terms of understanding the causes of personality disorder and identifying treatment targets. This is a potentially vital element of the research as, so far, no effective strategies have been identified to prevent the development of severe personality disorder.

The risk posed by Dangerous Severely Personality Disordered people has not, in the past, often been addressed effectively. The Prisoner Cohort Study will tell us who exactly is dangerous, and why. This group is likely to have a large range of economic, social and educational problems. The Prisoner cohort study will also help to improve knowledge of these issues and maybe offer potential for reducing and managing the risk presented by the DSPD group.

Identifying the DSPD group, managing their risk, and developing effective treatment remain significant challenges. The Prisoner Cohort Study represents an important step in providing the knowledge to meet these challenges. The rewards of this work will be improved public protection from serious offending and improved quality of life and services for the DSPD group.

The Prisoner Cohort Study will be rolled out nationally in November in 2002 and interviews will be completed by October 2003. Prison Governors will receive a fact-sheet in the near future providing further details and seeking their co-operation.

If you require further details please contact Matt Erikson on 020 7273 8199 or at matt.erikson@homeoffice.gsi.gov.uk

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Mental Illness and Imprisonment

Dick Frak, *Director of Service Development at* Rethinking Severe Mental Illness *(formerly the National Schizophrenia Fellowship).*

At any one time around 5,000 people in prison will be experiencing a severe mental illness[1]. Most of these people will have been diagnosed with schizophrenia, although significant numbers may also be diagnosed with manic depression, personality disorder or have a dual diagnosis involving drug or alcohol misuse. Up to 90 per cent of prisoners have a diagnosable form of less severe mental illness, substance abuse or sometimes both. In the general population at any one time less than one per cent will be diagnosed with schizophrenia and around the same percentage with manic depression. In prison, the percentage is over 13 per cent. This astonishing figure points to failings in the health and care systems outside prison but also poses immense challenges for prison staff and prisoners alike to rethink their approaches to mental health care.

Defining schizophrenia

Schizophrenia is not split personality; and violence or other forms of criminal behaviour are not amongst its symptoms, despite what the tabloid headline writers would have us believe[2]. In fact, people with severe mental illness are far more likely to be the victims of crime[3] and are far more likely to kill themselves than harm anyone else[4]. Schizophrenia is a complex and severe mental illness. Its symptoms can, broadly, be defined as 'positive' — adding something to the

1. *The NHS Plan*, Department of Health, July 2000.
2. British Journal of Psychiatry 1999, 174, 9-14 and *The Confidential Inquiry into Suicide and Homicide by People with a Mental Illness* (May 1999).
3. *Redressing the Balance: Crime and Mental Health*, UK Public Health Association, 2001.
4. *One in Ten*, National Schizophrenia Fellowship, 1999.

individual's behaviour or personality that was not there before; and 'negative' — detracting something from the individual's behaviour or personality[5].

Positive symptoms include external 'voices' or, more technically, 'hallucinations'. Individuals may also experience sounds other than voices and a few may experience different hallucinations involving smells or tastes. Although these are hallucinations, they are also 'real' in the sense that the brain registers them as such. For a person with schizophrenia, making sense of these hallucinations may involve creating a whole series of 'delusions' involving outside agencies out to attack or persecute them or God-like figures sent to guide their actions or actions of others. A person experiencing delusions may try to keep them secret, knowing that others would not understand. Some individuals are gradually overwhelmed and begin to act strangely according to the content of the delusional explanations.

Negative symptoms of schizophrenia may include a reduction in cognitive functioning-the individual may, for instance, become slower to think, talk and move, and may have become indifferent to social contact. Sleeping patterns may change so that they are happy to remain up all night and sleep all day. Body language may also be affected. The overall result is a reduction of motivation. Negative symptoms are much less dramatic than positive, but they tend to be more persistent.

Recognising these changes can be particularly difficult as the illness often develops during teenage years when it is quite acceptable for changes in behaviour to occur, particularly where the young person is experimenting with new freedoms and lifestyles. Dealing with them at any age in the context of a rule-governed institution such as a prison can be challenging, leading to conflicts with authority.

Causes of schizophrenia

The causes of schizophrenia remain poorly understood. People with close blood relations who have schizophrenia are certainly at a higher risk of developing the illness, pointing to some genetic factors. However, the majority of new cases of schizophrenia involve people with no identifiable family history of the illness, pointing to some other environmental explanations. The best explanation at present is that some people may have a genetic predisposition to schizophrenia but that it requires some outside 'trigger' for the illness to develop. There is little evidence that the use of street drugs, particularly cannabis, causes schizophrenia. However, there is a large body of evidence that cannabis and other drugs can act as a trigger in vulnerable people and can make many of the symptoms more intense.

The experience of mental health services can be particularly distressing for people from minority ethnic communities. Although there is no evidence to suggest that people from minority ethnic communities are medically more prone to develop schizophrenia, our own research[6] shows that they are twice as likely to be subject to compulsory detention under the Mental Health Act, and twice as likely as white people to be forcibly restrained.

Around one-third of people with schizophrenia will have one 'psychotic' episode and then make a full recovery. Another third will have recurrent psychotic episodes with varying lengths of mental well-being in between. Another third will experience the symptoms throughout their lives. For all these groups, effective treatments and services-although not 'cures' — exist which enable them to live meaningful and fulfilling lives. However, their availability is something of a lottery[7].

The 'mystery' of schizophrenia partly explains why so much fear and misunderstanding surrounds the illness and why people who experience it find themselves further burdened by stigma and outright discrimination across all walks of life. It is also true that schizophrenia — and mental health in general — has found itself way down the political and health pecking order, leading to decades of under-investment and second class service development and delivery. Members of the general public see distressed people, perhaps behaving bizarrely, interacting with services that they would not want to use themselves and come to the conclusion that severe mental illness is something to stay well clear of. Mental health is, in short, the Cinderella service of the NHS.

Changes in attitude and approach

However, things are changing-and at quite a pace. Since the election of the Labour government in 1997, there have been around 20 major policy announcements. In addition, the World Health Organisation produced its own report in 1998[8] establishing some key principles, not least that mental health care standards in prisons should match those on the outside. Mental health now sits alongside heart disease and cancer as priority concerns for the NHS.

Within the Prison Service new policies, strategies and reviews have been announced covering nurses, doctors, suicide, clinical governance issues. Perhaps most importantly, the overarching *Changing the Outlook*,[9] sets a strategy 'to set the direction of travel'

5. *The ICD-10 Classification of Mental and Behavioural Disorders*, World Health Organisation.
6. *No Change*, National Schizophrenia Fellowship, 1999.
7. *National Service Framework for Mental Health*, Department of Health, 1999.
8. *Mental Health Promotion in Prisons*, World Health Organisation Regional Office for Europe, 1998.
9. *Changing the Outlook: A strategy for developing and modernising mental health services in prisons*, Department of Health and HM Prison Service, December 2001.

for mental health services in prisons. Two themes run throughout the strategy. First, the Prison Service should not be expected to provide the healthcare needed for people with severe mental illness-that is the job of the NHS working in formal partnership with the Prison Service. Secondly, people with severe mental illness should receive the same quality of care in prison as they would expect to find in a quality NHS-led service outside.

Mental illness in prison

This does raise the question of whether people with a severe mental illness should be in prison in the first place. The cases of Keita Craig and Mark Keenan (summarised below) illustrate the fatal consequences of botched care. Rethink Severe Mental Illness worked with both families. They are unusual only in their sheer determination to find out what happened to their loved ones, why it happened and to prevent it happening to other prisoners and their families in the future. There are already a range of secure hospitals, regional secure units and medium secure units designed to accommodate people with severe mental illnesses who have committed serious crimes in a safe — for them and the public — therapeutic environment. Even if there were enough places to accommodate people who could make use of these services — and there are not — there will remain a group of people who, although no danger to themselves or the public, have a diagnosed severe mental illness and who have committed crimes that carry a custodial sentence. Our own position on this is quite straightforward:

People with a severe mental illness, including those on remand pending a psychiatric assessment report, should never be in prison.[10]

It is a position that does not go unchallenged, particularly by people with direct experience of the discrimination that accompanies severe mental illness. Their argument, in summary, is:

if it is wrong to discriminate against us in the labour market, surely it is wrong to discriminate against us in the criminal justice system.

Whichever principle is adopted, the reality is that there are 5,000 people who have a severe mental illness in prison today experiencing conditions that are far from ideal. Whose responsibility are they? The case of Keita Craig case (see below) highlights the difficulties for prison governors who find themselves the accommodation point of last resort for courts unable to place people in more suitable health or community-based facilities. As part of the Mental Health Alliance, we have been pressing the government to introduce a new legal right to assessment, care and treatment in the forthcoming Mental Health Act.[11] The NHS would then be under a statutory obligation to provide suitable care for people in need and, in the context of the criminal justice system, prisons would be relieved of a task they are not suited to perform.

Changing the Outlook does not go that far but it does demand a recognition

that prisoners remain part of the NHS community ... Mental health care, particularly for the most seriously ill, has to be provided through a partnership with the Prison Service in which the NHS makes a full and equal contribution.

The NHS Plan

This is very much to be welcomed, not least because it reflects what appears to be a developing assertiveness within the Prison Service in its relationship with the NHS. The NHS Plan is explicit in its prison-related targets. It states:

by 2004, 5,000 prisoners at any time should be receiving more comprehensive mental health services in prison. All people with severe mental illness will be in receipt of treatment, and no prisoner with serious mental illness will leave prison without a care plan and a care co-ordinator.

Changing the Outlook breaks the target down into what should be manageable chunks. To begin with 'receiving more comprehensive mental health services in prison' is translated to mean setting up mini community care programmes that mirror structures outside. The assumption that people with severe mental illness should be held in the healthcare centre (hospital) rather than on the wings (community) is rejected. There will be 'greater use of day care and wing-based treatments, mirroring the community scenario.' While this will relieve pressure on the healthcare wings, it raises the urgent need to ensure that wing officers are properly trained and supported and are able to make at least basic distinctions between those individuals who are wilfully uncooperative with wing regimes and those who are unable to co-operate. The 'in-reach' teams being set up now in pilot establishments will have a crucial role in providing that support, but their primary role must be to ensure the health of vulnerable prisoners, particularly those who become exposed to bullying and intimidation. There will need to be proper monitoring and evaluation of any tensions between these roles that emerge as the programme develops.

'All people with severe mental illness will be in receipt of treatment,' begs the question what kind of

10. *Prisoners With a Severe Mental Illness*, Policy Statement 18, National Schizophrenia Fellowship, February 2000.
11. *Care Before Compulsion*, Mental Health Alliance, 2001.

treatment? *Rethink severe mental illness* has long rejected a narrow medical model of treatment in favour of a holistic approach that sees drug and other medical interventions as just part of a wider treatment package. A holistic treatment package would include supporting an individual in building and maintaining a network of friends, ensuring adequate accommodation and providing access to paid employment or other meaningful activities. There will be real challenges for the Prison Service in ensuring that the full package is deliverable within the confines of a prison. Indeed, there will be challenges in delivering even a narrow medical model of 'treatment'.

Changing the Outlook also notes the National Institute for Clinical Excellence (NICE) review that calls for the wider availability of newer 'atypical' drugs that have fewer and less severe side effects than the older 'typical' drugs. This welcome development comes with a price tag, as some of the 'atypicals' can cost 30 times as much as their older 'typical' counterparts. *Changing the Outlook* calls for the Prison Service to show 'flexibility in making these and other effective treatments available.' But who will pick up the bill?

The Care Programme Approach

The NHS Plan states that: 'no prisoner with serious mental illness will leave prison without a care plan and a care co-ordinator.' This Care Programme Approach (CPA), as it is known outside prison, has not been without its difficulties. CPAs can be seen as passports to care. Each is a written record, developed between the individual and the care co-ordinator, of what services and treatments should be provided. Because these services may be provided by a host of different statutory and voluntary sector agencies, it is the job of the care co-ordinator to make sure that the package holds together and is delivered. The National Service Framework for Mental Health made the adoption of written CPAs one of first aims. However, as the first annual report of the NHS Plan Modernisation Board admitted: 'There is concern that these objectives will not be achieved and remedial action will be required.'[12]

For the Prison Service, adopting the Care Programme Approach will mean that responsibility for prisoners extends beyond the prison walls. Take one practical example — post-release accommodation. Research published earlier this year,[13] showed that over half of all prisoners with mental illness released from short sentences had nowhere to live. That will not be acceptable after 2004, if the NHS Plan targets and the aspirations contained within *Changing the Outlook* are to be met. Given the sometimes strained relationship between the Prison Service and the NHS, there must be a large question mark placed over the ability of all sides to develop over the next two years the joint-working arrangements with social services and other agencies required to extend the Care Programme Approach to prisons.

Part of the answer will come in the form of new staff, new training and skills development for existing staff and cash — the oil to make the cogs turn smoothly. A lot of the extra money that has gone into mental health over the past three years has been directed to the secure hospital sector. More still will be sent in that direction if and when the government's plans for detaining more people with what it calls dangerous severe personality disorder (DSPD) are put into effect. There are growing complaints from people affected by severe mental illness who live in the community that they have yet to see many changes, despite the promises. How much will be made available to assist the NHS and Prison Service to work effectively together and to allow the Prison Service to employ the numbers of new skilled staff it will need remains an open question. *Changing the Outlook* says that 300 new staff will be employed and that 'some specific funding' will come from the NHS, but it does not say how much. A great deal of reliance appears to be placed on the existing £90 million Prison Service healthcare expenditure — about half of which goes on mental health — being made to work harder. That may not be enough to turn what are, in many ways, ground-breaking, culture-changing, inspiring plans into practical realities.

Conclusion

Changing the Outlook recognises that 'mental health services in prisons have struggled to keep pace with developments by the NHS.' This is certainly true, not least the recognition by the NHS of the value of working in partnership with the voluntary sector in providing specialist information, advice support and services that are often more person orientated and flexible than those available within the statutory sector. The Prison Service has developed close relations with some voluntary sector partners, not least the Samaritans in suicide prevention. However, from our vantage point within mental health, it appears that a great deal more could be done to harness the knowledge and skills available within the voluntary sector. For instance, Rethink severe mental illness would be able to offer some training to Prison Officers and Prison Healthcare Staff to help put Changing the Outlook into practice. In addition to training, we may be able to help Prison Service staff make sense of and implement the strategy locally, so that it tackles the actual needs of prisoners and strengthens links to local heath and social care services as well as to the voluntary sector.

12. NHS Plan, Modernisation Board Annual Report, Department of Health, January 2002.
13. *Where Do They Go? Mental health, housing and leaving prison*, Revolving Doors Agency, 2002.

Keita Craig

by Cleo Scott, mother of Keita Craig

My son, Keita Craig, was just 22 when he died in Wandsworth prison on 1 February 2000. He died because those who should have been providing the care and treatment he so desperately needed failed him. That is not just my view as his mother, it is now, after a long and difficult struggle, the official position that has to be accepted by those who have been shown to have let Keita down with such tragic and avoidable consequences.

Keita had been diagnosed with schizophrenia — no crime in itself, but, like so many people in his position, he found himself ensnared by the criminal justice system. He was arrested in East Sheen, Surrey on Sunday January 30 after a woman had her handbag stolen. Keita went back to his flat and waited for the police to come. I still believe that it was a 'cry for help' rather than a bid to enrich himself at someone else's expense. Keita had been showing signs of a looming mental health crisis for some time but we, his family, had been unable to get him the right care because local services were, as usual, overstretched.

Keita appeared in court the next day. Everyone there knew that he was ill. Magistrates, court officials, the probation officer and social worker all agreed that Keita needed help from the health services not punishment from the Prison Service. But the court did not have the kind of diversion scheme operating that could have found him help straight away. Keita would have to spend a couple of days and nights in Wandsworth prison until he could appear at another court that did run a proper court diversion scheme.

The prison was telephoned and faxed repeatedly by court officials warning that Keita was at risk of harming himself. At Keita's request, those transporting him to prison searched his court cell, removed his shoelaces and placed him in a special cell in the prison van. Once inside Wandsworth, this 'care plan' fell apart. He was 'assessed' by a locum prison GP, had his shoelaces returned to him, was placed in a single cell with no special watch and was not allowed a visit from me despite asking for one.

The next day, Tuesday 1 February 2000, Keita was dead. He had taken his shoelaces and used them to hang himself from an upturned bed.

Keita should never have been in prison in the first place. Once in prison there was a complete failure to protect him. Yet no-one would stand up and take responsibility, admit that they had made a mistake or promise to make sure nothing like this would ever happen again. We protested. But we found ourselves ranged against an unsympathetic coroner who refused even to allow a jury to consider a verdict that laid some blame at the door of the prison service and a plethora of solicitors and barristers who attempted to silence Keita's voice in a babble of legal arguments.

With the help of the National Schizophrenia Fellowship and sympathetic lawyers found through Inquest, we took them all on — not just to get justice for Keita and a sense of closure for ourselves, but to make sure that no-one else would be failed as we had been. We marshalled out arguments, sought independent expert opinion and encouraged media interest. It took 18 long months, an appearance in the High Court, a second inquest spread over two weeks and the common sense of a jury unshackled by misleading legalisms to provide Keita with the justice that had been denied to him when he lived.

What has been achieved? Suicides in prisons across the country, running at record highs when Keita died, have now fallen dramatically; Wandsworth Prison now has a day centre — opened by my mother Erin Pizzey — to provide support for vulnerable prisoners, the Home Office and Department of Health have put a joint mental health policy in place and inquests must now allow families to point the finger at institutions that fail their loved ones as Keita was failed.

No family should have to go through what we have been through to get even this small taste of justice.

Mark Keenan

Mark Keenan died in 1993 at the age of 28 after hanging himself in the healthcare centre of Exeter Prison. He had been receiving treatment for severe mental illness for the previous seven years and was serving a four-month sentence for assault. Attempts to move Mr Keenan from the healthcare unit to the ordinary prison failed as his condition deteriorated whenever he was transferred. Staff were warned that Mr Keenan was a suicide risk.

On 1 May, a month into his sentence, two prison officers were injured when another attempt was made to move Mr Keenan, against the advice given the day before by a visiting psychiatrist. Mr Keenan was then placed in a segregation cell for seven days and had his sentence increased by a month. On 15 May, just a week before his original release date, Mr Keenan was found dead in his cell.

The family fought the case all the way to the

European Court of Human Rights. In April last year, the court found that his care and treatment in prison amounted to inhuman and degrading treatment. In particular, prison and health staff had failed to keep proper notes of his care and did not take into account the effect on his mental state of subjecting him to disciplinary measures and segregation. A prison doctor, unqualified in psychiatry, had also changed his medication without reference to anyone else.

The court found that the Prison Service had failed to take into account the mental health status of Mr Keenan when deciding how to treat him while he was in their care. Actions which may have been standard practice for a prisoner without a severe mental illness, were found to be inhuman and degrading when applied to Mr Keenan, a person with a history of severe mental illness.

However, from our vantage point within mental health, it appears that a great deal more can be done to harness the knowledge and skills available from within the voluntary sector. We support the recommendations made in the HM Prison Report on working with the voluntary and community sector.[14]

For more information on schizophrenia, visit the Rethink severe mental illness website at: www.nsf.org.uk. For more information on the organisation and the services it has to offer, contact: Dick Frak, Director of Service Development, Rethink, 30 Tabernacle Street, London EC2A 4DD. Tel: 020 7330 9100. Fax: 020 7330 9132. Email: dickf@ops.nsf.org.uk.

14. *Getting it Right Together: working with the voluntary and community sector: A Strategic Framework*, HM Prison Service, December 2001.

Working Positively and Productively in a DSPD Unit

Len Bowers, *Professor of Psychiatric Nursing City University and* **Paola Carr-Walker**, *Research Assistant City University.*

People with personality disorder (PD), whether they crop up in our professional or personal lives, are notoriously difficult to like, care for, or manage. It is no exaggeration to say that overall, there are entrenched negative attitudes towards them within most psychiatric services and professions. In outpatient psychiatry this can often mean that the person with PD is discharged at the earliest opportunity, or held at arm's length and seen as infrequently as possible. Should they become inpatients in acute psychiatric wards, they may be ignored or avoided by staff. They are far from the most popular group of patients in forensic psychiatric services, although there are specialist wards within the High Security Hospitals for PD patients. In every psychiatric setting there are some who refuse to accept PD people into care on the grounds that they are not treatable.

Because of their PD, such individuals often come into conflict with the law and turn up in prison. Staff working in the Prison Service, in getting to know them over a period of time, can clearly recognise that they are not psychologically 'right'. Yet securing treatment for them can be difficult or impossible, especially when psychiatric services seek to keep them out at every turn, partly because of the feelings of helplessness they cause in carers. It is because PD offenders do not seem to fit anywhere, or get what they need in terms of treatment and management, that the new DSPD services are being created.

There are many reasons why PD prisoners are disliked and unpopular. They behave in the difficult ways that many prisoners do, only more intensively, frequently, and constantly. For example, they engage in bullying of other weaker prisoners or of staff. This can involve anything from constant nagging demands, through arguing to the point that black turns into white, to hectoring, threats, or actual physical violence perpetrated by themselves or others at their behest. Nor is such aggression always directed towards any sensible