Improving the mental health of offenders in primary care

Strategies to enhance social inclusion are as important as medical interventions

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RESEARCH p 303

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According to a recent MORI poll, doctors are viewed by the public as the most trusted professionals; more than 90% of the public trust doctors to be truthful and 80% view them as helpful.[1] However, a qualitative study reported in this week's *BMJ* by Howerton and colleagues found that most offenders did not trust their general practitioners enough to ask them for help, despite experiencing high levels of distress, self harming behaviour, and emotional problems.[2]

Childhood abuse and early traumatic life events are associated with increased rates of neurotic disorders, including post-traumatic stress disorder, substance misuse, self harm, and antisocial personality disorder in adulthood.[3 4] Survivors of abuse have problems in trusting others (particularly figures in authority), and both victims and perpetrators of crime commonly have feelings of low self esteem, shame, and helplessness.[5 6] Male prisoners have high rates of lifetime traumatic experiences,[2-4] and not surprisingly these "offender-victims" experience high levels of psychological distress, yet are reluctant to seek help from health professionals.

Even in the general population, only a minority of people consult their general practitioner for emotional or psychological problems, preferring instead to turn to family members or friends for help.[7] Offenders may be a particularly difficult group to engage in primary health care because most are men, and men are less likely to seek help than women. In addition, their family and social networks are often severely disrupted (if they ever existed in the first place), thus depriving them of alternative sources of help and support.

Low rates of disclosure to health professionals and reluctance to seek help have also been noted in male and female victims of sexual assault and victims of domestic violence, with men being significantly less likely to disclose traumatic and distressing early experiences than women.[8] The National Survey of Sexual Abuse and Violence in Northern Ireland found that almost half of all identified instances of abuse had never been disclosed, and health professionals were rarely chosen as the channel of disclosure.[9]

Some men in the study by Howerton and colleagues said fear of being labelled as mentally ill was a reason for not seeking help from their general practitioner.[2] For many offenders it appears that the stigma of a criminal conviction pales into insignificance compared with that of being labelled as mentally ill. This suggests that the anti-stigma campaigns run by the Royal College of Psychiatrists (such as "defeat depression"[10]) may have failed to reach the most marginalised and socially excluded members of our society, arguably those who are at highest risk of developing mental health problems and who most need to have their underlying fears and prejudices challenged.

Offenders who are seeking care but who have complex social and psychological problems, high rates of drug and alcohol misuse, low compliance with treatment, and ambivalence towards figures of authority may not view primary health care as the solution to their needs.[2] Distress and dysfunction caused by childhood experiences of abuse, neglect, and deprivation are unlikely to be rectified by a single brief consultation or a course of antidepressants, which may be all that is available in a busy inner city practice.

Seeking help in itself is not necessarily beneficial to the individual. One study of rape victims who had contact with health professionals found that about one third rated their contact with the medical system as "hurtful," mostly because of encountering negative, disbelieving, or judgmental attitudes.[11] Similarly, several offenders in the Howerton study reported that previous negative or unhelpful contact with doctors had made them more reluctant to seek help again.[2]

The relationship between a doctor and his or her patient should ideally be one of a cooperative partnership, with shared decision making in which the patient is encouraged to take the lead.[12] In mental health care, the therapeutic alliance between health professional and patient contributes to therapeutic outcome, regardless of the type of treatment.[13] However, the establishment of a therapeutic alliance may be particularly difficult with offenders, whose only experience with figures of authority has been in the context of abuse or coercion. The requirements for doctors to communicate concerns about risk to multiagency public protection panels (MAPPPs),[14] and the proposed introduction of compulsory treatment in the community may further undermine the willingness of offenders to seek help from general practitioners.

The study by Howerton and colleagues[2] reported that offenders wanted their general practitioner to listen to them, treat them with respect, provide appropriate information, and to treat them with compassion. Negative, judgmental, or rushed responses do little to enhance trust or encourage disclosure of painful experiences. In addition, the evidence emerging from research on victim support is that all community services are most effective when they are coordinated and communicate with one another.[15] Services that don't liaise effectively are unlikely to help victims or ex-offenders. The more

complex the person's psychological and social problems, the more necessary a multiagency approach becomes.

Medical intervention can help only when combined with housing support, education, access to work, and specialist input from probation services and the voluntary sector. Educational and vocational strategies aimed at enhancing social inclusion may be more effective than medical interventions in reducing feelings of shame and stigma. Such strategies can enhance the psychological health of offenders and should be considered if offenders cannot be encouraged to seek help from their general practitioners.

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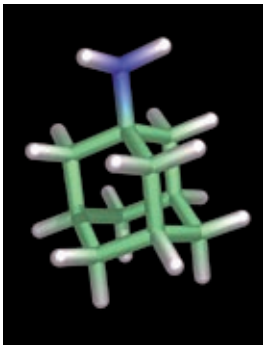
Preparing for the next flu pandemic

New clinical guidelines focus on coordinating services and standardising care



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In the past three years, the incidence of infection with the H5N1 variant of avian flu has increased in humans in southeast Asia during periods corresponding to winter and spring in the northern hemisphere.[1] More cases of H5N1 infection in humans increase the chances that the virus will adapt towards efficient transmission between humans and therefore of a flu pandemic.

The United Kingdom is well advanced in its preparations for a flu pandemic.[2] The British Infection Society, British Thoracic Society, Health Protection Agency, and Department of Health have recently developed and published provisional guidelines on the clinical management of pandemic flu.[3] These guidelines cover the clinical management of children and adults with flu during a pandemic.

In interpandemic years when influenza is circulating in the community, presentation with acute fever and new (or in chronic lung disease, worsening) cough is highly predictive of flu in adults.[4] In a pandemic, key predictive features may change as a result of altered thresholds for consultation, symptom presentation, and clinical features. If this occurs, an updated clinical definition will be released by the Health Protection Agency, informed by guidance from the World Health Organization.

Randomised controlled trials, cohort studies, and modelling studies show that antiviral agents, if given promptly, can reduce the length of illness, viral secretions, and complications; these agents may also reduce peak clinical attack rates.[5,6] The UK government has stockpiled enough oseltamivir for 25% of the population to be treated; if the clinical attack rate is higher then antivirals will have to be prioritised to risk groups.

Previous pandemics have shown that secondary bacterial complications (particularly pneumonia) have a high morbidity and mortality.[7-9] Antibiotic treatment for *Streptococcus pneumoniae, Staphylococcus aureus*, and *Haemophilus influenzae* should be considered at first consultation for adults who have serious worsening of symptoms or fever that does not start to subside after 48 hours, and for patients with chronic obstructive pulmonary disease or other severe comorbid disease (or both). Doxycycline or co-amoxiclav are recommended[3] in the community and in patients in hospital who are not severely ill.

Patients referred to hospital are likely to require management of worsening comorbid disease, such as cardiac failure or flu related pneumonia. Bilateral x ray changes in flu related pneumonia raise the possibility of primary viral pneumonia, which has a poor prognosis and should be treated as severe pneumonia.[3] Indications for transfer to critical care are no different in a pandemic, although limited resources will require effective triage and difficult ethical decisions.

In children, as in adults, fever, cough, and rhinorrhoea are cardinal symptoms of flu, but infants may simply be febrile and non-specifically unwell. Children should be given fluids, antipyretics (avoid aspirin), and antivirals—oseltamivir in liquid form can be prescribed for children aged 1-7 years.[3] Infants under 1 year are a particular problem. They have a higher risk of hospital admission and secondary bacterial infection,[10] and