The Sainsbury Centre for Mental Health

POLICY 7

POLICY PAPER 7

Getting the basics right: Developing a primary care mental health service in prisons

The Sainsbury Centre for Mental Health works to improve the quality of life for people with mental health problems by influencing policy and practice in mental health and related services.

We now focus on criminal justice and employment, with supporting work on broader mental health and public policy.

The Sainsbury Centre was founded in 1985 by the Gatsby Charitable Foundation, one of the Sainsbury Family Charitable Trusts, from which we receive core funding.

Summary

More than half of prisoners experience common mental health problems such as depression, anxiety and sleeping disorders. Very often these will be linked to a range of other problems including a history of poverty, family breakdown and substance use.

Most mental health provision in prisons is aimed at people with severe and enduring mental health problems. Most primary care in prisons is able only to address people's physical health problems. It has limited consultation times and is hampered by poor quality screening for mental health problems at prison receptions.

As a result, prisoners with common mental health conditions frequently go untreated. They experience unnecessary distress while in prison and return to their communities with the same problems they had previously, often exacerbated by their stay in prison.

Government policy since 2001 has been for prisoners to receive health care that is 'equivalent' to that which they would get outside. This should not mean the same services delivered in the same way. The needs of prisoners and the nature of the prison environment mean health care needs to be tailored to each institution and the needs of those within it to be of equivalent quality and quantity.

A good quality primary care mental health service in prison would devote more time to addressing prisoners' needs. This may include measures such as offering longer consultations; routine follow-up of people on antidepressant medication; access to evidence-based psychological therapies; and staff with sufficient training in mental health work.

Achieving such a service, and ensuring the improvements are sustained after people leave prison, requires a radical rethink of prison health care provision and testing new and innovative ways of offering care and support. Much greater emphasis needs to be placed on promoting and supporting health behaviour change among prisoners and primary care should play a central part in this. Developing new approaches to prison health care and primary mental health care requires more research and more discussion.

This paper proposes some first steps in reforming primary care in the shape of four key policy changes:

1. For each prison to be recognised as a practice in its own right with a dedicated primary care team.
2. Professional support and regulation, including a dedicated, multi-disciplinary professional body for prison health care.

3. A change to the GP contract, creating a Directed Enhanced Service for the most socially excluded groups of people in the community, including those leaving prison, to address the gaps in service many experience on release.
4. Incentives to share resources at the local level, including the creation of 'mini' local area agreements (LAAs) to manage the care and support of former prisoners.

Introduction

England and Wales together have the highest imprisonment rate in Western Europe. The prison population is fast reaching full capacity with over 81,000 people in prison at the time of writing despite the introduction of an early release scheme (HMPS, 2007). This population differs from the general population. It has a higher proportion of people with mental health problems, a history of abuse and neglect or drug/alcohol dependence, poor general health and low levels of registration with or visits to a general practitioner (Anthony & McFadyen, 2005).

The transfer of the commissioning responsibility from the Prison Service to the NHS, completed in 2006, aimed to improve the quality of health care services to prisoners. It brought with it the policy of 'equivalence', which was defined in 2001 as meaning that:

"Prisoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS" (DH & HMPS, 2001).

Since that transfer began, most research and policymaking about mental health in prisons has focused on the very pressing needs of prisoners with severe and enduring mental health problems. The introduction of mental health inreach teams in prisons up and down the country has helped to achieve this goal (Durcan & Knowles, 2006).

It has not, however, solved all of the problems we face in offering prisoners an equivalent mental health service to that provided in the community. Very little support is available to prisoners with common mental health problems, such as depression, anxiety and sleeping disorders. These problems are the business of primary care in the wider community but not, it would appear, in prisons.

More recently, however, addressing the needs of prisoners with common mental health problems has moved up the agenda for both commissioners and providers of prison health care. It is widely acknowledged that problems like sleeping, anxiety and mood affect functioning in all other aspects of an individual's life. By tackling these 'common' mental health problems an individual is more likely to succeed with rehabilitation and achieve a better quality of life upon release back into the community.

Mental health problems among prisoners

Surveys of health need in prison indicate that 70% of prisoners suffer from two or more mental health problems (including substance use and personality disorders) (Singleton *et al.*, 1998). Attempted suicide over a twelve month period ranged from 7% (in male sentenced prisoners) to 27% (in female remand prisoners) (Brooker *et al.*, 2002). Some 42% of suicides occurred in the first 28 days of custody (Pearce *et al.*, 2004).

Table 1 summarises the kind of mental health problems likely to be found in prisons. This is discussed in greater detail in a separate Sainsbury Centre briefing paper (Sainsbury Centre, 2007a).

Table 1: Mental health problems in prisons

	Prevalence amongst prisoners	Prevalence in the general population (adults of working age)
Psychosis	6% – 13%	0.4%
Personality disorder	50% – 78%	3.4% – 5.4%
Neurotic disorder	40% – 76%	17.3%
Drug dependency	34% – 52%	4.2%
Alcohol dependency	19% – 30%	8.1%
	Source: Singleton *et al.*, 1998	Source: Singleton *et al.*, 2000

Several groups of prisoners have additional needs or particular experiences that further increase their need for better mental health care.

Black and minority ethnic (BME) groups

The 'Count me in' census (Healthcare Commission, 2007) showed that people from Black and minority ethnic backgrounds are less likely to be referred to specialist mental health services via primary care than their white counterparts. African and Caribbean people are particularly over-represented in acute psychiatric wards and in secure hospitals (Rutherford & Duggan, 2007).

People from Black and minority ethnic backgrounds are also over-represented in prisons: comprising 20% of the prison population compared with 10% of the general population of the UK (Rickford & Edgar, 2005). The prevalence of mental health problems in Black and minority ethnic prisoners appears to be considerably less (Coid *et al.*, 2002) than compared to other ethnic prison populations. This may be due to lower rates of referral and recognition, including among foreign nationals, or a reluctance to seek help for mental health problems among Black prisoners.

Women

The prevalence rate for functional psychosis for women in prison is estimated at 14% (O'Brien *et al.*, 2003). The equivalent figure for the community is less than one per cent. Anti-social personality disorder is estimated at 31% in women's prisons.

Women prisoners are also more likely than men to suffer from common mental health problems. It has been estimated (O'Brien *et al.*, 2003) that the prevalence rate for all neurotic disorders (depression, anxiety, etc.) among women in prison was 66%, compared to 16% in the general household population. Self harm is more common in the prison population than in the community. In 1997, Her Majesty's Inspectorate of Prisons interviewed a 10% sample of all women in prison and concluded that 40% of women in prison have harmed themselves and/or attempted suicide, and 50% of women prisoners had been physically or sexually abused (O'Brien, 2003).

Young people

Almost 15% of the prison population is aged under 21 (Ministry of Justice/NOMS, 2007). Of these, 95% have at least one mental health problem, and 80% have two or more. Sleeping problems, anxiety and depression are the commonest problems. Levels of substance misuse are also extremely high, with figures quoted by Lader (2000) of between 50% and 60% of young offenders having used street drugs regularly in the previous twelve months.

There is evidence that for children their health can improve when in custody but that any gains are lost on release because services for juveniles in the community are not following them up properly (Chitsabesan *et al.*, 2006).

Older people

People over 60 years of age represent 2% (Home Office, 2006) of the total prison population. There are now more than 1,000 prisoners over the age of 60. Fazel and Danesh (2002) reviewed the treatment needs of older prisoners. They found that prescribing for physical long term conditions, such as cardiovascular or respiratory disease, was generally appropriate, and that clinical record keeping related to prescribing practice. However, they found that, although mental health conditions were recognised and recorded in the clinical record of one half of older prisoners, only 18% of those who needed medication received any.

Social exclusion among prisoners

There are many ways in which prisoners have previously been socially excluded and are likely to continue to be following their release. They include:

- 67% were unemployed before going to prison (Social Exclusion Unit, 2002);
- 70% will have no employment or placement in training/education on release (Niven & Stewart, 2005);
- 65% of prisoners have numeracy skills at or below the level of an 11 year old, and 48% have reading skills at or below this level (Social Exclusion Unit, 2002).

This high level of exclusion is often no better on release. A recent review conducted for Sainsbury Centre (Williamson, 2006) found:

- Mortality rates for non-natural causes in the year following release are 3.5 times greater than for the general population for the 15-34 years' age group, and 10.6 fold for the 35-54 years' age group.
- 42% of released prisoners have no fixed abode.
- 50% of released prisoners have no GP.
- Drug related mortality was seven times higher in the two weeks following release than at other times at liberty.

Primary care in the NHS

Primary mental health care is mental health care provided by generalist and family doctors (GPs) or other primary care staff, such as nurses and counsellors.

General practice in the UK is provided either by self-employed GP principals or by employed, trained and accredited general practitioners. Practices, not individuals, have a nationally-agreed contract, known as the nGMS (new General Medical Services) contract, with their local primary care trust.

This contract, re-negotiated in 2004 and reviewed at regular intervals, introduced many new concepts to the management of what was previously considered to be a relatively under-regulated service. In particular the contract for the first time defined what was considered to be essential care, which must be provided by all practices, and the sort of care that might be considered extra to, or enhanced, general practice.

To encourage the delivery of high quality essential care, an incentive system was developed, called the Quality and Outcomes Framework (QOF: see Box 1).

Box 1: The Quality and Outcomes Framework (QOF)

The QOF is a point system applied to each practice. Points are awarded for delivering against a number of previously agreed outcome measures. Each point has a monetary value. There are 1,050 points available to each practice, of which 550 are available for high quality clinical outcomes and 500 are for high quality administrative outcomes. Clinical outcomes are reviewed every two years, and amendments made in the light of new clinical evidence and changing government priorities.

In the community, the distinction between specialist and primary care is based on whether or not a person will be cared for by a specialist mental health team. The criterion which most mental health trusts apply is whether or not the person has a severe and enduring mental illness – in conformity with the recommendations of the *National Service Framework for Mental Health* (DH, 1999). Those who are not in contact with specialist services are supported entirely by primary care.

The scale of the challenge

A recent Sainsbury Centre report calculated that working age adult community mental health service staffing represented 55% of what was needed to implement the Government's mental health policies (Boardman & Parsonage, 2007).

The same paper estimated that a typical category B men's prison with 550 inmates would require an inreach service of 11 whole time equivalent specialist mental health staff to meet the needs of its population. Those prisons for which information is available indicate that the average size of an inreach team in 2006 was just three whole time staff (Steel *et al.*, 2007). Provision relative to need is therefore only one-third of the level required and in many cases characterised by teams comprising solely of nurses rather than the multidisciplinary teams envisaged by policymakers (HMIP, 2007).

As in the community, a primary care mental health service in prisons would be expected to provide care for all those who are not supported by these specialist teams. Primary care services in prisons have not only to deal with more people with mental health problems, but people with more complex needs, and with less support from specialist services.

There is little information about whether or not there are 'sufficient' primary care staff to meet the needs of the prison population, nor whether there is the correct mix of professionals. What is clear is that using the norms that one would expect for a community general practice is inappropriate. We need urgently to develop a consensus about the appropriate norms for a prison population.

Existing primary care provision in prisons

There is currently no national information on the amount of resource being spent by PCTs on commissioning prison mental health care, either from specialist mental health trusts, or as part of the day to day work of primary care teams. Nor is there any way to compare the costs being spent on prison primary care with that spent outside.

Likewise, there is no national information on the number of primary care clinicians (doctors, nurses or other therapists) working in prisons, nor any way of judging whether or not this level of provision meets the health needs of prisoners.

This dearth of information is a serious barrier to further development of services. Examples of clinical practice that improve the health of prisoners are almost impossible to share nationally because there is no shared framework or shared structure between different prison primary care services.

While undertaking the research for this paper, however, a number of approaches to offering prisoners primary care mental health services were identified in prisons across England and Wales. These are listed in Box 2.

Physical health care in prisons, by contrast, can be of high quality. The prison environment lends itself to the structured care of long term conditions such as diabetes and heart disease. Greater control of diet and exercise, associated with improved compliance with medication, all increase the beneficial outcomes of treatment (Braatvedt *et al.*, 1994; MacFarlane, 1996; Seals, 1997).

Overall mortality rates for all causes are lower in the prison population than among the general population. It was estimated (Clavel *et al.*, 1987) that the Standardised Mortality Rate (SMR: the mortality rate for 100 people in a particular group compared to 100 people in the general population) was 0.84. It was found that the SMR continued to fall for conditions such as cancers and circulatory disease as the duration of incarceration increased.

Box 2: Examples of current practice

- Making information about depression (in the form of leaflets and training) available to prison staff to aid recognition of the condition.
- Providing Assessment and Care in Custody and Teamwork (ACCT) assessors – who identify prisoners at risk of self-harm or suicide – with enhanced training in mental health and clinical supervision from registered mental health nurses (RMN).
- Incorporating mental health promotion within a prisoner's induction programme, including advice on drug misuse and information on managing common mental health complaints.
- A mental health drop-in clinic offering self help information / advice to prisoners and to education department staff who have concerns about their students.
- A primary care psychological therapies (PCPT) team, providing evidence-based and brief interventions to prisoners.
- A dedicated mental health crisis response service.

Prison primary care staffing

There is no national infrastructure that supports postgraduate training for clinicians of any background to work in prison mental health care. Neither is there any specific requirement for professionals working in prison to have any extra skills above and beyond that which is needed for registration.

Most of the information we have available focuses on prison GPs. The University of Durham (Pearce *et al.*, 2004) surveyed the training needs of primary care doctors working in prisons on behalf of the Department of Health, as part of the preparation for the transfer of responsibility for health care provision to the NHS in 2006.

This appears to be the only survey of training needs and characteristics of doctors working in prisons, and is now somewhat dated. It is therefore difficult to say if the situation has changed in any way since 2004.

In relation specifically to training in mental health beyond undergraduate level, only 33% of respondents to the 2004 survey had had at least a six month attachment at senior house officer (SHO) level (currently Foundation Year 2) in general psychiatry, and only 15% were approved under Section 12 of the 1983 Mental Health Act (the section of the Act that empowers suitably trained doctors to co-sign committal papers). This was despite the acknowledged high prevalence of mental health problems in the prison populations by the doctors themselves.

Doctors working in prisons recognised that they were poorly trained and would benefit from further training in managing particular clinical conditions. A majority felt that extra training in mental health issues would be important.

Postgraduate diploma and masters courses do exist for prison health care, but the demand for these courses seems variable. Information from the Royal College of General Practitioners indicates that no doctors took the diploma course in 2006 and a combined three Royal Colleges' diploma programme ceased running several years ago.

Less is known about the skills of nurses and other primary care professionals in prisons. It has been estimated that about one third of the 1,000 or so prison nurses are registered mental health nurses (RMNs) but that they are employed in generic nursing roles and have significant administrative duties (Durcan, 2006).

Putting equivalence into practice

Government policy (DH & HMPS, 2001) states that prisoners should have access to the same range and quality of services as they would get in the wider community. This notion of 'equivalence' is the aim of both commissioners and providers of prison health care services.

"The Government's policy for prison health is enshrined in the principle of 'equivalence of care'... Prisoners should receive the same level of health care as they would were they not in prison – equivalent in terms of policy, standards and delivery.... The prison population is conceptualised as a community and the health care provided within prison should be equivalent to primary care in the NHS including specialist out-patient services. Any prisoner requiring more than primary care is to be transferred from prison to hospital to receive it." (Wilson, 2004)

This should not, however, be interpreted as meaning that prisoners require *the same* service as the general community. The aim of equivalence with the prison population is to provide health care services of a range and quality which deliver the same *outcomes* for prisoners as they do for the general population and that reflect the level and complexity of their needs.

Both service providers and commissioners are now realising that more resources are required to deliver equivalent health care to prisoners and to carry out research on what interventions and models of service are most effective within prison.

In addition, many prisoners fall out of contact with health services on release. An equivalent service would therefore also ensure prisoners received adequate support after they were released, for example by helping them to register with a GP in the community if they are not already registered.

What should a primary care mental health service offer?

Due to the complexity of the needs of offenders, delivering a primary mental health care service which mirrors that in the community is not necessarily effective. Understanding the similarities and differences between prisoners and the general population is very important to delivering primary mental health care services and achieving the desired outcomes.

Table 2 highlights a number of issues that need to be considered when developing and delivering an 'equivalent' primary mental health care service in a prison.

Table 2: Issues facing a prison primary care mental health service

The prison population is made up of mainly men	Even in the general population men are less likely to seek help from health services than women.
Prisoners lack regular access to family and friends	Even in the general population only a small proportion of people seek help from their general practitioner for mental health issues. They prefer instead to speak with relatives or friends.
Stigma of mental illness	Some offenders prefer the label of 'criminal' to being labelled 'mentally ill'.
"What is the GP going to do to help me?"	Offenders very often have complex social and psychological problems, high rates of drug and alcohol misuse and low compliance with treatment. They often feel that primary care is not going to meet their needs.
Lack of trust in authority figures	Most offenders do not trust their general practitioner enough to ask them for help, despite experiencing high levels of distress. Past experience of people in authority may discourage the development of a therapeutic relationship.

(Howerton *et al.*, 2007)

In addition to these considerations, there will be very significant differences between prisons in the kind of service they need and can support. Establishments with large numbers of remand prisoners will be able to offer less continuity of care than those with a more settled population. Security levels may also have an impact on the logistics of organising primary care clinics.

In delivering primary mental health care to the prison population, or indeed any health care service, there needs to be:

- A robust needs assessment.
- A training and workforce development plan.

- A process for co-ordinating care with wider community services.
- The development of an appropriate health service infrastructure.

Each PCT, in partnership with the local authority, has a public health department to undertake needs assessments for specific population groups. Within each prison for which the PCT is responsible, there needs to be a process which translates the assessment of need into the following principles:

- A prison-wide approach to the mental wellbeing of prisoners.
- A holistic model of care incorporating medical, non-medical (e.g. psychological therapies) and behavioural interventions.
- A primary care workforce which understands the needs of the prison population and specifically mental wellbeing.

There are a number of practical points which need to be considered when delivering a primary care mental health service that complies with these principles. These are derived from the increased complexity of the health care needs of prisoners.

Appointments

It is simply not possible to offer a prisoner the care they need in a short consultation given the complexity of their situation. Prisoners consult prison doctors at a very high rate for a range of issues. Some prisons currently do not operate an appointment system at all: instead prisoners are escorted to surgeries en masse, kept in holding cells while waiting to be seen by a doctor before being escorted back by security staff. Prisoners need more time devoted to addressing their health and social care needs, for example through the availability of longer appointments in primary care clinics.

Routine follow-up

Routine follow-up appointments should be arranged, for people prescribed antidepressants, with a doctor or another member of the team. This can be arranged through *chronic disease management systems*. These are being developed within the Improvement Foundation's collaborative on common mental health conditions. They are also described in the National Institute for Health and Clinical Excellence Guidelines for depression (NICE, 2004). Those with chronic mental health problems should also be encouraged to see the same team member at each visit. This is likely to be easier among prisoners on long sentences than those on remand or on short sentences, and will be hampered by the frequent movement of prisoners from one establishment to another within the prison system.

IT support

Prison primary care needs information technology support that is equivalent to that available to general practice in the community. Practices in the community are all computerised. Every consultation, and each element of the consultation, are electronically recorded. The diagnosis, the examination, the medication advised and prescribed, and referral to specialist services are all recorded electronically. Community practices are all linked to the national NHS spine, allowing effective transfer of data, and patient information. Prison practices should have exactly the same opportunities as community practices, since without these opportunities the appropriate development of services is undermined through a paucity of high quality information.

A consistent and shared 'formulary' of Read codes (the computer codes GPs use to record a person's diagnosis in their medical records) should be used by the primary care team. Regular review of the people who are given codes for severe and enduring mental health problems will allow regular follow-up and monitoring, including vital physical health checks. This is included in the Mental Health Quality and Outcomes Framework (QOF) used by general practice in the community and provides a benchmark against which prison health care services can judge their performance.

A new IT system is due to be introduced in prisons shortly. It is hoped this will bring improvements to the management of patient records, in particular when prisoners are moved from one establishment to another.

Medication

Regular audits should be carried out into medications prescribed for mental health problems across the spectrum. Linked to the medical diagnosis, this becomes an effective way for teams to review their performance and how they compare with other practices, inside prison and outside.

Workload

The 'mental health workload' of each of the members of the primary care team should be reviewed regularly. If it falls disproportionately on one or a small number of staff, ways should be considered to share the workload, so that skills are maintained in all team members, and that skills fit the needs of the population.

To meet the criteria listed above, the service would need:

- A performance framework which is relevant to the health needs of the prison population and incorporates the views of those receiving care.
- An IT infrastructure to enable the collation of data about both activity and outcomes.
- Care that reflects prisoners' complex and changing needs. This should include social as well as health care and help to prepare for life outside prison: to have somewhere to live, help with substance misuse, support to re-establish family life, and help to find a job.
- Care that incorporates and applies the principles of 'shared care' between primary and specialist mental health services.
- A locally designed service to meet the specific needs of the population of the individual prison.

The policy solutions to better primary care

Achieving a good quality primary care mental health service in prisons will not be easy. We still have a long way to go to establish effective models of provision and levels of service with dedicated resources. This would be facilitated by four key policy changes:

1. The prison as a practice population

The prison population needs to be a recognised general practice population. Each prison primary health care service would become a practice in its own right.

This way the flexibilities and benefits of primary care and primary mental health care, which are already available to the general population, are also available to prisoners. The model of general practice in the UK is widely regarded as one of the best in the world, and for this group of individuals with complex needs, we should be providing the best available care. The current administrative and financial structure for community general practice allows funds to be targeted at areas of high need and comparisons to be made between different practices' scores within the Quality and Outcomes Framework (QOF).

By contrast, the current *ad hoc* commissioning of prison primary care services by PCTs, and in many cases the provision of the service by the PCT as well, makes the service susceptible to financial pressures elsewhere within the PCT. The conversion of prison populations to a practice population will protect the resources available for prison health care.

Once the population has been defined, and its needs described, a set of quality and clinical outcomes should be set out by the commissioning PCT, which is based on the identified need. Applying this to the prison population would require an assessment of what changes need to be made to the national QOF to reflect more accurately the differing processes needed to deliver the same eventual health outcomes.

By applying such a process of identifying quality and clinical outcomes for prisons, the commissioning authority can performance manage the care being provided, and compare it to other institutions with similar populations. The process also provides financial incentives to the prison practice providing care, equivalent to general practices in the community.

The practice team should also have the ability to consider practice based commissioning (PBC) as a means to commission specialist services for its population (see Box 3). To do this, a budget will be needed for each prison. This allows for benchmarking of resources for health care in prisons, and for appropriate co-ordination of the various funding streams so that the best use is made of current resources.

Box 3: Practice based commissioning

Practice based commissioning is the result of government policy to devolve the commissioning of health care services to front-line clinicians. In the community this is done by either individual practices or by groups of practices. They are provided with a virtual budget, which they can use to commission services from acute and specialist trusts; the intention is that these front-line clinicians will know what the needs of their local population are, and are sufficiently flexible to consider different and innovative ways of commissioning services that are both in the clinical interest of their patients, and economically beneficial.

For a prison practice to commission specialist services in the same way as community practices, they too will need a virtual budget. This will allow comparisons to be made:

- **with other prisons** – are prisons with similar populations receiving similar budgets?
- **between prison and community** – is the prison population receiving an adequate allocation, relative to health care need, to the community?

Making each prison a practice in its own right will, for the first time, put in place the elements needed to ensure that the health needs of the prison population are being assessed and addressed effectively. Not only will this infrastructure allow prisoners' needs to be assessed and addressed, but the practice based commissioning process will allow practices to implement new ways of working themselves. There would be the opportunity to use resources in different ways, measured against clear outcomes, and compared with other prisons providing care to similar population groups.

2. Professional support and regulation: a new body for prison primary care

Professionals working with prisoners need the requisite skills, knowledge and attitudes to meet their needs appropriately.

A formal infrastructure including a professional organisation should be developed to support the professional working in a prison practice. This needs to be a new body, whose main roles would be:

- Professional accreditation: determining what skills professionals need to practise in prison primary care and whether individual practitioners possess those skills.
- Provision of peer support and educational activities.
- Internal performance management.
- To support research and development of primary health care activities in a prison environment
- To act as a central expert resource for government and other external bodies.

As an example, such a new body could develop the role of a general practitioner with a special interest (GPwSI) in prison health care. These are general practitioners who have developed special skills and training in a particular field of clinical care, (e.g. a GPwSI in surgery might undertake minor surgical procedures such as excision of skin lesions in their own surgery, rather than referring the patient to a hospital). The new body would first describe the roles that a GPwSI in Prison Health Care might fulfil, then what capabilities and knowledge such a specialist might need to meet those roles. The body could also commission (or provide) the training to deliver these specialists, and could then accredit the appointment. Finally, the new body could also manage aspects of performance management, such as complaints and assessments of standards of care.

As a minimum, each prison should have a primary care team that can demonstrate that its members have the requisite skills and knowledge to deliver appropriate care. This may be that each member has a postgraduate qualification, or has attended appropriate postgraduate training, up to a level agreed by the new professional organisation. Such skills should include:

- Structured problem-solving counselling techniques
- Activity planning – to manage depression
- Teaching controlled breathing – to manage anxiety
- Teaching relaxation – to manage anxiety
- Motivational interviewing – to manage alcohol and drug misuse
- Supporting graded exposure to feared situations – to manage anxiety, particularly phobias
- Encouraging more appropriate thinking (cognitive skills) – to manage depression and anxiety
- Helping people to re-attribute their physical symptoms to an emotional cause
- Assessing suicidality
- Managing self-harming behaviours.

A workforce gap assessment should be undertaken to ensure that the skills of the team meet the needs of population. Clinical supervision will be vital for team members who take on a significant counselling or mental health workload. Additionally, a rotational placement scheme should be developed in all prisons. This would give individual clinicians the opportunity to work in both prisons and the general community.

3. Changing the GP contract: the Directed Enhanced Service for Social Exclusion

The life chances of prisoners released at the end of their sentence are poor. There are many complex reasons for this, but it is mostly a consequence of the social exclusion experienced

by ex-prisoners. Other groups of individuals also experience social exclusion, particularly the homeless.

The nGMS contract should be reviewed to consider how PCTs may be required to deliver health care for these 'hard to reach' groups.

We recommend that a new service, a Directed Enhanced Service for Social Exclusion, is developed that will combine the needs of these various groups, the ex-prisoners, the homeless, and those who are violent and disruptive, so that the services which they need are available in one site. Such a service should be an extension of the current obligation on PCTs to deliver a service for violent patients.

Such a service would provide the opportunity for primary care teams to work closely with social services, drug and alcohol services and mental health teams, to provide a tailored service to groups of people with complex needs. It would also provide the opportunity to develop innovative models of care, not based on the traditional general practice surgery, which Howerton *et al.*, (2007) has demonstrated does not meet the needs of this group of people.

This arrangement would also give services the opportunity to develop strategies aimed at enhancing their clients' social inclusion. Educational and vocational strategies are more likely to be effective than medical interventions in reducing feelings of shame and stigma and should be considered if ex-offenders cannot be encouraged to seek help from standard primary care services.

4. Incentives to share resources: a mini-LAA

There is as yet little evidence that managing the health needs of offenders reduces re-offending, except in the field of drug and alcohol misuse. It is nevertheless an attractive assumption. Considering prisoners who have been recently released, 50% have no GP, and over 40% have no fixed abode. The re-offending rate is high, as is their mortality and morbidity. If they have nowhere to live, and no way to manage their health needs, then it is not surprising that they may re-offend.

Investment in managing their health needs can therefore have a benefit in many ways, and it would be appropriate to consider shared resources to deliver that health care.

A policy solution does exist – the Local Area Agreement (LAA). LAAs cover large populations, such as the entire population of a PCT which can be between 500,000 and one million people. The membership is drawn from NHS bodies and from a variety of other organisations such as the local authority, local ambulance trust, the police and criminal justice services. The voluntary sector is also represented at a senior level.

The LAA allows resources to be shared to achieve national targets. Inevitably such a large undertaking can be beset by complex bureaucracy, and competing demands. LAAs are blunt instruments that are not good at the sensitivity and lightness of touch needed to change GP behaviour, or to work at the 'small community' level of GP practices.

Practice based commissioning, meanwhile, does provide the tools to change GP behaviour, as it encourages entrepreneurial skills, but it is restricted to health care. Practice based commissioners lack the same opportunities as a PCT within an LAA, to deliver on wider public health needs such as promoting employment or supporting vulnerable people.

What is needed is a system with the benefits of the LAA arrangement, but at PBC level – a mini LAA. This would have all the benefits of sharing resources experienced by LAAs, but at a much smaller population level. It would also provide the governance to give local authorities and the voluntary sector a tangible role in commissioning decisions taken at a community level.

Practice based commissioners would have a governance structure to take a broader view of commissioning and involve other stakeholders who contribute in other ways to the wellbeing of the local population, while ensuring that savings remain within the local area, albeit not to the NHS itself.

This same recommendation has also been made for the delivery of improved employment outcomes for people with mental health problems (Sainsbury Centre, 2007b). In both cases, this is a logical extension to the development of PBC and will allow effective joint working between health and other services at the local level.

Conclusions

The prison population is a group of people who are incarcerated either as punishment for crimes they have committed or in anticipation of a trial in court. There has never been an intention that they should be denied appropriate health care during

that time. In fact, it is now government policy that the health care this group is offered is equivalent to that which they would receive if they were not in prison. However, these individuals have greater, and more complex, health needs than those who are routinely managed in the community: they need more care and support, tailored to their needs both in prison and outside.

Much greater attention needs to be given to motivating and supporting prisoners in changing behaviours which have damaged their health and in promoting behaviours that have a positive impact. Prison health care and mental health care services will need to change radically to support this, but more research is required before this can be described.

This paper points to some of the ways a very significant gap in the NHS's ability to improve health and treat ill health among a very vulnerable group of people with complex needs can be addressed. It shows that some significant policy changes will be needed to make progress, and that a great deal of work remains to be done. If the NHS is to achieve equivalence of care for prisoners, and support the most excluded people in society, improving primary care mental health must be a top priority for commissioners, providers and policymakers. This is an issue that must be ignored no longer.

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