Saturday 17 October 1998

BMJ

Severe mental illness in prisoners

A persistent problem that needs a concerted and long term response

It will surprise few that mental health problems are common in people in prison, especially those on remand.[1 2] But in the light of the longstanding policy consensus that people with severe mental illness should be cared for in health and social services, the results of a recent national survey of mental disorders in prisons are still a shocking indication of inappropriate and inadequate psychiatric care on a huge scale.

The survey, funded by the Department of Health,[3] was based on semistructured clinical interviews and is the latest in the important series of studies of psychiatric epidemiology in Great Britain carried out by the Office for National Statistics.[4] Its most dramatic finding is the high rate of functional psychosis: 7% of sentenced men, 10% of men on remand, and 14% of women in both categories were assessed as having a psychotic illness within the past year. Although methodological differences render comparisons with previous studies of prisoners difficult, the key comparative figure is 0.4% for adults in the general population.[4] People with a dual diagnosis of mental illness and substance abuse pose a special problem, also a current concern in the United States.[5]

Some may discount neurotic symptoms as inevitable—even the rate of 75% of women on remand—for who would not be depressed or anxious? But the 20% of men and 40% of women who have attempted suicide at least once (over 25% of women in the previous year, 2% of men and women in the previous week) suggests that these symptoms are not wholly related to their current situation. The high prevalence of antisocial personality disorder also may not cause much surprise in this population: 63% of remanded men, 49% of sentenced men, and 31% of women in both groups. But it suggests that longer term strategies are needed beyond punishment for specific offences.

In 1996 Farrar from the NHS Executive could write that government policy had been consistent in 1983-95 in advocating that mentally ill offenders “should be cared for in health and social systems and not the criminal justice system.”[6] Six years after the Reed report recommended diverting many people from prison into psychiatric care,[7] and in spite of some initial growth of court diversion schemes and transfers of mentally disordered prisoners to hospitals,[8] the numbers in our prisons are still substantial. Five years after the Health of the Nation strategy made mental illness a key area and drew specific attention to the needs of mentally ill offenders[9] there is little evidence that government policy is effecting the fundamental changes required.

BMJ 1998;317:1025–6

The policy implications are important and far reaching. Firstly, secure hospital accommodation is already inadequate and under pressure. Uncertainty surrounds the future of the high security special hospitals, and any reduction or reconfiguration of them would shift patients into the NHS. The Secretary of State for Health’s policy initiative emphasising safety for both patients and the public may also add to the demand for secure NHS provision.[10] Addressing these pressures concurrently will require vision, dedication, and resources.

Secondly, there are many hundreds of men and women remanded in prison for long periods of time, many of whom suffer from longstanding mental disorder, current mental illness, or both. For them, effective treatment is an issue of basic human rights, as is the need to continue speeding up the criminal justice process itself.

Thirdly, many men and women now in prison are no threat to the public and their primary need is for good psychiatric treatment and long term care. They should not be in the criminal justice system, but we have not solved all the problems of providing alternative care. It is not a circumscribed medical problem or merely a matter of compliance with drug regimes; indeed, traditional medical models are seriously limited in this context. Long term care is needed, mostly in the community, and—though it has been said endlessly before—it must be by partnership and teamwork between medical, social, educational, and criminal justice agencies. Clear leadership is also needed, and a commitment to a rehabilitation culture that has never been widely adopted.

An effective service combining individual care and public protection must be a flexible, 24 hour service. If this means something more assertive than aftercare and more paternalistic than current practice, so be it, but community care programmes for these clients must recognise their peculiar lifestyles. Out of prison many are essentially homeless, with limited, not very supportive, social networks, often close to alcohol and drug cultures. Routine health care cannot easily serve them. We need to find some way of mobilising individual continuing care packages which will address both their mental health and social problems and reduce the risk of their reoffending.

If this is to happen the government must be realistic about the scale of the task. Far more secure NHS accommodation and community programmes may be needed than has ever been envisaged. The survey indi-

cates that there may be about 4500 men and 400 women in prison with recent or current psychotic illness. A single professional team with a ring fenced health and social care budget for severe mental illness community care must replace existing fragmented arrangements. Offenders are especially vulnerable to social exclusion, and local psychiatric and social services need a shared ideology of commitment and engagement rather than deflection and avoidance. Nothing short of a government wide response is required. Department of Health action has effected substantial but still insufficient development of local medium secure forensic psychiatry services,[11] but health care in the prisons remains a Home Office responsibility. The responsibility for rehabilitation and reintegration into stable communities is shared by many government departments. The secretary of state for health's cabinet colleagues should be reminded of their common responsibility for a just and effective response to the needs of this most vulnerable and marginalised group in our society.

Tom Fryers *Professor*
Traolach Brugha *Senior lecturer*

Section of Social and Epidemiological Psychiatry, University of Leicester, Leicester General Hospital, Leicester LE5 4PW

Adrian Grounds *Lecturer and consultant forensic psychiatrist*

Institute of Criminology, University of Cambridge, Cambridge CB3 9DT

David Melzer *Clinical senior research associate*

Institute of Public Health, University of Cambridge., Cambridge CB2 2SR

1 Maden A, Taylor CJA, Brooke D, Gunn J. *Mental disorder in remand prisoners.* London: Home Office Research and Statistics Directorate, 1996.
2 Birmingham L, Mason D, Grubin D. Prevalence of mental disorder in remand prisoners: consecutive case study. *BMJ* 1996;313:1521-4.
3 Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. *Psychiatric morbidity among prisoners.* London: Stationery Office, 1998.
4 Meltzer H, Gill B, Petticrew M, Hinds K. The prevalence of psychiatric morbidity among adults living in private households. *Psychiatric survey report No 1.* London: HMSO, 1995.
5 Hegner RE. *Dual diagnoses: The challenge of serving people with concurrent mental illness and substance abuse problems.* Washington: National Health Policy Forum, George Washington University, 1998.
6 Farrar M. Government policy on mentally disordered offenders and its implications. *J Ment Health* 1996;5:465-74.
7 Department of Health and Home Office. *Review of health and social services for mentally disordered offenders and others requiring similar services; final summary report.* London: HMSO, 1992.
8 Home Office. Statistics of mentally disordered offenders, England and Wales, 1996. *Statistical Bulletin 20/97*, London: Home Office, 1997.
9 Performance Management Directorate. *Health of the nation: mentally disordered offenders*, Leeds: NHS Management Executive, 1993.
10 Department of Health. *Frank Dobson outlines third way for mental health.* London: Department of Health, 1998 (press release).
11 Department of Health. *On the state of the public health: annual report of the Chief Medical Officer of the Department of Health for the year 1996.* London: HMSO, 1997:170-9.

NHS Direct

Evaluate, integrate, or bust…

General practice p 1054

BMJ 1998;317:1026–7

The gradual introduction of NHS Direct, the 24 hour health telephone helpline due to be a national service by the year 2000, is a small but important symbol of the modern NHS.[1] It has been designed to respond to the fastest growing influences on service industries: consumerism and technology.[2] NHS Direct aims initially to do for the health service what cash machines have done for banking: to offer a more accessible, convenient, and interactive gateway. Its longer term aim should be to help the NHS change its predominant ethos from paternalism to partnership.[3]

This method of delivering services is not particular to health care. Telephone services in other sectors have been one of the fastest growth areas in employment in the United Kingdom. However, the speed of planned growth of NHS Direct (pilots launched March 1998, more bids invited May 1998 and announced in July 1998, 19 million people (40% of England's population) to be covered by April 1999) might suggest that fulfilling political promises precedes rigorous evaluation. A more likely interpretation is that the research is aimed at clarifying not if NHS Direct develops but how. At this rate of expansion, the learning needs to be rapid and responsive.

Those charged with developing and evaluating NHS Direct need to address five key issues. Firstly, to ensure that NHS Direct is both safe and effective, evaluation should establish the best process (how are the calls answered, which decision support software works best?) and the best content (on which guidelines should the advice be based?) for the service. Until recently the evidence on the safety and effectiveness of telephone consultations services has been mixed. More robust evidence is now emerging, as in the study by Lattimer et al in this week's issue (p 1054).[4] This shows no increase in the rate of adverse outcomes (such as death) in people managed by a nurse telephone consultation service with decision support software when compared with those managed by doctors in the traditional manner. As the authors acknowledge, the promising results of this research probably depend on the setting, the method of training of the nurses, and the particular decision support software.

The second challenge is to ensure that a national service develops national standards. Do we perpetuate the natural experiment of pilot sites developing the service differently for too long, or do we stifle creativity by imposing uniformity too early? Too much individual autonomy for too long in the development stage may cause the same problems for NHS Direct as it has done for general practice computing systems.

The third challenge is to develop NHS Direct as an integral part of the NHS with a coordinating function for accessing health (and health related) services. The gateway to the NHS is changing rapidly with the development, and likely convergence of, general practitioner cooperatives, primary care groups, health information services, nurse telephone consultation services, and NHS Direct. A strength of the NHS is its potential to provide a seamless service, promoting col-