**The complexities of mental health in a Young Offender Institution: reflections from a medical student project**

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**Context**

In an incisive editorial “Catch 22”, Professor Wass states “we urgently need to explore alternative avenues for delivering education” [1]. In November 2018, MPs highlighted prison healthcare as a public health issue, with mental health, especially in those of Black, Asian and Minority Ethnic background (BAME), of particular concern [2][3][4]. We would like to share what we learned from shadowing a psychiatrist and conducting a medical student project on the mental health screening at a Young Offender Institution in the south of England.

New arrivals to all UK Young Offender Institutions are assessed for mental health problems within 10 days using the Comprehensive Health Assessment Tool (CHAT). This determines whether they are referred to the Mental Health team.

**Project aim / Research question(s)**

1. How many patients on the Mental Health team caseload were referred by CHAT screening on arrival and how many were referred later?
2. What are the reasons for later referral?
3. Are those of BAME background more likely than white inmates to be referred later?

**Description**

In the summer of 2017 I spent a very interesting day shadowing a Consultant Psychiatrist at a Young Offender Institution. Insights into the high rate of mental health problems in these ethnically diverse young people made me keen to widen my experience of mental health services [5]. In January 2018, I carried out a study of mental health screeningat the Young Offender Institution, using data from the 64 patients on the current caseload of the Mental Health and Wellbeing Team. I recorded Age, Ethnicity, Referral type (via the CHAT on arrival, or referred later), Days between arrival date and referral date, and Reason for initial non-referral if applicable.

**Outcomes**

The median age of the 64 patients was 17 years (range 15-18), all were male and 47% (30/64) were BAME. Almost half (44%, 28/64) of patients had not been referred on initial CHAT screening. The mean time to referral was 118 days (range 3-556). Table 1 outlines the reasons for later referral.

BAME patients on the caseload were significantly less likely to have been picked up on initial assessment than white patients: 37% (11/30) of BAME patients vs. 74% (25/34) of white patients (p<0.003).

**Conclusions**

Findings highlight the clinical challenges of mental healthcare in a Young Offender Institution. Nearly half (44%: 28/64) of the patients on the Mental Health and Wellbeing Team’s caseload had not been referred for support on their initial presentation, and BAME patients were significantly less likely to have been identified on arrival. Interestingly BAME patients made up only half (30/64) of the caseload, despite making up two thirds of the institution as a whole and being more likely than white inmates to suffer from serious mental health problems [3].

A strength of this study is its focus on a “hard to reach” group. Limitations include the relatively small sample size of only male inmates from a single institution. Also we cannot say whether the patients’ mental health issues existed at the time of initial screening, or developed whilst in the institution. Reasons for later referral included issues that may have pre-existed (such as ADHD), as well as issues that may have developed in prison (anger management, issues related to sentencing).

**Reflection**

Medical students may receive little education about healthcare provision in Young Offender Institutions. But as an aspiring GP, I am aware that GPs treat many people with mental health problems including young people with complex social circumstances and patients who have spent time in prison. GPs also provide medical care within Young Offender Institutions and it was interesting to observe the clinical challenges of this environment. These include working with a transient population of vulnerable young people with complex backgrounds, working with prison staff to balance discipline with rehabilitation, as well as practical challenges such as prison lockdowns meaning frequently cancelled appointments.

However, this seemed to be a uniquely rewarding form of clinical work. I saw targeted therapies for becoming a parent or for anger management, and witnessed the benefits of psychoeducation. Many of the patients were engaged with their recovery, insightful and positive about their futures. It was inspiring to see that the mental health team often played a central role in young people turning their lives around. I hope this project will therefore inform my future practice by giving me a more nuanced understanding of offender healthcare as well as an awareness of the barriers BAME groups can face in accessing care.

One solution may lie in medical education. A 2016 study looked at barriers to mental healthcare among BAME groups, and concluded that “healthcare providers need relevant training and support … to deliver individually tailored and culturally sensitive care” [3]. Wass points out that “at a time when health care moves increasingly into the community … so must education” [1]. From my experience of learning at a Young Offender Institution, I would add that primary care education can also be enriched by incorporating experiences from less conventional primary healthcare settings including secure environments such as Young Offender Institutions.

**References**

[1] Wass V. Editorial: Catch 22. Education for Primary Care. 2018; 29: 123.

[2] Iacobucci G. Prisoners’ health: government must do more, say MPs. BMJ. 2018; 363: k4607.

[3] Memon A, Taylor K, Mohebati L, Sundin J, Cooper M, Scanlon T et al. “Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England”. BMJ Open. 2016; 6(11): e012337.

[4] The Mental Health Foundation. “The Mental Health Needs of Young Offenders”. Updates (2002). Available at: <https://www.mentalhealth.org.uk/publications/mental-health-needs-young-offenders-update> [accessed 24.06.2018]

[5] Lennox, C. “The health needs of young people in prison”. British Medical Bulletin. 2014; 112(1): 23.

**Table 1**

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| --- | --- |
| **Reason for 28 Later Referrals to the Mental Health and Wellbeing team** | **Number**  |
| Attention Deficit/Hyperactivity Disorder assessment or monitoring | 4 |
| Low mood | 4 |
| Anger management | 4 |
| Sentencing / court date | 4 |
| History of Physical or Sexual Abuse | 2 |
| Trauma work | 2 |
| Mood swings | 1 |
| Possible psychotic symptoms | 1 |
| Autism Spectrum Disorder assessment | 1 |
| Impulsivity | 1 |
| Victim of assault in prison | 1 |
| Assessment of cognitive function | 1 |
| Not noted | 2 |
| **Total** | **28** |
|  |  |

Of the 28 patients referred later, 17 were not referred initially due to no mental health issues being identified, nine had issues identified but declined input, and two lacked engagement with the assessment.