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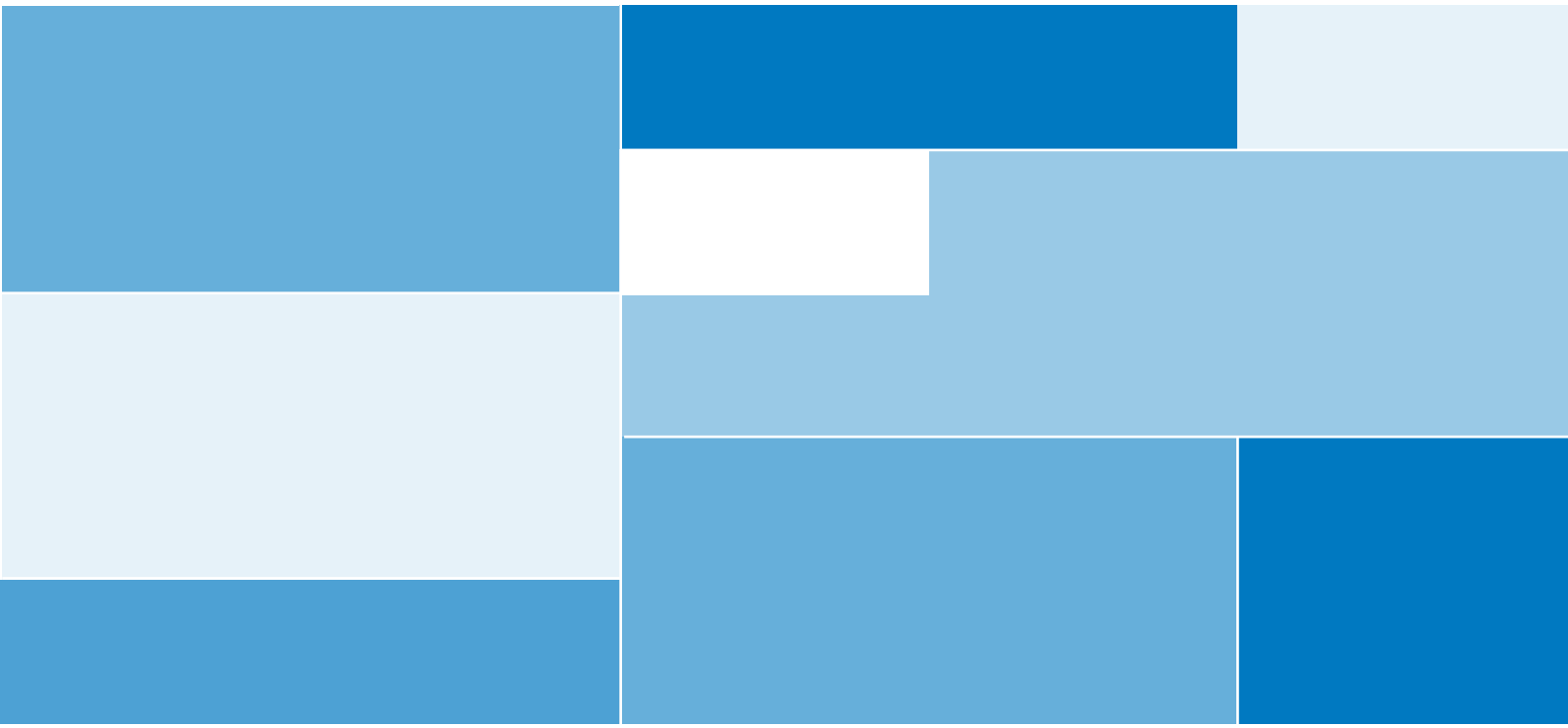
Improving Access to Psychological Therapies

NHS

Offenders

Positive Practice Guide



January 2009

"Relieving distress, transforming lives"

Offenders

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1. Background and policy framework

1.1 Offenders and their families represent one of the most socially excluded groups in our society, with some of the highest levels of morbidity, in terms of both physical and mental health problems. More than half the offenders in prison experience common mental health problems such as depression and anxiety, very often linked to issues such as a history of family poverty, family breakdown and substance misuse. Over half of the women in prison have experienced domestic violence and a third have experienced sexual abuse.[1] The Fawcett Society estimates that 40% of women in prison will have received help for a mental or emotional problem in the year prior to custody.

1.2 Offenders often experience significant problems gaining access to adequate health and social care services, adding to their problems of social exclusion, and putting them at greater risk of continued offending.

1.3 The quality of mental health care (either in prison or in the community) for offenders with common mental health problems still lags behind services available to the rest of the population. Service provision for offenders is either not provided or very patchy. Providing Improving Access to Psychological Therapies (IAPT) services for offenders is a challenge but has considerable potential rewards.

1.4 Health-related characteristics among offenders are:

- significantly poorer health than the rest of society;
- a far greater level of mental health problems that in many cases are not being adequately met;
- poor educational attainment;
- at least ten times more likely to commit suicide and self harm;
- unlikely to have been registered with a primary care practice prior to commencing sentence; and
- significantly greater incidence of drug and alcohol abuse.

1 Social Exclusion Unit (2002) *Reducing re-offending by ex-prisoners,* London, Office of the Deputy Prime Minister, p.138.

1.5 Offenders and their families should receive the same standards of care as the wider community, similarly resourced, and with effectiveness of care measured and designed to meet their needs.

1.6 England and Wales have the highest imprisonment rate in Western Europe, with the population exceeding 80,000 in 2007 and expected to rise beyond 100,000 by 2014 (Carter 2007). The "majority of these prisoners need support for their mental health and experience high levels of mental distress".[2]

1.7 Since April 2006, primary care trusts (PCTs) have been responsible and accountable for the commissioning and quality of health care delivered in prisons, as well as implementing the seven standards of the *National Service Framework for Mental Health*.[3]

1.8 This includes the general principle that the same range and quality of health and mental health services should be accessible to prisoners, appropriate to their needs, as are available to the general population through the NHS.

1.9 The new Gender Equality Duty came into effect in 2007. This requires PCTs to ensure that access to IAPT services is equal for both men and women. Therefore, commissioners of IAPT services will need to ensure that women who come into contact with the criminal justice system have access equal to that of men.

2 Durcan, G. (2008) *From the Inside: Experiences of prison mental health care*, London, Sainsbury Centre for Mental Health

3 Department of Health (1999) *National Service Framework for Mental Health: Modern Standards and Service Models*, London, Department of Health

2. Understanding the needs of offenders

2.1 Offenders tend to come from the more deprived and socially excluded sections of our communities and have significantly higher than average needs in terms of health care. Offending behaviour can sometimes be linked to the offender's health problems and should be factored into a Joint Strategic Needs Assessment (JSNA).

2.2 Community Mental Health Teams operate wing-based services in prisons, both addressing secondary care mental health needs and contributing to primary care day care, transfer arrangements and suicide prevention. In practice, most of these teams have confined themselves to working in prisons with offenders with severe and enduring mental health illness. Therefore, there is often no service available to offenders with mild to moderate mental health problems. However, initiatives to improve the mental health of offenders offer a valuable opportunity to identify and tackle the wider health needs of a vulnerable and socially excluded population. Many offenders have health and social care needs linked to their offending behaviour.

2.3 PCTs must ensure that, as with any service they commission, there is:

- a JSNA that establishes the needs of offenders and plans to meet those needs;
- standards of access and quality of service provided by suitably qualified professionals equivalent to those enjoyed by anyone else living in the PCT area;
- robust performance management of health services in prison settings, with mechanisms in place to identify and tackle poor performance; and
- continuity of care when offenders leave prison.

Additionally, in ensuring that IAPT services meet the needs of offenders there may be a number of other consequential benefits, such as:

- reducing offending behaviour that is health related or linked to the offender's mental health problems;
- reducing further symptoms and rates of depression among offenders;

- reducing or preventing the onset of more serious mental health problems;
- improving the quality of life for offenders in a prison or living in the community;
- reducing rates of attempted and completed suicide; and
- improving the health and social care of women and their families.

2.4 IAPT services should be available and effective for both men and women who come into contact with the criminal justice system, as well as those who are at risk of offending. The needs of men and women who come into contact with the criminal justice system will differ. Women are far more likely to be the primary carers of children, which can make their prison experience significantly different from men. Women also tend to be located in prisons a long way from their homes (due to there being fewer prisons for women), which can have detrimental effects on family relationships, receiving visits and resettlement in the community.

2.5 Commissioners should ensure that IAPT services are available and effective for offenders from a range of circumstances. While offenders should be regarded as part of the ordinary community population, with many offenders in prison for only short periods and their needs broadly similar to other members of the local community, commissioners should be aware that there are also complexities and distinct differences from the rest of the population.

2.6 It is important to consider the needs of offenders in three broad groups (for both men and women):

- offenders serving lengthy prison sentences;
- offenders remanded in custody or serving short prison sentences; and
- offenders living in the community.

2.7 **Offenders serving lengthy prison sentences** (of two years or more) are likely to be (more) stable geographically, located in one prison for much (or all) of their sentence. Their needs are probably met best by the primary care mental health service in their prison.

2.8 **Offenders remanded in custody or serving short prison sentences** are much more challenging to engage. They are likely to move between prison, hospital and community, as well as moving between different prisons. They are likely to be the responsibility of different services with each change of location.

2.9 **Offenders living in the community** will consist of those serving community sentences or remanded on bail, and some of those remanded in custody or serving short sentences at various times.

2.10 The psychological needs of the three groups may be similar but IAPT services will require a flexible approach to meet their complex health and social care needs effectively. Key principles of this should be that:

- IAPT services should be designed to give effective support to all three groups of offenders;
- IAPT services should deliver the same quality of care to offenders as any other member of the community, measured by patient outcomes, to reduce health inequalities;
- continuity of care as people pass into, through and out of the criminal justice system is a critical issue in respect of delivering effective care; and
- effective IAPT interventions need to be proactive, incorporating assertive outreach, patient tracking, identified support personnel and advocates.

3. Removing barriers to access

3.1 Offenders face a number of barriers that prevent them accessing psychological therapy services for their mental health needs. The main barrier is that services are not available – or offered – to them. In some prisons, the mental health care may be commissioned using general prevalence studies rather than a local needs assessment and thus may not cater for the higher prevalence among offenders.

3.2 High levels of social exclusion can mean that some offenders do not have access to GPs and therefore have poorer access to primary care, limiting their access to IAPT services. Practices can and do provide effective services for offenders, but if offenders cannot access them, the value of these services is diminished. Promoting self-referral routes into IAPT services could be a valuable method of removing this barrier for offenders without access to GPs.

3.3 The frequent changes of location among offenders on remand or serving short sentences mean that treatment received before imprisonment is often not continued to the same standard – if at all – in prison. Similarly, those offered treatment in prison are often not able to continue treatment on release into the community.

3.4 Offenders living in the community often have no access to psychological therapies because of organisational or professional boundaries. Health professionals may not believe that they have the necessary skills to deal with the needs of offenders and therefore may not be willing to offer treatment.

3.5 Offenders' beliefs and behaviours may prevent themselves receiving psychological therapies, such as:

- believing that mental health problems are shameful and so deliberately hiding symptoms from health professionals;
- fearing that they may serve longer sentences for having mental health problems;
- believing that the effort, stigma and shame will outweigh the benefits of receiving help;
- self medicating with alcohol (particularly men) to mask their moods or feelings and stop them being detected;

- having difficulty accessing general services such as GP surgeries in the first place (especially relevant for offenders serving community sentences);
- fearing statutory services and not wishing to engage with health professionals;
- fearing that mental health problems will invite an investigation from social services and may result in children being removed; and
- fearing that they may have to disclose violence and abuse that has occurred (or is occurring).

3.6 In planning and commissioning IAPT services that are effective for offenders, commissioners may wish to include the expertise of professionals from other organisations, such as:

- social services;
- probation;
- area prison representation;
- National Offender Management Service via regional representatives;
- prison governors;
- police;
- women's centres; and
- forensic mental health services.

4. Engaging with offenders

4.1 Proper and effective engagement with all three groups of offenders (both men and women) is essential if IAPT services are to meet the needs of the local population.

4.2 Commissioners may find it useful to utilise the expertise of voluntary and community sector organisations, faith groups and other statutory organisations, such as probation services, to encourage engagement with offenders. Such organisations may act effectively as intermediaries by:

- providing commissioners with information that helps to engage the target group;
- raising awareness and signposting individuals to the IAPT service (by being included in the referral pathway to IAPT services); and
- providing useful feedback to help IAPT services improve the way they encourage engagement.

4.3 Offenders serving long prison sentences may be easier to engage than the other groups of offenders, as they are more likely to remain the responsibility of a single PCT (and less likely to move from prison to prison).

4.4 Offenders on remand or serving short sentences need careful collaboration and co-operation between a range of services such as different prisons, different PCTs, different NHS trusts, probation services, addiction services, women's centres and so on. Their brief periods in custody might provide a unique opportunity to begin to engage them with psychological services, but excellent liaison with other services will be essential to meet their needs.

4.5 PCTs should treat offenders living in the community as a socially excluded group who experience significant health inequalities, and work with other agencies, such as probation services, in assessing needs.

4.6 Collaborative working with other services, such as social care, regional partnership boards and probation offender managers offers PCTs the opportunity to improve GP registration of offenders, develop effective strategies for tackling the health inequalities of offenders and improve access to psychological therapies by opening up other possible referral pathways.

5. Training and developing the workforce

5.1 It is an important principle that the IAPT workforce should reflect and be representative of the local community. The capacity and capability of therapists must be appropriate for the people they will be seeing. IAPT services need to recruit, develop and retain a workforce able to deliver high quality services that are fair, accessible, appropriate and responsive to the needs of different groups and individuals, including offenders.

5.2 The training of staff is an important aspect of addressing inequalities within an IAPT service. It is essential to improve the competences and capacity of the IAPT service workforce to overcome any possible professional bias and personal prejudices. Commissioners should be satisfied that service providers are taking steps to ensure that the therapy workforce understand, are aware of and are sensitive to the specific needs of offenders (including those within the community, those in prisons and those who frequently move between prison and the community).

5.3 Therapists may need additional training and advice on safety issues and require extra supervision when working in a prison setting. Co-morbidity, dual diagnosis and literacy problems are particularly relevant for offenders.

Acknowledgements

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