



The Sainsbury Centre

for Mental Health

**BRIEFING 32**

An introduction to a topic of current importance or controversy, giving clear and independent comment and analysis of the issues that lie behind it.

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## BRIEFING 32

**T**he Sainsbury Centre for Mental Health (SCMH) works to improve the quality of life for people with mental health problems by influencing policy and practice in mental health and related services. We now focus on criminal justice and employment, with supporting work on broader mental health and public policy.

SCMH was founded in 1985 by the Gatsby Charitable Foundation, one of the Sainsbury Family Charitable Trusts, from which we receive core funding.

Photograph by F.R.A.Taylor

# Mental health care in prisons

## Introduction

England and Wales together have the highest imprisonment rate in Western Europe. The population has nearly reached full capacity with over 80,000 people in prison during the month of April (HMPS, 2007). There is a high degree of overlap between the populations in contact with mental health services and with criminal justice services.

The quality of mental health care available in our prisons is frequently poor. The Government has acknowledged the need to improve the situation and by April 2006 responsibility for prison health care was fully transferred from HM Prison Service to the NHS. *Changing the Outlook* (DH & HMPS, 2001) stated that, "prisoners should have access to the same range and quality of services appropriate to their needs as are available to the general population through the NHS". This introduced the aim of 'equivalence' to prison mental health care. It recommended the introduction of specialist mental health teams to work with those prisoners who have 'severe and enduring mental illness' and that mental health provision in prisons should reflect what was being developed in the community. However, it made no mention of care for those with common health problems who would otherwise be supported by primary care in the community.

Figure 1: Mental health problems in prisons and the general population

	Prevalence among prisoners	Prevalence in general population (adults of working age)
Psychosis	6% – 13%	0.4%
Personality disorder	50% – 78%	3.4% – 5.4%
Neurotic disorder	40% – 76%	17.3%
Drug dependency	34% – 52%	4.2%
Alcohol dependency	19% – 30%	8.1%
	Source: Singleton <i>et al.</i> (1998)	Source: Singleton <i>et al.</i> (2000)

Making prison mental health services equivalent to those in the community is an enormous challenge. Prisons are overcrowded and lack staff skilled in dealing with mental health problems. For NHS staff, working in prisons is a major change of culture as security takes precedence over health care.

This briefing paper examines the provision of mental health care in prisons. It looks at what has been achieved to date and identifies priorities for further work.

The Sainsbury Centre for Mental Health (SCMH) has launched a new work programme to improve mental health care for people in contact with the criminal justice system. We will be at the leading edge of advocating for progress and of finding practical ways of achieving improvements.

### Mental health problems in prison

Around 70% of sentenced prisoners suffer two or more mental health problems (Singleton *et al.*, 1998) and 20% of male and 15% of female prisoners have previously experienced a psychiatric acute admission to hospital (Prison Reform Trust, 2007). Remand prisoners are also more likely to have several such problems (Singleton *et al.*, 1998). Figure 1 shows the prevalence of mental health problems in prisons compared to the general population.

Many prisoners have a combination of mental health problems, substance misuse, personality disorder and learning difficulties as well as a range of other issues to deal with.

Rates of self harm and attempted suicide in prison are high. There were 67 prison suicides in 2006 and a total of 22,324 self-harm incidents recorded during 2005–6 (Prison Reform Trust,

2007). Attempted suicide over a 12 month period ranged from 7% (in male sentenced prisoners) to 27% (in female remand prisoners) (Brooker *et al.*, 2002). The greatest risk of suicide or self harm is among newly arrived prisoners in their first seven days in prison (Shaw *et al.*, 2004).

Although the prevalence of mental health problems in prison is high, most of these will be common conditions, such as depression or anxiety. A smaller number have more severe conditions such as a psychosis. Not all prisoners enter prison with mental health problems: for some, being in prison will lead them to develop depression or anxiety, for example.

From evidence given to it, the Joint Parliamentary Committee on Human Rights (JCHR, 2004) concluded that “prison actually leads to an acute worsening of mental health problems”.

Some groups, such as women and young people, suffer disproportionately from mental health problems in prison.

### Ethnicity

People from Black and minority ethnic (BME) communities represent about 10% of the UK population (ONS, 2001) but in prison this rises to approximately 20% (Rickford & Edgar, 2005). This can be partly explained by the presence of foreign nationals in UK prisons. The rate of diagnosed mental health problems is lower in BME groups than among the white population. This may be due to a number of reasons including the lower rates of referral and recognition (Durcan & Knowles, 2006). There is a need for further research in this area.

## Women

Of the 80,261 people in prison on 30 April 2007, 75,891 were men and 4,370 were women (Ministry of Justice/NOMS, 2007).

The number of women in prison has increased dramatically (Rickford, 2003). Women prisoners are twice as likely as their male counterparts to have received help for a mental/emotional problem in the 12 months prior to imprisonment (Prison Reform Trust, 2000).

Women serve shorter sentences, but during that time their children may be taken into the care of the local authority, and they may lose both their job and their home, increasing the likelihood of re-offending and mental illness. The Women's Offending Reduction Programme (Home Office, 2004) has acknowledged this and aims to reduce women's re-offending by ensuring that women receive greater support before, during and after custody. The Home Office-commissioned Corston Review recently recommended completely replacing the women's prison estate and creating better alternatives (Home Office, 2007).

## Young people

Of the 80,261 people in prison on 30 April 2007, 11,827 were under 21 years (Ministry of Justice/NOMS, 2007).

Young people in prison have an even greater prevalence of poor mental health than adults, with 95% having at least one mental health problem and 80% having more than one (Lader *et al.*, 2000). Few have any qualifications or had worked prior to prison and most had traumatic experiences prior to their incarceration. They are 18 times more likely to commit suicide in prison than in the community (Prison Reform Trust, 2007).

## Unemployment and social exclusion

Prisoners are disadvantaged in many ways before coming into contact with the criminal justice system:

- ❖ 67% were unemployed before going to prison (Social Exclusion Unit, 2002)
- ❖ 70% will have no employment or placement in training/education on release (Niven & Stewart, 2005)
- ❖ 42% of released prisoners have no fixed abode (cited in Williamson, 2006)

- ❖ 65% of prisoners have numeracy skills at or below the level of an 11-year-old and 48% have reading skills at or below this level (Social Exclusion Unit, 2002).

Prisoners are also significantly more likely to have been in local authority care during childhood and to have truanted and faced exclusion from school than the general population (Social Exclusion Unit, 2002).

A criminal record, low educational attainment, health problems and a lack of stable housing can make it very difficult for prisoners to find employment on release (Prison Reform Trust, 2006). The Chartered Institute of Personnel and Development reports that people with a criminal record are part of the 'core jobless group' that more than 60% of employers deliberately exclude when recruiting (CIPD, 2005).

## Mental health care in prison

Most prisons in England and Wales now have a mental health inreach team. These teams are intended to support those prisoners with the most serious mental health problems (DH & HMPS, 2001). It is estimated that 10–20% of prisoners are in this group (Singleton *et al.*, 1998).

The creation of inreach teams is the most significant mental health development in prisons to date, and is quite unprecedented. But unlike the new teams in the community there has been no implementation guidance for inreach teams and those commissioning them.

Therefore their role and function is different from prison to prison. While inreach teams should include a mixture of staff such as psychiatrists, social workers, mental health nurses and other nurses, in most prisons, teams are mainly made up of nurses, with varying degrees of medical support.

Teams often aim to have a broad role (Durcan & Knowles, 2006):

- ❖ reaching out to the wings of the prison where the prisoners reside;
- ❖ focusing on prisoners with severe and enduring mental health problems;
- ❖ working with health care and primary care practitioners in prisons;
- ❖ raising mental health awareness, particularly among prison staff;
- ❖ offering evidence-based interventions (such as cognitive behavioural therapy);
- ❖ offering a similar multidisciplinary service and model of care to that which a community mental health team provides outside prison.

In reality, the range of interventions offered by the teams is very limited. Several teams in London (Durcan & Knowles, 2006) say that on the whole their work is restricted to assessment, mental health monitoring and medication management, but with considerable effort going into liaison and seeking information from services outside the prison such as community mental health teams.

Their role is also restricted by the frequent movement within the prison population. Remand prisoners may be in prison for short periods. Sentenced prisoners also move frequently from one establishment to another. Overcrowding plays a role in this too.

Many prisoners with common mental health problems are referred to the inreach teams. This is because they are given little or no treatment or support from other health services in the prison. These 'inappropriate referrals' put added pressure on inreach teams and restrict the time they can give to each person.

### Identifying mental health problems in prisons

Any prisoner thought to be in need of a mental health service will undergo an assessment process. Because agencies in prisons all tend to work independently of each other, prisoners with mental health problems may be recipients of multiple assessments, with considerable overlap between each.

Inreach teams are not involved in the medical screening of new arrivals to prison. Screenings in reception are conducted by prison health care staff who may not have mental health training. Reception itself can be a chaotic process in which large numbers of people arrive at one time. As a result, prisoners with mental health problems have often not been identified and therefore placed on ordinary location (Parsons *et al.*, 2001). Once on ordinary location it is even less likely that a mental health problem will be identified (Birmingham, 1998).

Most prisons use a standardised screening tool, the Don Grubin health screening tool (Carson *et al.*, 2003) to assess the health of prisoners at reception. Participants in a recent review of London's prisons thought that this tool was not always effective in identifying mental health or substance misuse problems (Durcan & Knowles, 2006). Considerable work is being done to improve screening procedures. A new tool has been piloted across ten prisons and is now adopted for use for all new prison receptions (Birmingham & Mullee, 2005; Carson *et al.*, 2003).

### Transfer to NHS care

An alternative resource for some people in custody is a secure NHS inpatient facility. The development of medium secure forensic units (see Box 1) has been unco-ordinated, leading to patchy provision and under-provision (Coid *et al.*, 2001). This has resulted in delayed transfer to such facilities.

Some prisons have 24-hour health care facilities which include inpatient units. General health care beds can be used for any medical need, but their use tends to be dominated by prisoners with mental health problems. It has been estimated that around 40% of prisoners held on health care wings were awaiting transfer to NHS secure accommodation (HMPS, 2004). There are also only three forensic units (with three more in development) for adolescents in all of England and Wales.

For the purposes of compulsory care, prisons are not recognised as hospitals under the Mental Health Act 1983. People must be transferred to an NHS hospital for treatment if compulsion is required.

Transfers to the NHS, while having reportedly improved since the introduction of inreach teams, do remain a problem because of the length of time that prisoners have to wait. A review of London prisons found that there was often a difficulty in getting secure beds and an apparent reluctance by NHS providers to accept responsibility for follow-up care (Durcan & Knowles, 2006).

The Department of Health and Home Office have published revised guidelines on transfers to the NHS from prisons. They are designed to address some of the "unacceptable delays in the transfer of acutely mentally ill prisoners to and from hospital under Sections 47 and 48 of the Mental Health Act 1983" (DH, 2005). The guidelines make clear the responsibility of commissioning PCTs in arranging transfer. They also deal with cases where the prisoner has no fixed abode, in which case the PCT where the offence leading to imprisonment took place has this responsibility.

#### Box 1: Medium secure forensic units

Medium secure forensic units provide placements for patients who do not need the high level of security provided by a high secure hospital but who are not suitable for placement in a general psychiatric facility. Patients who are placed in a medium secure unit may be sent direct from the courts, transferred from prison for reasons of acute and severe mental illness, transferred from a high secure hospital by way of a 'step down', or transferred from general psychiatric facilities where staff have found them difficult to manage and they have posed a risk to themselves or others.

## Primary mental health care

Primary care in prisons is variable. The All Party Parliamentary Group on Prison Health (2006) reported that primary mental health care is extremely weak. Some prisons are served by prison doctors and others by a local GP practice. Pearce *et al.*, (2004) identified that while 58% of prison doctors worked with prisoners with mental health problems, most had not received any training in psychiatry. Prison nurses provide a significant proportion of the primary care service. Many prison nurses including those with mental health training are employed in a generic health role. Those that have tried to provide primary mental health care have often found this difficult due to staff shortages and the broader demands of the generic role.

Prisoners with common mental health problems such as depression, anxiety, emotional distress and adjustment problems, have high levels of unmet need. The need for a range of psychological therapies is great.

## Dual diagnosis services

It is estimated that a large proportion of prisoners have both mental health and substance misuse problems (Brooker *et al.*, 2002). However, there is a big gap in 'dual diagnosis' services in prisons and a lack of co-ordination between different teams. Substance misuse services, such as detoxification, have historically been outside the remit of health care. Counselling, Assessment, Referral, Advice and Throughcare services (CARATs) provide support for people with substance misuse problems in all prisons. But research shows that substance misuse and mental health teams often refer prisoners onto each other, rather than seeking to work together (Durcan & Knowles, 2006). There is also a lack of skills and knowledge in dual diagnosis care among workers and poor communication with services outside of prisons (Hughes, 2006).

## Alternatives to imprisonment

Custody and court liaison services exist to divert people with severe mental health problems from the criminal justice system to the health service before they even get to prison. Research by Nacro shows that where such services are working well they can be effective (Nacro, 2005), but too often they are unable to have a major impact on the system for reasons including:

- ❖ They do not work at both police stations and courts.

- ❖ They do not function on all days of the week.
- ❖ They do not have the power to admit patients to beds (e.g. for lack of a doctor in the team).
- ❖ There are no suitable facilities in hospital or the community to which to divert people.

The international evidence of effective diversion systems in the USA, Australia and Canada is an area worthy of review and in particular their application to the UK context.

## Care after release

Continuity of care between prison and the community is also a huge challenge. It is not helped by the fact that approximately 50% of sentenced prisoners are not registered with a GP prior to being sent to prison (Social Exclusion Unit, 2002) and the same proportion have no GP on release. This means that if treatments begin in prison they cannot be followed up in the community.

Many released prisoners have nowhere to live. In one study 49% of prisoners with mental health problems had no permanent residence on release (Revolving Doors, 2002). Melzer *et al.*, (2002) reported that 96% of prisoners with mental health problems were released without supported housing arrangements being made, and this included those who had committed serious offences.

Men recently released from prison are eight times more likely than the general population to commit suicide. Women are 36 times more likely to kill themselves (Pratt *et al.*, 2006).

Mental health services in the community often seem reluctant to maintain responsibility for people once they are imprisoned, even if they were involved with them before. Prison inreach teams are not always informed about whether a new inmate was previously in the care of a community mental health team. It has also been reported that mental health services are reluctant to accept people released from prison, especially those with substance misuse problems or a personality disorder (Durcan & Knowles, 2006).

Work done in prisons is often undone when a prisoner is released. Some individuals may be in distress because they are being released from prison into the same situation that led them to crime in the first place. Often prisoners return to using street drugs (Social Exclusion Unit, 2002). It is vital that, upon leaving prison, people are well supported and linked in to community services and that there are services available in the community to support them.

## User Involvement

SCMH has recently conducted interviews with approximately 100 prisoners across five establishments in the West Midlands as part of a broader review of mental health provision. Most prisoners expressed concerns about leaving prison and how the lack of support on previous releases had in their view led them to re-offend and spend further time in prison. Much of what has been reported in this briefing paper was confirmed by those we interviewed, especially the lack of co-ordinated care in prison and on release for those with a 'dual diagnosis' of mental health problems and substance misuse.

Developing user involvement in prison poses considerable challenges, but the views and feedback of the end user are as essential in prison mental health care in supporting the development of effective care as they are in community mental health care.

## Conclusion

The prison service's expectation that inreach teams would deal with all mental health problems is in opposition to community models of mental health care, where it is expected that the vast majority of mental health problems will be managed within primary care and only people with severe conditions will be referred to secondary services. Prison inreach teams have been described as under-resourced, overwhelmed by referrals and limited in the range of interventions they can offer.

A better mental health care service in prisons could be achieved with:

- ❖ the use of more effective and consistent models of diversion;
- ❖ developing primary care services in prison to treat and support common mental health problems; this could include the development of a primary mental health nursing role;
- ❖ co-ordinated services for prisoners with a 'dual diagnosis' of mental health problems and substance misuse;
- ❖ policy guidelines and national standards for inreach teams;
- ❖ support and training for health care staff to develop specialist skills;
- ❖ an improved process of transfers from prison to NHS care;
- ❖ better co-ordination and team work among the agencies in the prison and with the NHS outside prison;

- ❖ improved resettlement programmes to reduce the number of re-offenders;
- ❖ the development of user involvement in prison mental health care.

SCMH has launched a new work programme to address many of these issues, for further information see page 8 (back cover).

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## The Criminal Justice Programme at the Sainsbury Centre for Mental Health

The Sainsbury Centre for Mental Health (SCMH) has launched a new work programme to improve mental health care for people in contact with the criminal justice system.

Our aim is to be at the leading edge of advocating for progress and of finding practical ways of achieving improvements. Our priorities are:

1. Diversion: Keeping people with serious mental health problems out of the criminal justice system through better custody and court diversion schemes.
2. Mental health care: Support for those offenders currently getting the least effective care:
  - ❖ those with common mental health problems, such as depression and anxiety;
  - ❖ those with personality disorders;
  - ❖ those with a 'dual diagnosis' of both mental health problems and substance misuse;
  - ❖ and to support the development of improved primary mental health care systems.
3. Resettlement for people with mental health problems to ensure better access to employment, housing and health and social care when they are released from prison.
4. Young people: Support for young people with mental health problems who come into the criminal justice system.

Our aim is to achieve change through research and analysis, piloting and evaluating new approaches, and promoting good practice from the UK and abroad.

For further information on our work and to register for our monthly email bulletins visit our website at [www.scmh.org.uk](http://www.scmh.org.uk)

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