998

<b>Experience</b>	<b>Men sentenced (%)</b>	<b>Men remand (%)</b>	<b>Women sentenced (%)</b>	<b>Women remand (%)</b>
<b>In Local Authority care as child</b>	26	33	25	29
<b>Victim of violence in the home at any time in the past</b>	25	28	48	51
<b>Victim of sexual abuse at any time in the past</b>	8	9	31	34

Prevalence of mental disorders among community and delinquent samples of adolescents

<b>Disorder or condition</b>	<b>Community samples (%)</b>	<b>Delinquent samples (%)</b>
<b>Conduct disorder</b>	2–10	41–90
<b>Attention deficit disorders</b>	2–10	19–46
<b>Substance abuse and dependence</b>	2–5	25–50
<b>Mental retardation</b>	1–3	7–15
<b>Learning and academic disabilities</b>	2–10	17–53
<b>Mood disorders</b>	2–8	19–78
<b>Anxiety disorders</b>	3–13	6–41
<b>Post-traumatic stress disorders</b>	1–3	32
<b>Psychosis and autism</b>	0.2–2	1–6
<b>Any disorder present</b>	18–22	80

Source: Kazdin AE. Adolescent development, mental disorders and decision making of delinquent youths. In Grisso T, Schwartz RG (eds), *Youth on Trial: A Developmental Perspective on Juvenile Justice*. Chicago: University of Chicago Press, 2000, vol. 2, pp. 33–64.  
Evidence is summarised from a range of studies. The levels of disorders in adolescents held in detention centres or prisons tend to be towards the higher end of the range.

