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THEMATIC PAPER

MANAGING THE MENTAL HEALTH OF PRISONERS

A novel prison mental health in-reach service in Somaliland: a model for low-income countries?

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We express particular thanks to colleagues in Borama, including Mr Omer Said, the former head of Borama Prison, and Mr Said Ali, the current head, for their support. We offer special thanks to Professor Fadma Abu-Bakr, Dean of Amoud Nursing School, and Dr Walhad, Dean of the College of Health Science at Amoud University, for their encouragement in working within the prison. We owe a debt of thanks to Mr Abdikani Askar, our nurse colleague who provided such excellent input to the prisoners.

Prison in-reach mental health services are reasonably well developed in advanced economies, but virtually nonexistent in low- and middle-income countries. We describe the development of a small prison in-reach project in Somaliland, a self-declared independent state which has experienced conflict and poverty in equal measure. After careful planning and cooperation with local agencies, the service provides sessional input to a regional prison, including assessment and treatment of a wide range of psychiatric conditions. The project has had some unexpected benefits, which are described. The success of the project reflects the effectiveness of collaboration between local stakeholders and international agencies, and could be used as a model for the development of in-reach services in other low-income countries.

There are over 10 million people in prisons worldwide. Prisoners are more likely than the general population to experience psychiatric morbidity, with about one in seven having a treatable mental illness (Fazel & Baillargeon, 2011). Substance misuse, personality factors and risk of suicide (World Health Organization, 2007) are particular problems, and prisoners often present with complex and multiple needs (Singleton *et al*, 1998). Over the past few decades, the concept of equivalence – that prisoners are entitled to the same standard of healthcare as that provided outside prison – has been the main driving force in improving prison mental healthcare (Exworthy *et al*, 2012). Services have attempted to put systems in place to identify at-risk prisoners, both at the time of reception and during their incarceration. For example, in the UK, prisoners are screened for mental health problems on detention and referred to prison in-reach services (staffed by mental health nursing and medical personnel) if required. Detainees can be transferred to the prison healthcare wing or moved to an external hospital under the provisions of mental health legislation. Despite this progress, equivalence is still rarely achieved and demand for in-reach services far outstrips supply (Ginn, 2012).

Notwithstanding these difficulties, prison mental health services in high-income countries are much better than those in emerging economies. In many jurisdictions, services appear to be virtually nonexistent. For example, prison-based mental health services in India are unheard of (Sarkar & Dutt, 2006). We are not aware of any in-reach services on the African continent, despite the high prevalence of mental disorders (Audi *et al*, 2008; Naidoo & Mkize, 2012).

It was with this background that we considered the development of a basic in-reach mental health service within a prison in Somaliland, following a

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visit to Borama Prison in October 2010. We hope that the model may be appropriate for other low-income countries.

Somaliland and the King's THET Somaliland Partnership

Somaliland is an autonomous region that declared independence from Somalia in 1991, following a traumatic civil war. Despite relative stability and political progress, it remains one of the poorest countries of the world, and its healthcare system continues to struggle. Mental health is very much neglected, and has no state funding. There are no resident psychiatrists and no mental health legislation to safeguard the rights of patients. There are, though, a number of psychiatric hospitals, both public and private, in the main population centres, and some out-patient clinics.

Mental illness is exacerbated by the almost universal use of khat, a euphoriant drug associated with behavioural disturbance and the development of psychosis (Odenwald *et al*, 2009).

As in many countries, mental illness is stigmatised, with families reluctant to access the limited services available. As a result, patients can represent a huge burden to relatives, who are usually the main carers. Acutely disturbed behaviour, due to the lack of appropriate treatment, is often managed at home by chaining the patient. Some families rely on the prison system for containment and respite, even when their ill relative has not committed any crime (Handuleh, 2012). There is a strong local belief in spirit (*jinn*) possession as a cause of mental illness, and therefore traditional and religious healers play a significant role in management.

Over the past 12 years, mental health services in Somaliland have improved greatly, thanks in part to a collaboration between King's College London, a British charity called the Tropical Health and Education Trust (THET) and local partners in Somaliland (Leather *et al*, 2006; Sheriff & Whitwell, 2012). This King's THET Somaliland Partnership (KTSP) has offered capacity building in the country's healthcare system since 2000, in all fields of medicine. Psychiatrists, nurses, pharmacists and other disciplines from the KTSP mental health group support undergraduate and postgraduate teaching, curriculum development, service improvements and external examination, by working closely with university deans and other clinical leaders (Gavaghan & Hughes, 2013). The group supports professional development through distance learning via Medicine Africa (http://www.medicineafrica.com). The authors are both members of KTSP.

Development of the prison in-reach service

There are seven prisons in Somaliland, controlled and managed by the Ministry of Justice, in collaboration with the Ministry of the Interior and the Police Department. Courts do consider mental health issues in those attending trial, but there is no mental health legislation which influences disposal. Therefore, those defendants with mental health problems found guilty of an imprisonable offence are sent to prison rather than hospital, where they remain untreated.

Borama Prison has approximately 300–400 inmates at any time, the vast majority being men. Most of the prisoners have been convicted, while others are on remand. As noted above, a large number of the inmates with mental illness have been neither convicted nor charged with an offence, but are incarcerated to provide containment or respite for their families, at the latter's request. The prison is busy and overcrowded.

Phase 1 – consultation

We discussed the need for in-reach support and developed a model that might be provided within current resources, based on provision in UK prisons. We agreed a phased plan of implementation, following discussions with the Dean of Amoud Medical School and local partners. With permission from the Ministry of Justice and the Police Department, we met with the prison director to discuss our ideas and seek support for the project. He was very receptive and recognised the impact of mental health problems in the overall management of the prison. He estimated that 40% of inmates displayed unusual behaviour that might be related to mental illness and/or khat use. He acknowledged that some prisoners who were behaviourally challenging because of mental illness might be kept in their cells continuously or chained, because prison officers did not know how to manage them.

We liaised with the legal department of Amoud University, to ensure that lawyers working within the court system were aware of the project and to encourage their support when representing clients with mental health problems.

Finally, we discussed our proposals with local families and carers.

Phase 2 – training

Following the agreement of the prison authorities, J.I.M.H. began training sessions for prison guards and some police officers, over the course of 3 months. This focused on basic information on mental illness and management, including signs and symptoms, suicide risk and self-harm, managing challenging behaviour, de-escalation techniques, the role of medication and the impact of khat on behaviour and psychosis. The curriculum was based on that used by the KTSP mental health group for teaching medical and nursing students, but modified for the present population. Fifteen staff members, including female guards, completed the training.

Pre- and post-training questionnaires indicated that there was significant improvement in prison officers' knowledge and ability to identify those with mental illness, especially depression and personality difficulties, and the impact of khat and illicit substances. Officers were open to considering

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alternative approaches to managing prisoners with mental health problems.

Following the training session, the prison governor decided to stop khat use throughout the prison. This intervention alone resulted in improvements in adverse behaviour as the project progressed.

It was agreed that the in-reach team would consist of one doctor (J.I.M.H.) and a nurse, who had shown an interest and aptitude in the assessment and treatment of mental illness. The nurse was given additional training in triage, initial treatment options, management of challenging behaviour and referral pathways to hospital if necessary. He was able to administer medication. During the project, support and supervision were provided by KTSP clinicians based in the UK.

Phase 3 – intervention

The in-reach service began in May 2011, initially as one weekly session lasting 3 hours. Prisoners requiring assessment were selected by prison officers and taken from their cells to a visitor room to be assessed. Officers usually selected between four and six prisoners per week for clinical assessment. Initially, assessments were carried out by J.I.M.H., with the nurse observing. As the project proceeded, the nurse took over and successfully treated most of the patients, supervised by J.I.M.H. Treatment included a range of oral and depot antipsychotic medication, in addition to antidepressants. Medication was supplied by charities in accordance with World Health Organization recommendations. Advice was given to staff regarding management. Some of the prisoners who were released continued treatment at the local out-patient clinic. Treatment was free.

The development of the project had an unexpected impact on the judicial and governmental authorities locally. As knowledge of the service grew, lawyers and judges began to request the assessment of defendants who appeared obviously unwell, primarily regarding their fitness to plead. They began to reflect on the presence of mental illness when considering disposal and sentencing. During the project, several detainees who were clearly psychotic were transferred to the newly opened in-patient unit at Borama hospital, guarded by prison officers during their stay.

Other positive consequences emerged as the project continued. J.I.M.H. was able to identify and treat comorbid medical conditions in the prisoners assessed. We noted this was another unmet need in the service. In addition, the team agreed to see prison guards and their family members with mental health problems. Consequently, these workers appeared better able to perform their duties and sickness absence decreased.

Findings

During the 1-year period from May 2011 to April 2012, there were approximately 340 male and 4 female inmates in the prison. In total, 161 people were assessed under the project: 146 prisoners and 15 prison guards (Table 1). Their ages ranged from 16 to 65 years. It is noteworthy that 57 inmates had not been charged or convicted, but imprisoned at the request of relatives for containment and respite. Interestingly, most of this group had a history of violence, so it was likely that families had a low threshold for requesting support from prison authorities. All of the prisoners assessed had a history of khat use, but this was considered of diagnostic significance in only 45, who presented with khat-induced psychosis.

Conclusion

This novel prison in-reach mental health service in a low-income country built on local resources and expertise and was supported by international partnerships. Although based on the principle of equivalence, it differed from Western models in a number of ways. For example, it was not embedded within the prison itself, but was provided through regular sessional out-patient support for assessment and treatment. We are not aware of similar projects elsewhere in northern Africa, or indeed beyond.

Table 1
Population assessed

	Inmates	Prison guards	Total assessed
Male	142 (88.1%)	11 (6.9%)	153 (95.1%)
Female	4 (2.4%)	4 (2.4%)	8 (4.9%)
Total	146 (90.7%)	15 (9.3%)	161 (100%)
Offences (inmates only): *n* = 146 (90.7% of total assessed)			
Robbery	17 (10.5%)		
Murder	20 (12.4%)		
Arson	42 (26%)		
Rape	10 (6.2%)		
No charge	57 (35.4%)		
Diagnosis (inmates and prison officers combined): *n* = 161 (100%)			
Primary substance misuse (khat)			45 (27.9%)
Psychosomatic presentation			31 (19.3%)
Delusional disorder			25 (15.5%)
Depression			24 (14.9%)
Bipolar mania			14 (8.7%)
Schizophrenia			13 (8.1%)
Dementia			9 (5.6%)

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The project identified a large need, with around 50% of prisoners experiencing psychiatric distress over the study period. The project was implemented without additional cost, but with increasing use of nursing input over time. Prison officers, with training, were able to identify psychiatric morbidity, a finding previously recognised in other countries (Birmingham, 1999).

We were surprised by the large number of people admitted to prison at the request of relatives. We hope this number will fall, following the opening of the first in-patient unit in Borama during the study period. Treatment of prisoners, in addition to the prohibition of khat at the prison, led to a noticeable reduction in violence and allowed prisoners to spend additional time out of their cells. The use of chaining and physical coercion reduced. Once engaged, prisoners were offered out-patient follow-up on release.

The project also had some unintended positive consequences. Medical conditions among prisoners were identified and treated and prison staff were supported in their own mental health needs, leading to improvements in management and economic benefits. There appeared to be improvements in attitudes to mental disorder among staff and families, although this was not measured. The project seemed to lead to improvements in the legal assessment and disposal of prisoners with mental health problems and led to the release of six inmates who were arrested while acutely mentally ill.

We hope this model can be used as a template to introduce similar services in other low-income countries. Cooperation with prison and government agencies is essential.

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MENTAL HEALTH LAW PROFILES

Mental health law profiles

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While in a general sense both Canada and Malta belong to the Anglo-Saxon tradition of case law, with respect to Canada this is only partially so, because the country's federal structure necessitates 13 different mental health laws and Quebec, one of the federal provinces, follows the French tradition of basing law in statute. This diversity notwithstanding and despite the fact that there are differences between the federal provinces' laws, the authors have performed impressively in summarising these various laws and demonstrating the fundamental unity that underlies them, namely giving primacy to universally agreed human rights. Canadian law, as summarised here, appears to reflect a historically conservative but politically/philosophically liberal approach to human rights, the emphasis of which is on protection of the citizen from undue intrusion from the state.

The new Mental Health Act in Malta, while maintaining this focus, also aims to move a step further forwards by addressing issues of social inclusion and well-being as well. This is one of the remits of the newly created post of Commissioner in that country. Such a widening of perspective seems wise in view of the repeated reports in previous papers in this series, that often law protective of human rights is enacted but services – both to provide safe and secure care and to support social inclusion – are lacking.

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