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Two Challenges Affecting Access to Care for Inmates with Serious Mental Illness: Detecting Illness and Acceptable Services

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The overrepresentation of people with serious mental illness in correctional facilities is a modern truism and troubling.[1] What causes this overrepresentation is complex and controversial; what we need to do about it is relatively less controversial. The state clearly has a duty to attend the mental health needs of the people it chooses to incarcerate,[2] recognising that this is a population of people who may well have been underserved for the mental health needs prior to incarceration. For a variety of reasons, prison inmates can be reluctant to accept care and treatment in custody. Correctional mental health services, therefore, must take positive and active steps to find the people we should be caring for and ensure that we offer treatment, or at least give the person the active chance to refuse it should he or she wish to do so.[3]

Evidence from the literature suggests that we are not good at matching clinical service delivery to the numbers of people who we know from multiple epidemiological studies are in fact likely to have serious mental illness (for this purpose defined as a lifetime diagnosis of a psychotic illness, bipolar disorder, or current major depression).[3,4] Whilst there are many other mental disorders that prison inmates commonly experience, including posttraumatic stress disorder, substance misuse disorders, and attention-deficit hyperactivity disorder, the first priority of mental health services must be to the most unwell and the most distressed.[5]

Measuring how well we do this has not been a feature of correctional mental health service provision to date. One measure to help us with this is called "rates under care"—namely, whether we reach the number of inmates we expect should receive specialist mental health care.[6] To achieve rates under care of around the 15% to 20% of a standing prison population that meta-analyses predict we should treat, first we require sophisticated screening, triage, and assessment processes that identify those in need, and second, we require mental health services available to prison inmates that are acceptable and are received without fear of stigma or exploitation. Failure to treat mental health needs may be a barrier to the person's ability to engage in the correctional rehabilitation programs and may increase the risk of restrictive practices and incidents in prison.[7]

Two articles in this journal address different aspects of this care pathway in the Correctional Services of Canada (CSC). These are a welcome contribution to these issues. The article by Martin et al.[8] considers mental health screening of persons at the entry to correctional mental health facilities and variations of the rates under care achieved, and the second article by Brown et al.[9] examines prescribing behaviour of mental health services in CSC. We focus on the article by Martin et al.[8]

Screening is a well-established health technology. The Commission on Chronic Illness (CCI) in 1961 defined screening as "the presumptive identification of unrecognized disease or defect by the application of tests, examinations, or other procedures which can be applied rapidly. Screening tests sort out apparently well persons who probably have a disease from those who probably do not."[10] Screening programmes for disease became common in many countries during the second half of the 20th century (e.g., screening programmes for tuberculosis, syphilis, diabetes, and cervical and breast cancer).

Screening for psychiatric conditions is less common than for physical illnesses. The military can be credited for

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pioneering mental health screening as a means of selecting out those unsuitable for the service. In 1917, the US Army began to administer psychological tests "to help to eliminate from the Army at the earliest possible moment those recruits whose defective intelligence would make them a menace to the military organisation."[11] Men who scored positive on the test were referred for a more detailed psychological test. Advances in screening in prisons were slower to get established and have often been made as a consequence to litigation. In the United States, the landmark *Ruiz v. Estelle* judgment identified the need for screening all inmates to identify those who require mental health treatment.[12] Although screening of prisoners is now an integral practice in modern criminal justice systems, there remains debate as to the most effective method of doing so.

The key moment in the development of screening tools for mental illness in prisons was the development of the Referral Decision Scale (RDS) by Linda Teplin in the United States, a tool derived originally from the Diagnostic Interview Schedule (DIS).[13] This was later shortened by Steadman and colleagues[14] to develop the Brief Jail Mental Health Screen (BJMHS). A brief screening tool was developed in the United Kingdom by Grubin and colleagues[15] with a similar purpose. Both of these tools are short, 4 questions in the case of the Grubin screen and 12 questions in the case of the BJMHS. The other widely used tool is the Jail Screening and Assessment Tool, which is a semistructured interview lasting 20 minutes to half an hour and is perhaps better seen as a triage than a screening tool.[5] These tools have greatest scientific and psychometric support.[16]

Martin et al.[8] performed a retrospective cohort study of 7965 admissions to Canadian federal prisons between November 2012 and September 2014, which were followed for a median of 14 months. They report interesting ethnic and gender differences with respect to prisoners' likelihood of disclosing mental illness at screening and of subsequently receiving treatment between males and females. These findings have important practical and policy implications for the design of services.

It is apparent from this study that the "screening" tool employed by CSC is not one of the above screening tools but rather a battery of assessments that are well-recognised measures of distress, depression, or self-harm risk and some specific questions about recent mental health contact. The article does not describe the diagnostic profile of those defined as being in positive need of intervention. Notably also, many inmates refused to participate in the screening interview. We note that nearly a fifth of black inmates who did not receive treatment were not screened and had lower referral rates compared to other ethnic groups even if screened.

Martin et al.[8] describe differential rates of distress, recent mental health contact, and self-harm ideation in different provinces, with lower rates of mental health treatment engagement than would be expected after the intake assessments from epidemiologically derived prevalence rates of mental disorder in this population.[17] The finding that fewer people access care despite available services is similar to that found in other studies in the United Kingdom, New Zealand, and the United States.[7] That ethnicity, notably immigrant status, is associated with poorer health care access is also challenging. The authors raise important questions about the nature of the screening, engagement, and acceptability of services. This is perhaps the most important finding from the study, reminding us of the difficulty that we encounter in engaging prison inmates with mental disorder in treatment and the challenge of developing more sensitive and sophisticated means of achieving this.

This problem might be addressed by using improved evidence-based tools. The authors rightly note that effective screening presents an opportunity to overcome some structural barriers to access but will not in itself overcome the attitudinal barriers that may impede access to appropriate care. How care itself is delivered may be impactful. In New Zealand, Pillai et al.[18] demonstrated that enunciating a clear model of care for an assertive in-reach prison team can enhance referral rates, caseloads, and community outcomes with no change in resourcing.

Findings of variable rates between provinces at entry are interesting and important, and they warrant further investigation with more tightly defined diagnostic groups to see if those variations do relate to the quality of mental health services available in provinces prior to entry into the federal correctional system.

Thus, the study raises important questions about how we protect those who are suffering and in need of care, as well as how we fashion and deliver those services in a way that is acceptable and effective to prison inmates. We are reminded that incarceration is only a moment in the trajectory of somebody's life; mental health needs exist before, during, and after incarceration. How well those needs are met in custody can have a powerful impact on their trajectory during and after incarceration.

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