Mental health and detention

Marcus Roberts and **Alison Cobb** draw attention to the injustice that ensues from the move towards increased use of preventative detention for mental health patients and the inadequacies of services in prison.

The detention of people experiencing mental health problems presents itself in a number of – interlocking – ways. For a start, nine out of ten adult prisoners in England and Wales – and 95 per cent of young people in prison – have one or more mental disorders. In 2002, the Social Exclusion Unit found that 72 per cent of sentenced male prisoners and 70 per cent of female prisoners were experiencing two or more mental disorders – respectively 14 times and 35 times the level in the general population (Social Exclusion Unit, 2002). This is partly because a disproportionate number of people with mental health problems end up in prison, but it also reflects the realities of often grim prison environments, particularly against a background of an explosion in prison numbers.

Mental health services and imprisonment

Despite some significant strides forward in the provision of mental health services in prison, a prison stretch is not good for mental health; neither Pentonville nor Holloway could be safely described as therapeutic environments. Indeed, it could be argued that the punitive elements of a prison sentence involve forms of deprivation that have been actively designed to undermine mental health and well-being (such as separation from family and friends and long periods of confinement in a cell). This helps to explain the very high incidence of depression and anxiety in prisons.

The Social Exclusion Unit (2002) concluded that 7 per cent of male and 14 per cent of female sentenced prisoners had 'psychotic disorders' as defined by the researchers – that is, they had a diagnosis of either 'schizophrenia' or 'manic depression'. This is a shocking statistic. Pretty well everyone agrees that these people should not be in prison. Yet the provision of court diversion schemes – directing people with more serious mental health problems from the criminal justice system into secure mental health services – remains patchy in Britain, and is not yet supported nationally by a proper statutory framework. In addition, those who enter prison with a serious mental health problem, or develop one inside, can spend months in a custodial environment awaiting transfer to hospital under the Mental Health Act (1983, as reformed in 2007).

The 2002/2003 annual report of the Chief Inspector of Prisons estimated that four in ten prisoners in prison health care centres should have been in secure NHS accommodation. In 2004, it was discovered that at any one time at least 40 prisoners assessed as needing a transfer to hospital had been waiting over three months for it to take place (Mental Health Alliance, 2007).

Researchers at the Sainsbury Centre were told on a visit to HMP Brixton in 2006 that all the prison's health care beds were occupied by prisoners with mental health problems, of whom four were awaiting transfer or assessment for transfer under the 1983 Mental Health Act. In three London prisons, the Sainsbury Centre found that health care staff had forcefully injected prisoners with drugs under common law provisions (Sainsbury Centre for Mental Health, 2006).

Against this background, the Department of Health is currently piloting a national waiting time standard of 14 days for the transfer of acutely mentally ill prisoners from prison to hospital under the Mental Health Act. While progress is being made, and there is clear recognition from government that the existing state of affairs is cruel and unusual, there is still a long way to go.

Forensic mental health detention and risk

Part of the problem is the increasing numbers of people being detained in secure forensic mental health services, which provide for people who have been in contact with the criminal justice system. In September 2007, a report for the Sainsbury Centre for Mental Health (Duggan and Rutherford, 2007) found that levels of detention in secure psychiatric wards had reached a record high of 3725 in July 2007. The population of high and medium secure units rose by 45 per cent between 1996 and 2006 – another incidence of record-breaking increases in the use of detention services. As Sean Duggan, the Sainsbury Centre director of prisons and criminal justice, said:

> With prisoner numbers reaching record levels, we need viable alternatives for people with the most severe mental health problems. Currently, medium secure beds are the only option in many places. The number of people being detained in these units is growing year on year.

He continued:

> these figures raise important questions for national policy. Are

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> secure hospitals the best form of diversion from prison? Would community based alternatives be better?

But the detention of people with mental health problems through the criminal justice system is only one issue. Arguably more than any previous government, New Labour has been prepared to expand the use of detention not simply as a punishment for crime – based on the sentence of a court, and bounded by principles of justice and proportionality – but as a mechanism for managing risk (or perceived risk) and preventing crime.

This trend is apparent in a number of recent policy developments – for example, the debate over extension of detention without charge for terrorist suspects and the introduction of the indeterminate sentence of Imprisonment (or Detention) for Public Protection for violent and sexual offences that is helping to drive prison overcrowding. For the mental health world, of course, the rise of a 'minority report' approach was most evident in the long process of reform of mental health law. A core reason there was such wide, deep and impassioned resistance to the government's proposals for reform of mental health law was that the political focus was not primarily on the therapeutic function of hospitals – or the protection of people deprived of fundamental rights and liberties – but on exaggerated public safety fears, particularly in the aftermath of the Michael Stone case.

In an article in the BMJ, Professor Nigel Eastman (2006) voiced the concern of many psychiatrists that the mental health system was 'being used to effect preventive detention of people who cannot benefit from treatment'. This is not what health services are for. The government should not use mental health services to warehouse difficult people who are unconvicted of any crime and for whom they can provide no help.

As a service user witness commented to the pre-legislative scrutiny committee that looked at the 2004 incarnation of the mental health bill:

> The new legislation seems to have been born out of a few high profile cases. The publicity that invariably follows such cases has forced the government into a knee-jerk response based on public misconception. But it is totally disproportionate to the real situation. In reality there are very few individuals who need the protection of a secure environment for their own and public safety.

If it was possible to assess risk accurately, then a serious moral case might be made for the use of preventative detention. But it is not – and we certainly should not be looking to the red top papers for guidance on risk. It is only in extremely rare cases that people experiencing mental health problems present any risk to the public. Roger Dobson has observed in an article entitled 'Are schizophrenics the lepers of our time?' that 'statistically we are all 400 times more likely to die from flu than to be killed by a mentally ill patient' (Dobson, 1998). Dr George Szmukler (2000) claims that the risk of being killed by a psychotic stranger is 'around the same as that of being killed by lightning . . . about 1 in 10 million'. A Cochrane Review of the available research evidence concludes that 238 people would need to be compulsorily treated in the community to avoid a single arrest (cited in Kisely *et al*., 2006).

Treatability and the 2007 Mental Health Act

The Mental Health Bill that was eventually passed in July 2007 amended the 1983 Act rather than introducing the new Act envisaged in 2004. Though the changes it made were less fundamental, it still achieved the government's main agenda by allowing people with personality disorder to be detained on the basis of a less rigorous test of treatability and by introducing community treatment orders. People may be discharged from detention in hospital onto a community treatment order (CTO), which means they will be required to accept treatment and may be recalled to hospital. The number of detentions under the Act has remained fairly stable in recent years (47,400 detentions during 2005–2006 and 14,600 people in detention at the end of that year). With CTOs, the reach of the Act could go much further. The use of CTOs has the potential to increase the number of people under detention in psychiatric hospitals in a not disimilar way that the increased use of recall for released prisoners is contributing to the rise in prison numbers.

Perhaps the key message is that when you combine stigma and misinformation, a growing risk averseness across our culture and moral panic about crime and mental health, the human – and human rights – costs are high. ■

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