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).

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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.

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.

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. Ironically, this was particularly so for people suffering from the most severe mental condition, psychosis. Many prisoners of all types had received previous psychiatric treatment. 15% of men and 27% of women had done so in the year before coming into prison. 10% of men and 17% of women prisoners had been psychiatric inpatients at some time.

The continuingly high prevalence of psychiatric disorder in prisons clearly suggests a failure of care systems in the community. The development of secure forensic psychiatry services has failed to reduce the number of severely mentally ill persons in prison, and the move to community based models of general mental health care has not prevented the criminalisation of psychiatric patients.

There are a number of reasons for this failure. Some relate to the sheer difficulty of dealing with this client population. Their psychiatric needs are complex, with symptoms from multiple categories of disorder. Very frequently clients have 'dual diagnoses', that is, a major psychiatric disorder compounded by abuse of alcohol and a range of street drugs. The difficulties of helping such clients are all too apparent, even without the involvement of the criminal justice system, and service providers and planners are struggling with decisions about the best configuration of services. Moreover, the other aspects of social exclusion experienced by prisoners are barriers to the effective management of their mental health problems. Homelessness in particular makes it hard for them to be linked in with effective services. Women prisoners are particularly vulnerable to exploitation and abuse by criminal men when they leave prison. Prisoners often lack skills necessary to normal and productive life, making it much easier for them to slot back into the social milieu that supported their original offending.

The publication of the *National Survey of Psychiatric Morbidity among Prisoners* was followed by changes in policy towards healthcare in prison. At the heart of the proposals was the notion of equivalence. In other words prison healthcare should be equivalent to the NHS in its policies, organisational arrangements, and health care standards. *Changing the Outlook* (DoH & HMPS, 2001) is a humane document emphasising that prisoners with mental health problems need, variously, access to mental health promotion, primary care services, wing-based services, day care, in-patient services, transfer to NHS facilities, and through-care. The original recommendation was that the NHS should take over the delivery of health care in prisons in its entirety, but we now have the compromise of shared care and responsibility. The deadline for transfer of the responsibility of health care from prisons to the NHS is April 2006, although many PCTs have taken this on already.

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While the introduction of community mental health inreach teams in prisons represents a worthy, well-motivated and well thought-out initiative, the practicalities of implementation should not be under-estimated. They will need very clear strategic decisions. Protocols of service remits are essential, but they have to be the right protocols.

Central to the provision within prison of mental health services, broadly conceived, are decisions about what resources are appropriate and how they should be organised and deployed. Many of the teams introduced so far appear to be primarily nurse-led, with a skills mix lacking counselling, psychology, and occupational therapy, and with limited psychiatric input. In consequence there are too few non-medical treatments. Moreover, although community mental health inreach teams were originally intended to mirror CMHTs

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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 especial 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 under-resourced high-secure units, as there would be less pressure to arrange transfer to NHS facilities.

The provision of effective health care in prisons is only one element in dealing with the problematic overlap between mental health services and the criminal justice system. There are two other elements: the tendency for people with mental health problems to be inappropriately incarcerated in the first place, and the difficulties of engineering effective continuity of care straddling the prison-community boundary.

Retributive justice has little in common with the principles of mental health care, although occasionally it may be useful for people to know their actions have consequences, even if they were conducted in the context of mental illness. Moreover, a minority of the mentally ill in prisons have committed crimes of such seriousness that their health care must remain very secondary to containment. Nevertheless, the criminal justice system is bound to defer to other imperatives, even if we feel these are misplaced when the mentally ill end up as collateral damage.

A major problem in managing people who are acutely mentally ill concerns their transfer to mental health facilities outside prison. The requirements of good mental health care in these circumstances include the retention of patients in a place where they can be treated effectively and consistently. This may mean an open ward, a locked ward, or in exceptional circumstances, a medium secure unit. Moreover, when the patient recovers, the need for containment may decline, particularly if their crime was committed when they were actively ill. The Home Office must be consulted about transfers under Sections 47 and 78 of the *Mental Health Act,* and they always take a juridical view of the level of security required. Thus they often insist that prisoners be placed in a medium secure unit, even when, despite their crime, they would never be deemed suitable if they had not been a prison transfer. This results in considerable delays, and the local primary care trust has to be strongly persuaded that they want to spend their money on what they see as an inappropriate psychiatric placement. The reformative aspects of justice obviously sit more easily with mental health interventions, whose appeal should increase with the promise, or at least the possibility, of reduced recidivism.

People working in the mental health services have always known that the period of highest risk of relapse, readmission and indeed suicide, is in the immediate aftermath of discharge: the development of community-based services was intended to reduce these dangers. The same risks face released prisoners. Thus the effective care of mental ill health in prison is always jeopardised by release, which needs to be managed so that all appropriate supports are in place. Unfortunately, there are serious problems in enlisting the cooperation of community mental health teams in taking prisoners on, made worse by catchment area disputes, particularly with homeless clients. There are of course significant costs involved in taking such people on, and this adds to the sense of reluctance.

Many of the failures to establish adequate follow-up provision arise from structural mismatching between the criminal justice system and mental health services. Care pathway planning can be seriously disrupted when people are released unexpectedly, or suddenly transferred to another prison. Recently, the well-set plans for one of my clients were ruined when she was transferred to the Midlands four days before release. The recent Offender Mental Health Care Pathway (DoH, 2005) is an attempt to deal with this sort of situation. It remains to be seen if the new National Offender Management Service will succeed in promoting continuity of support for prisoners leaving prison. If it did, it would greatly facilitate continuity of mental health care.

I take a strong view on the levels of mental ill health in our prisons. It is a cultural blemish that reflects badly on our country, and it will only really be remedied by societal initiatives. In the meantime, genuine advances have been made in caring for the mentally ill people in our prisons, and this will be enhanced if moves are made to rationalise managerial and administrative responsibilities and procedures. ■

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