
DEALING WITH MENTAL DISORDER IN PRISONERS

Author(s): Stephen Ginn

Source: *BMJ: British Medical Journal*, Vol. 345, No. 7885 (1 December 2012), pp. 26-27

Published by: BMJ

Stable URL: <https://www.jstor.org/stable/41724415>

Accessed: 25-03-2020 17:45 UTC

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact support@jstor.org.

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at <https://about.jstor.org/terms>



JSTOR

BMJ is collaborating with JSTOR to digitize, preserve and extend access to *BMJ: British Medical Journal*

bmj.com

Analysis: Prison environment and health (*BMJ* 2012;345:e5921)Analysis: Elderly prisoners (*BMJ* 2012;345:e6263)

DEALING WITH MENTAL DISORDER IN PRISONERS

Mental disorders are common among prisoners in England, but treatment is inadequate, says **Stephen Ginn** in the third of his series of articles on prison healthcare

Figures quoted for psychiatric morbidity in prison are often very high. Around 90% of prisoners in England and Wales are reported to have at least one type of mental disorder or substance misuse problem.¹ This is not just a British phenomenon: a systematic review of surveys from Western countries² found 3.7% of male prisoners had psychotic illness, 10% major depression, and 65% personality disorder, figures that are much higher than in the general population (table).

Although crime has been consistently associated with severe mental illness,³ there is no agreed explanation for the high prevalence of mental disorder in prison. Many studies assume that prisoners' mental health difficulties pre-date imprisonment.⁴ An opposing view is that the prison experience worsens mental health, and anxiety and depression are understandable reactions to prison regimes.⁴ Another view is that prisons are behaving as intended. If prison's purpose is to contain "difficult" sections of the population, then a substantial number of mentally disordered people in prison is to be expected.⁵

In this article I focus on prisons in England and Wales and examine three broad concerns: how to keep mentally disordered people out of prison, how to recognise and treat them when in prison,

and what happens on their release back into the community.

Use of "diversion"

"Diversion" is a process by which someone who is in contact with the criminal justice system is identified and directed towards appropriate mental healthcare, particularly as an alternative to imprisonment.⁶ Diversion can take place at any stage in the criminal justice process. For instance, at the time of arrest a forensic medical examiner can judge a suspect unfit for interview and refer him or her to mental health services⁷ or a court may pass an order under the Mental Health Act instead of a prison sentence.⁷

Schemes for diversion in England and Wales focus on magistrates courts, with some based in police stations.⁶ These services were first introduced in the 1990s but, with no national strategy, evolved in an uncoordinated way, leading to wide variations in size, effectiveness, and availability.⁸ A 2009 report from the Centre for Mental Health, a non-governmental organisation, described diversion arrangements as "seriously underperforming."⁶ The report estimated that diversion services see only one fifth of people with mental ill health passing through the criminal justice system and that the opportunity

to divert some people with severe mental illness is missed.⁶ Also published in 2009, the Bradley report examined the experiences of the criminal justice system among people with mental health problems.⁹ It proposed the creation of a network of criminal justice mental health teams to divert people towards support services.⁹

Bradley wrote that community, rather than prison, punishment leads to an improvement in clinical outcomes.⁹ Two suggested reasons for this are better access to mainstream mental health services for people when they are outside prison and the improved well being that results from an individual being kept within their own community environment.⁹

The coalition government accepted the Bradley report's recommendations and stated its commitment to the implementation of liaison and diversion services at all police custody suites and criminal courts in England and Wales by 2014 subject to "business case approval."¹⁰ Additional funding of £50m (€63m; \$81m) was provided,¹¹ and existing diversion services are involved in development and evaluation of this service. The initiative has attracted support from prison reform and mental health advocacy groups,¹² but information on progress is not yet publicly available. There are no estimates to indicate the expected effect on the number of prisoners with mental health problems or its cost effectiveness.

Treatment of mental disorders in prison

Managing people with mental disorders within a prison is challenging. Prisoners make complex patients. They have multiple social disadvantages before they enter prison, such as low educational attainment, unemployment, and homelessness,¹³ and psychiatric comorbidity is much higher than in the general population. One study found that over 70% of male sentenced prisoners showed evidence of two or more mental disorders.^{1 14}



Prevalence of mental disorders among prisoners in Western countries compared with general population estimates²

	Men		Women	
	% of prisoners	% of general population	% of prisoners	% of general population
Psychosis	4	1	4	1
Depression	10	2-4	12	5-7
Any personality disorder	65	5-10	32	5-10
Antisocial personality disorder	47	5-7	21	0.5-1
Alcohol misuse or dependence	18-30	14-16	10-24	4-5
Drug misuse or dependence	10-48	4-6	30-60	2-3
Intellectual disability	0.5-1.5	1	0.5-1.5	1
Post-traumatic disorder	4-21	2	10-21	3



GEORGE STEINMETZ/SPL

The prison environment is testing for healthcare staff and prisoners. Prisons are crowded, noisy, boring, and porous to illegal drugs¹⁵; prescribed medication is also traded.¹⁶ Prisoners are confined to their cells for as long as 23 hours a day.¹⁷ In 2009-10 in England and Wales an average of 1587 prisoners are transferred between prisons each week,¹³ and it is difficult to build therapeutic relationships with prisoners who are relocated frequently.¹⁸ Some prisoners do not view themselves as psychiatrically disordered and do not wish for psychiatric treatment. Other prisoners will lack the motivation to comply with treatment, particularly for substance misuse and personality disorder.¹⁹

All prisoners are screened for mental disorder during a short basic health examination on arrival in prison as part of the reception process. This has been criticised for being undertaken by poorly trained staff, and for health records failing to accompany prisoners on transfer.¹⁸ The recent introduction in England and Wales of SystmOne,²⁰ a prison-wide electronic health records system, should improve the exchange of information.¹⁸ However, there are concerns that reception fails to identify some prisoners with severe mental disorder.²¹ Screening is largely a one-off event,²¹ but the time available for assessment may be too short or the physical setting not conducive.²¹ Prisoners may also be reluctant to reveal details of mental health problems for fear of appearing weak.²¹ Although prisons often contact general practitioners for health information on new prisoners, they are not required to do so. However, since 40% of prisoners say they have not had any contact with a GP,²² health records may not be available.

In general, prison psychiatry teams have a similar structure to community teams. Common mental disorders such as depression and anxiety are seen by prison general practitioners, and "in-reach" teams assess and treat severe and enduring mental illness.¹⁸ Prisoners are usually

referred to in-reach teams by non-psychiatric prison healthcare staff, although prison officers or the prisoners themselves sometimes make the referral.²³ There is no standard for in-reach teams; some are very well resourced, but others considerably less so.¹⁸ In-reach teams have varying degrees of consultant psychiatrist support.¹⁸ In many prisons the introduction of in-reach teams has exposed inadequacy in primary care for mental health problems,⁸ with teams receiving referrals for problems that could be treated without specialist input.⁸ High demand for mental health expertise in prisons means that many in-reach teams can provide care only to those most severely in need,²⁴ and some prisoners may not be seen by either primary or secondary care staff.^{21 25}

In-reach teams often work in isolation,²⁴ and there is a tendency for the various teams that support prisoners with mental health problems to work separately rather than together.¹⁸ Poor links were found with other teams, such as those involved with resettlement or supervising suicidal or self-harming prisoners, and joint work between substance misuse and mental health teams is often weak.²⁴ This "siloes" working means that many mentally ill prisoners do not receive the range of services they require.¹⁸

Intellectual impairment in prisoners is largely neglected.²⁴ There is no agreed prevalence,²⁶ but one estimate is that it affects 20-30% of prisoners in England and Wales.²⁶ Even if impairment is identified, prisons have little to offer.²⁴ Also poorly served are prisoners whose mental health problems make it difficult for them to engage with their sentence plan—an action plan that focuses on those issues a prisoner must address to reduce the possibility of reoffending. "If you're a lifer or on an indeterminate sentence for public protection this is a disaster," says Luke Birmingham, consultant forensic psychiatrist at Isle of Wight Prison. "Since they can't do interventions to reduce risk, prisoners don't progress and parole boards won't consider their release. Prisoners get stuck and end up way over their sentence tariff with no prospect of release."

Out of prison care and resettlement

Neither prisons nor their healthcare facilities in England and Wales are recognised as hospitals under the Mental Health Act, and prisoners require transfer if they need compulsory treatment. This could be to a community inpatient ward or a medium secure unit. The time taken for transfers was a concern raised by many people contacted during research for this article. The process can drag on for months,¹⁸ and resulting delays are distressing to prisoners, families, and staff. Reasons for delay include reluctance on the part of general services to work with prisoners,²⁷

separate assessments for each possible placement,²⁷ and high secure service bed occupancy.²⁷

Ensuring continuity of psychiatric care and maintaining any improvement on release to the community is another major challenge and frustration. Prisoners can be released unexpectedly and return to distant communities. "Release is a breakpoint for care," one prison psychiatrist told me. "Prisoners we're seeing as patients can be released without warning. They go to court in the morning and don't return later in the day. Our team then has to do its best to sort things out," he said. Even when a release is planned, "linking prisoners into community services is difficult when community mental health teams have different referral thresholds and decline to automatically see patients previously under prison secondary care," he said.

Even a better planned release can be problematic. There is little assistance for any prisoner on leaving prison.¹⁸ Half of released prisoners can be without a general practitioner.²² Former prisoners have poor employment prospects,¹³ and many return to the same environment they encountered before their sentence. Prisoners with mental health problems are less likely than other prisoners to benefit from prison based rehabilitation.²⁸

What way forward for prison mental health?

We must acknowledge that provision of community mental healthcare also has significant shortfalls. Nevertheless, there is plenty of scope for improving prison care. Evidence on the needs of prisoners with mental health problems and how best to respond to them needs strengthening, and continued development of diversion services must be a priority since prison is not a suitable place for anyone with acute severe mental illness. Integrated team working, better identification of psychiatric morbidity, and improved discharge procedures are also needed.

Ever increasing prisoner numbers in England and Wales put prison staff and facilities under strain, creating an environment that is unpleasant for prisoners and creates obstacles to good care. If problems are not to be exacerbated, government and agencies must work together to improve the prison experience.

Stephen Ginn Roger Robinson editorial registrar, *BMJ* mail@stephenginn.com

Contributors and sources: SG is an ST5 trainee in general adult psychiatry and was the 2011-12 Roger Robinson *BMJ* editorial registrar. Information for this series was obtained from an unsystematic literature review, prison visits, and discussions with prison doctors, prison nurses, prison and forensic psychiatrists, prison governors, prison reformers, prison health managers, prisoners, criminologists, sociologists, and prison inspectors.

Competing interests: None declared.

Provenance and peer review: Commissioned; not externally peer reviewed.

References are in the version on bmj.com.

Cite this as: *BMJ* 2012;345:e7280