What shall we do about the high rates of mental disorders in prisoners?

Paul Bebbington looks at the gaps in provision for the high proportion of offenders who suffer from mental and emotional disorders.

As I write this, the prison population in England and Wales has reached 77,622 and is growing at 250 per week. Prison capacity will rise to 79,100 by mid-2006. This is in the context of generally falling crime rates, and very high recidivism rates in those released from prison. Britain has the highest incarceration rate in western Europe, and yet there few political constrains to this policy.

We have no reason to doubt that increasing prisoner numbers means a parallel increase in the numbers of mentally ill prisoners. It has been known for many years that psychiatric disorders are very common among prisoners. In Britain, research about this dates back at least 20 years. The National Survey of Psychiatric Morbidity among Prisoners in England and Wales is the definitive source of information on the subject (Singleton et al., 1998).

The most severe type of psychiatric disorder is psychosis. This is characterised by delusions and hallucinations. One of the particularly distressing findings from the survey was how frequent this disorder was in the prison population. Between 7% and 14% of different prisoner types appeared to have experienced psychotic illness in the previous year. This compares with less than half a percent in the general population. These figures are really large. They suggest that in 1997 there were about 4,500 men and 400 women with psychosis in prisons. This is despite the fact that even at that time there was a clear Home Office and Department of Health policy of transferring severely mentally ill persons from prisons to hospital, and of diverting them from prison in the first place. There is certainly little evidence from my clinical experience suggesting that this policy is much more effective these days. The consequences for prisoners of having psychotic disorders were not good. For example, they were more than four times as likely as others to be placed in ‘stripped’ conditions.

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It is now eight years since it was carried out, and although it has had some impact on the management of mentally ill prisoners, in my view this is less than it should have had. I was involved in the design and implementation of the national survey, and over the last two years, I have been working as a consultant psychiatrist in a Community Mental Health Inreach Team in Holloway prison. This has enabled me to have a first hand, if personal, view of what the problems are.

The findings of the National Survey of Prisoners are striking indeed. It was carried out at a time when there were only 62,000 prisoners in the 131 penal establishments in England and Wales. At that time, women constituted less than 5% of the prison population, although subsequently they have been the fastest-growing group among prisoners (Prison Reform Trust, 2003). The survey itself took place in two phases: the first involved lay interviewers, but one in five of the sample were then followed up by interviews with clinicians. It was particularly important that the survey involved standardised ways of assessing mental disorder that allowed comparisons to be made with equivalent surveys of the non-prison population of Britain. Only 6% of prisoners refused interview, and all in all over 3,000 prisoners were interviewed. This was despite the inherent difficulty of contacting prisoners who were likely to be moved at short notice. The survey covered both males and females, and both sentenced and remanded prisoners.

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Very large numbers of prisoners also suffered from ‘neurotic’ symptoms like depression and anxiety. Between 40 and 75% of different prisoner types had a diagnosis of some kind of neurotic illness. Again this is far higher than in the general population. As an example, at any time around 2% of the general population are suffering from the relatively severe condition of ‘depressive episode’. The equivalent figure for male sentenced prisoners was 8%. For male remand prisoners it was 17%, for female remand prisoners, 21%, and for female sentenced prisoners, 15%. These psychiatric disorders are associated with
high rates of suicidal thinking. Indeed, over a quarter of female remand prisoners had apparently attempted suicide in the year before interview. This is of course a key issue in prisoners (Shaw et al., 2004).

As might be expected, similarly large numbers of prisoners met the criteria for different sorts of personality disorder: 78% of male remand prisoners, 64% of male sentenced prisoners, and half of women prisoners. Most common was antisocial personality disorder, but there were also many cases of paranoid personality disorder, and borderline personality disorder was particularly frequent in women.

Problems with substance abuse were very general. Over half of male prisoners and a third of females had been drinking hazardously before imprisonment. Drug dependence was also rife, particularly in women, in whom the frequency approached 50%. 40% of women remand prisoners reported injecting drugs at some time in their lives.

Most prisoners originate from segments of the general population at highest risk of psychiatric disorder. The survey emphasises the high levels of early social disadvantage experienced by offender populations. Between a quarter and a third of the different types of prisoner had been in local authority care as a child. Others had been in institutions. Over 40% had left school before the statutory age. Half the women and a quarter of the men had experienced violence at home, and one third of the women reported sexual abuse. The general stressfulness of their lives continued into adulthood, as indicated by their reporting of recent multiple life events, often of severe degree. It also extended into their lives in prison: following imprisonment, many prisoners with psychiatric disorders experienced victimisation, the theft of personal possessions, and threats of violence. It is apparent that for many of these people prison merely added the judicial version to a social exclusion that had already been well established before their imprisonment.

It is clear from these figures that many prisoners experience severe and multiple problems and multiple pathologies. Indeed, the problems are sometimes interpreted as pathologies. It is not surprising that both the mental health system and the criminal justice system find it difficult to discover effective ways of improving the lot of prisoners with mental health problems, and in the process reducing their recidivism.

Although some psychiatric help was available to the prisoners in the survey, many had not received any, either because they declined it or had been refused it when they had asked for it. Around a fifth of prisoners reported asking for help for their psychiatric or emotional problems in prison and having it refused. Around a fifth of prisoners reported asking for help for their psychiatric or emotional problems in prison and having it refused. Around a fifth of prisoners reported asking for help for their psychiatric or emotional problems in prison and having it refused. Around a fifth of prisoners reported asking for help for their psychiatric or emotional problems in prison and having it refused. Around a fifth of prisoners reported asking for help for their psychiatric or emotional problems in prison and having it refused.

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in focusing on clients with severe and enduring mental illness, there has been considerable pressure to broaden the range of problems dealt with, with consequent attenuation of resource. This may be no bad thing, but the resource needs to increase. There is, even now, quite a lot of resource in prison for dealing with people with mental health problems, but there are considerable administrative and liaison problems. These resources include: the prison psychology service; substance misuse teams like the CARATS (Counselling, Assessment, Referral, Advice and Through-care services) we have in Holloway; detoxification and rehabilitation services; primary care; voluntary services. Many of these remain administratively under the Home Office, making liaison more difficult than it might be and running the risk of duplication of effort. There are understandable but unproductive difficulties in the free flow of information. Working with prison officers is of course fundamental: relations are generally positive, but most are unskilled in dealing with mental health problems. Prison staff need and want training in mental health awareness.

The practical difficulties outlined above form particular barriers to developing more effective ways of helping prisoners with dual diagnosis. There are also special difficulties in managing self-harm in an essentially punitive environment, and new techniques currently being deployed in the community could with advantage be introduced in prisons.

The Mental Health Act itself creates problems: its provisions for compulsory treatment are not applicable in prisons. This sometimes means having to watch someone descend into a deteriorated psychotic state while arrangements are slowly made to transfer them. On the other hand, changing the Mental Health Act to allow compulsory treatment would turn prisons into medium secure units. Moreover, when the mental health problems are so long-standing or severe, a medium secure unit is...