DEZVOLTAREA ASISTENȚEI COMUNITARE ÎN DOMENIUL SĂNĂTĂȚII MINTALE PENTRU DEȚINUȚI

Comments on the

EVALUATION REPORT 2009

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Models of services in prison

In the UK as in most other countries, it has repeatedly been found that (a) prisoners have a higher rate of mental health problems than in the community as a whole, and (b) services are inadequate to meet their needs. One of the documents attached is a recent (2007) report of Her Majesty's Inspectorate of Prisons (HMIP) which describes this problem.

There is as yet no agreed format for providing mental health services inside prisons, but several reports have suggested that a "Stepped Care" model which is recommended for use in the community can also be applied in prison. Such a model has been used in HM Prison Liverpool for the past two years and I am currently involved in an evaluation of it.

The idea of stepped care has been proposed in a number of documents provided by the National Institute of Health and Clinical Excellence (NICE) which has the task of reviewing evidence on the outcomes of treatment for all health-related problems and issuing guidance for the government and for healthcare practitioners. I am attaching summary reports issued by NICE on: anxiety, depression, obsessive-compulsive disorder (OCD), schizophrenia, eating disorders (ED), antisocial personality disorder (ASPD) and violence. Some of them describe the stepped care model.

You can find the full, detailed reports and guidance on the NICE website at:

http://www.nice.org.uk/guidance/index.jsp?action=byType&type=2&status=3

Models of services for rehabilitation in the community

In the UK, in addressing mental health problems this is done mainly through Community Mental Health Teams (CMHTs) which are part of local arrangements organised within and funded by the National Health Service (NHS). They are responsible for the routine delivery of mental health services to the community, and many offenders who are not in prison have access to them just as any other citizen. Where offenders have served short periods in custody (short-sentence prisoners), there is no legal requirement that they should be supervised on release. Therefore they could easily "slip through the net". However anyone in that position who has a mental health problem can go to see his or her General Practitioner (GP) (= family doctors, who are the "gatekeepers" to all kinds of health services) and be referred to a CMHT.

People who have severe and enduring mental health problems in the community and who are supported by CMHTs will be visited regularly by community psychiatric nurses; in addition they will regularly see a clinical psychologist, they may be seen by social workers, and their medication will be

reviewed from time to time by a psychiatrist. Where such individuals have a history of non-compliance with treatment, they may be more closely monitored using *Assertive Outreach* or similar kinds of services which are more intensive. CMHTs usually also liaise with employment, accommodation and other services to provide a "package" of inter-connected services for a person in this position

Where a prisoner has served a longer sentence he or she will be monitored through post-sentence or parole supervision by the Probation Service. That service also works inside prison, and attempts to make links between a prisoner's experience inside and after leaving prison; this is called *ThroughCare*. However, prisoners are sometimes detained in prisons a long way from where they live. Therefore it is sometimes difficult to make this liaison work well, and contacts are often by telephone and letter rather than face-to-face.

Some prisoners are assessed in prison and are considered more dangerous. That is, the assessment indicates that they may present a serious risk of harm to others or to themselves. That will usually be because of the seriousness of the "index" offence (homicide, serious assault, rape, sexual offence against children), or the number of previous convictions, or because they have been diagnosed with a serious mental health problem. In these cases their progress will be monitored after release through what are called the *Multi-Agency Public Protection Arrangements* (MAPPA). This involves regular joint meetings between the police, prison service, probation, and health services; sometimes also involving housing agencies or other providers of services. I was for several years a member of the management board of a service of this kind in Liverpool, known as *Resettle*, which coordinates services for prisoners with severe personality disorders.

Cooperation between prison administration and central government authorities

In the UK the Ministry of Justice issues policies on all aspects of the administration of criminal law, the penal system and provision of services to offenders. Different departments within it deal with the police, and prisons and probation. The latter two agencies are now jointly organised through what is called the National Offender Management Service (NOMS). In England and Wales, prisons are organised into nine regions covering different parts of the country. Scotland and Northern Ireland have their own separate prison services. Probation services in England and Wales are organised into 42 local services but they are all accountable to NOMS headquarters. NOMS sets budgets, issues and monitors policies, and makes senior staff appointments. There is close monitoring of service delivery through a system of "performance indicators". Overall, the process is highly centralised, although there is still room for local initiatives of various kinds.

Case management procedures

I hope that the documents I downloaded and copied last time may provide a range of background information on case management models and procedures.

Information on mental health for use by prisoners and guards

I suggest that the NICE summary guidance, mentioned above, could be used for briefing guards on the factors that affect some frequent mental health problems, and how to manage them. On a previous workshop I prepared several sets of *Powerpoint* slides on some common mental health problems and psychosocial interventions relating to them, and if needs be I can copy all of that material to you.

Information for use by families, professionals, employers and others in the community

Essentially the same kind of information needs to be given to families, employers, lawyers, and other professionals who are involved in services for people with mental health problems, as that given to those directly involved in work with them in prison services or mental health services. However, it should be prepared in a format they can understand, with non-technical language, and many services in the UK prepare specially designed leaflets for distribution to other groups to explain what their relative, or employee, or client is suffering from and how he or she may be given appropriate understanding, help and support. Where necessary, that could also be used to explain the risk that might be involved and how best to manage them.

Emphasis on medical/psychiatric diagnosis

There is considerable debate on the origins or causes of mental illness and disorder. That debate has a lengthy history and it continues in the present day. Psychiatry, which is a branch of medicine, continues to be the dominant model in how mental health problems are understood; and the profession of psychiatry continues to be the most powerful one in the design and the provision of mental health services (and in the formation of government health policy in many countries).

The "medical model" that underpins that approach, translated from the same model in physical health, makes a number of assumptions: principally that mental illness is caused by a "pathogen". In some cases this can be identified. The field of organic psychiatry focuses on problems of this kind. They include for example *toxic confusional states*; *traumatic brain injury*, *seizure disorders*; *Alzheimer's dementia*; and other syndromes which clearly have organic causes. For other syndromes, the model of biological psychiatry assumes that although the cause has not been identified, given sufficient research it will eventually be identified. The first stage in doing that is to observe and classify mental health problems, and the diagnostic systems (DSM and ICD) were developed to mirror the process used in physical medicine. Following diagnosis, biomedical psychiatry then assumes that they key to successful treatment is also a physical one – psychopharmacology, or the administration of psychotropic medication, or sometimes other somatic treatments such as electro-convulsive therapy (ECT), psychosurgery (e.g. lobotomy), etc.

There is however a fundamental problem with this approach. For the vast majority of mental health problems, there is no known pathogen. Furthermore, it appears unlikely that any single cause will ever be found for most types of mental health problems. At various points there have been claims that a single cause (in terms of genes or brain chemistry) has been found for schizophrenia, alcoholism, depression, and personality disorder. In previous years it was believed that such a cause would be found for homosexuality. Alongside this, the standard classification systems used in the diagnosis of mental health problems have been shown to have several weaknesses. They are not always well supported by research; the divisions between categories are unclear; and there is a serious problem of "comorbidity" that calls into question the accuracy and validity of the diagnostic process.

It is likely that biological factors play a part in individual vulnerability to some kinds of mental disorder. They may influence its onset and maintenance, and the extent to which it will respond to treatment. In the overwhelming majority of cases however, very large amounts of research suggest the following.

1) The causes of most mental disorders are complex and "multi-factorial", that is, there are numerous separate causes and they interact with each other in different ways.
2) The same mental health problem can be caused by different types of factors.
3) The same causal factor can give rise, in different individuals, to different types of problems.
4) The majority of mental health problems are at the very least influenced by, and may often be directly caused by:

a. Learning experiences including socialisation

b. Life events including traumas

c. Social circumstances including deprivation

d. Psychological processes including beliefs and attitudes, and limitations in abilities in areas such as problem-solving, coping, interpersonal skills, and self-management/self-regulation.

5) Whether the causes of mental health problems are due to biology, socialisation, personality, social circumstances or social structure, they are all expressed at a personal, psychological level in individuals' observed behaviour and reported experience. Psychological events are the "final common pathway" and most problems and disorders need to be addressed at a psychological level. I am attaching a pdf of a paper that sets out a model of this.

6) The ways in which societies respond to mental health problems can have a profound impact on how they are experienced, how long they last, and how easy or difficult they are to manage. In other words, culture plays an important part in the perception of mental disorder and how it is "constructed". For example, World Mental Health Organisation (WHO) data show large variability across societies in the long-term course of schizophrenia.

This is not incompatible with an acceptance that human beings are products of biological evolution, or that brain-behaviour relationships are crucial to understanding how people function. But learning and experience are also pivotal in determining how individuals adapt to society and to personal stress. Even if there are genetic vulnerabilities they are likely to be expressed in association with environmental events and processes. Furthermore, psychological events can influence brain processes: learning occurs through the growth of neural networks, the human brain shows enormous "plasticity" and can be shaped by environment and experience as much as the other way around.

All of this, which is today well supported by extremely large amounts of evidence, suggests that a medical/psychiatric model of mental disorder addresses only one aspect of the problem, and is only one perspective amongst others. It suggests that to understand mental illness and disorder properly, other perspectives are essential. It also suggests therefore that services for people with mental health problems require the involvement of other professionals in addition to medicine. This highlights the important of *multi-disciplinary teams* (MDTs) in organising and delivering services. Moreover, there is no reason why psychiatry should be the most prominent profession in such groups: rather, their members should have equal status, power and influence, with information being combined and decisions made jointly.

The presumption that a genetic or other organic cause can be found for mental health problems distorts the way research is done. If it is expected that one day there might be a drug which can treat the problem, and profits to be made from that, there is likely to be more money available for research. By far the largest proportion of research funds available for studies of mental illness in the UK and USA is devoted to biomedical studies. Inevitably, progress in understanding the psychosocial factors that influence the development of disorders is much slower by comparison.

Detection of malingering and other deception

There has been quite a lot of research on the problem of detecting simulation or malingering of mental illness. A research study conducted many years ago showed that it can be very easy to convince psychiatrists that someone is suffering from a serious mental health problem. A group was specially trained to present themselves to mental health services and to complain of hearing a voice saying the word "thud", and no other symptoms. All were hospitalised and diagnosed as mentally ill. Understandably, this research study caused considerable controversy when it was first published.

The use of a multi-disciplinary team can be very helpful in trying to discern is someone is malingering, because it enables different members to conduct separate assessments and to compare their impressions and note the consistency of presentation. Many psychological assessments incorporate scales for detecting or taking account of impression management, both of the "faking bad"

and “faking good” varieties. Some psychometric scales and some interview schedules can be used that include questions which will reveal attempts at misrepresenting problems to professionals.

Symptoms associated with aggression

A large-scale review of predictors of criminal and violent recidivism conducted by Bonta and his colleagues in 1998 suggested that clinical diagnosis was a poor predictor of likely future violence. Criminal History variables were superior, and in the main only two kinds of severe mental health problems have been shown to be associated with a heightened risk of acting violently: antisocial personality disorder, and some kinds of delusion as in paranoid schizophrenia. I have attached a pdf of this paper. There is a great deal of research on this issue and it is difficult to cover it adequately in a short statement of the present kind.