We read Senior et al's (2014) recent article with interest. Here we consider additional opportunities to improve prison mental health care.

The model of care for the general population is primary care led. The first port of call is either the practice nurse or the GP and this should be reflected in prison health care. This is conceptually critical to the idea of equivalence (DH 2001). In truth, GPs are not enthusiastic about working in prisons. A combination of multiple morbidity, poor physical environment, high rates of complaint from patients, drug seeking behaviour and anti-social hours are off-putting to many.

The complexities of prisoner populations, one prison is not much like another, require a degree of site-specific thought about provision. The Improving Access to Psychological Therapies (IAPT) initiative is one arm of primary mental health care but not the only one. Most psychiatric disorder in prison is not serious mental illness (SMI). Rather, it is personality disorder (PD) plus or minus alcohol and substance misuse and demands a range of approaches to accommodate prisoners' journeys, both criminal justice and personal. The Offender Personality Disorder Pathway strategy, developed by the Department of Health and the National Offender Management Service (Joseph & Benefield, 2012), has focussed on the identification, assessment and management of this group rather than active treatment. Pathways for PD patients need to be supported by clinical initiatives not least because of the links between PD and self-inflicted death. Mental Health Inreach provides only one component of the potentially comprehensive range of psychological therapies which need to be tailored to the complex needs of the population and be feasible to deliver in prison.

The Government's enthusiasm for the treatment of SMI should also be seen in the context of the shifting understanding of diversion. The original intention of diversion (ref 66/90) was for the mentally ill to avoid imprisonment unless the charges were grave enough to require the security of prison for a brief time. Nowadays, mental health teams, embedded in prisons, as opposed to "in reaching" into them, undertake the long term treatment of the chronically mentally ill in prison, without a corresponding change in speed of transfer of the acutely mentally ill. This might be understood as a Machiavellian initiative to reduce the need for secure hospital beds but, if so, it does not seem to have been effective. As such, despite the initiatives, a fundamental inequality persists whereby severely ill prisoners wait weeks, sometimes months, to receive the hospital care others would get the same day or very soon afterwards (Bartlett et al 2012). Ironically, this second rate service is due principally to the lethargy and resistance of the external NHS, not the clinicians who have gone native inside.

We welcome the opportunity, afforded by Senior et al's (2014) paper, to highlight the mental health needs of additional groups of prisoners and to describe how services and models of care have developed to meet these needs and where gaps and limitations in care still persist.

Word count 499

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