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The principle of equivalence of care has been an important driver in improving healthcare, including mental healthcare, for prisoners throughout the Western world. Put generally, prisoners should not be denied access to healthcare provisions enjoyed by the general population by virtue of their incarceration. This has been enunciated in the international (United Nations General Assembly, 1990; World Health Organisation, 2008) and European literature (Council of Europe, 1998; CPT, 2002). Domestically, the principle of equivalence has been defined as ensuring that prisoners have 'access to the same quality and range of health care services as the general public receives from the National Health Service' (HM Prison Service & NHS Executive, 1999).

It has been said the aspiration of equivalence of psychiatric care in prisons can never be fully achieved; in part because the custodial environment is inherently detrimental to mental health and also because prison mental health care cannot provide the factors necessary to promote good mental health, including family support, work and liberty (Niveau, 2007). Further, prisoners often present with a particularly complex admixture of mental health problems such that community equivalent primary care models may not necessarily be the best fit for this population.

In England and Wales, national policy for prison healthcare over the past two decades has been underpinned by the principle of equivalence of care (Home Office, 1990; Home Office, 1991; HM Prison Service and NHS Executive, 1999). The principle is applied across a range of prison healthcare interventions, at both strategic and operational levels. Accordingly, prison populations are conceptualised as part of the community and the healthcare provided to prisoners can be measured by estimating how closely it resembles services that would be available to the general population through the National Health Service (NHS), which provides healthcare services for the population in England and Wales (Wilson, 2004).

Standards for the provision of mental healthcare were set out in the National Framework for Mental Health (Department of Health, 1999). These standards state that *"any service user who contacts their primary health care team with a common mental health problem should have their mental health needs identified and assessed and be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it"* (Standard 2).

The higher prevalence of mental ill-health in prisoners compared with the general population is well established and there is an excess representation of mental disorders at all levels of severity (Fazel and Danesh, 2002; Hassan et al, 2011). Despite demonstrably high levels of mental health morbidity and behavioural disturbance there are persisting difficulties in accessing hospital beds for those with acute mental health problems (Forrester et al, 2009; 2010).

Prison based services for those with severe and enduring mental illnesses have been considerably enhanced over the last decade, largely stimulated by the national policy document 'Changing the Outlook' (Department of Health and HM Prison Service, 2001). A particular emphasis was afforded to mental health in-reach teams, which was envisaged to deliver the specialised (secondary) care provided by community mental health teams outside prison. However, many people referred to these services have exhibited primary care mental health problems (Brooker & Gojkovic, 2009).

Psychological therapies can be utilised as a paradigm to examine the 'fit' of the principle with access to such therapies in a penal context. Building on recommendations from the National Institute for Health and Clinical Excellence (NICE), the Improving Access to Psychological Therapies initiative (IAPT) has been rolled out across England and Wales in recent years. IAPT is designed to improve mental health and general wellbeing by providing a range of psychological

interventions for people presenting to primary care services in the community with mental health problems not intense or severe enough to require referral to secondary care services. There is a particular focus on anxiety and mild to moderate depression, which is primarily addressed using Cognitive Behavioural Therapy (CBT) (NICE, 2004 (a) & (b)). By early 2011, 95% of primary care trusts in England and Wales were hosting the IAPT programme, facilitating wide population access through a primary care framework that incorporated a self-referral mechanism. Recovery rates for patients with depression and anxiety treated through the IAPT programme have been reported as between 40-55% (Clark, 2011; Richards & Borglin, 2011).

Delivery of the IAPT programme to the prison population has lagged behind community implementation. The Department of Health (2009) issued positive practice guidance advising that commissioners should ensure the availability and effectiveness of IAPT services for offenders from a wide range of circumstances, emphasising the importance of equivalence of healthcare for this population and recommending that multiple agencies should work together towards this aim. It also noted the prison population had been served by clinical psychology services that had remained restricted in their nature and scope and consequently equivalence in general service provision had not been met (Department of Health, 2009).

Besides the provision of risk assessments, primarily for sentence planning and parole purposes, a key focus for prison psychology services in recent years has been the development and management of accredited Offending Behaviour Programmes (OBPs). These are aligned with the ‘What Works’ principles in reducing offending behaviour (McGuire, 2006). The Prison Service currently provides a range of accredited OBPs (32 by 2010) and over 9,000 offenders completed accredited OBPs in 2010/11 (House of Commons, 2008; Ministry of Justice, 2010). In addition, these programmes are complemented by a number of dedicated units (e.g. Dangerous and

Severe Personality Disorder units, Close Supervision Centres) and non-accredited interventions which have been developed to meet local and specialist needs.

Overall, accredited OBPs have assisted in reducing reoffending rates by between 10% and 24% (Sainsbury Centre for Mental Health, 2008; Sadlier, 2010), with one randomised controlled trial indicating a medium treatment effect for a particular OBP, ‘Enhanced Thinking Skills’ (McDougall et al, 2009).

The role of common mental disorders in offending behaviour may be direct or indirect, influencing other factors such as interpersonal conflict, employment and substance use, all of which have been identified as key criminogenic needs (Motiuk, 1998; Zamble and Quinsey, 1997). Thus effective mental health treatment and programme adaptation can assist prisoners in addressing their offending behaviour, rehabilitation and resettlement needs and the co-application of primary care mental health treatments and offending behaviour interventions could improve overall outcomes (Sainsbury Centre for Mental Health, 2008).

The forensic psychology service, provided within the National Offender Management Service, is currently undergoing change in its overall structure, with a reduction in input into some OBPs and enhanced emphasis on risk assessment processes and specialised forensic interventions. The focus of the service will remain largely on offending risk and rehabilitation work. However, the complex needs of prisoners, including the over-representation of primary care level mental health needs, is also recognised and a more integrated and individualised psychological approach to prisoners is being sought.

Better integration of the aims of health and justice through the amalgamation of the objectives and delivery of OBPs and primary care mental health provision could now be timely as well as more suited to the problems encountered within prison populations.

There are presently no published evaluations or outcomes of IAPT services for prisoners. However, IAPT has been designed to treat a wide range of disorders, including, for example, generalised anxiety disorders, obsessive compulsive disorders, post-traumatic stress disorders, and social anxieties and given the established high prevalence of common mental disorders amongst prisoners (Singleton, Meltzer & Gatward,1998), the introduction of a cognitive behaviourally based treatment programme has face validity.

The “low-intensity” IAPT clinician supports the patient through self-help materials, encouraging them to conduct the exercises contained within them and to apply the various techniques to their lives. However, this approach has limitations in prison environments which introduce barriers to service access (Black et al, 2011). Moreover, those with difficulties such as lower intelligence quotients (IQs), attention deficit hyperactivity disorder, underlying personality disorder or compromised literacy and numeracy, which are particularly prevalent in prison populations (Singleton, Meltzer & Gatward, 1998), are potentially compromised in their ability to take part in lower intensity interventions which rely upon manualised self-guidance.

By adopting a human rights based perspective of prison healthcare and acknowledging both the burden of healthcare needs of prisoners as well as the State’s obligation to safeguard the health and well-being of those deprived of their liberty, the limitations of the notion of equivalence appear stark. IAPT programmes in the community are primary care based services. By contrast, its uptake in the prison environment has been slow. In part this is because prison psychologists have been involved in developing and running accredited OBP. It is also because the complexity of mental health conditions in prisons demands a focus on secondary care services. It is argued the imperative now is to move beyond minimal or equivalent standards and seek equivalence of objectives (Lines, 2006). This can be achieved by utilisation

of the concept of the ‘right to health’ which takes no account of a person’s legal status, can articulate the level of healthcare needs as well as measure progress towards their effective realisation and examines whether healthcare services are available, accessible, acceptable and of good quality (AAAQ) (Exworthy et al, 2012). Such an approach is able to ignore the artificial comparison between the general population and its members who are imprisoned. It recognises that prisoners form a very specific subgroup of the community from which they are drawn and have complex and multiple mental healthcare needs that also have interactions with offending behaviour. It is contended that the AAAQ model addresses these needs, for example through an IAPT programme, and circumvents distinctions between primary and secondary care.

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