# From the Inside

## Experiences of prison mental health care

**Graham Durcan**

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The following is an extract from the report ***From the Inside.***

It is essential reading for everyone who wants to find out more about the experiences of prisoners and staff of mental health care in prison.

***From the Inside*** costs £10 (plus p&p). To order, call 020 7716 6795 or visit our publications page at www.scmh.org.uk

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This report is dedicated to Deidre Rice: a real champion for improving prison mental health.

# Foreword

*by Lord Ramsbotham*

In October 1998 the Office of National Statistics (ONS) published a report entitled *Psychiatric Morbidity among Prisoners in England and Wales* (Singleton *et al.,* 1998). It was, and remains, a seminal document. It set out, in stark detail, the scale and nature of an extremely serious problem, graphically analysed in Graham Durcan's admirable analysis of the situation in five West Midlands prisons, namely the number of prisoners with mental health problems whose needs are not being fully addressed during their time in custody.

I have to admit that, on being appointed Her Majesty's Chief Inspector of Prisons in December 1995, I had no idea of the size and shape of the problem, because it was not one that received much attention in the national press. Immediately before taking up this post, I had chaired an NHS hospital trust. My excellent Director of Mental Health insisted that I trained as a lay assessor, firstly so that I could contribute something useful to the work of the hospital, and secondly so that I might better understand the impact of drugs on adolescent brains. This was in relation to the increasing evidence of latent problems, such as schizophrenia, being advanced by drug use: the cause of a tragic suicide that took place soon after I took up my post.

I mention this because, during my first prison inspection, of the women's prison HMP Holloway, I became aware not only of the large numbers with mental health problems, but of the total inadequacy of Prison Service health care arrangements. I was amazed to find that the Prison Service was not even part of the NHS, having, since 1947, been allowed to run its own medical affairs. As a result only 10% of all prison doctors were qualified to act as GPs in the community, no documentation passed from GPs to prisons or back again, and psychiatric staff were virtually non existent. I set about trying to rectify this, and am glad that, in 2003, the NHS became responsible for funding health care in prisons.

I mention this because, at the base of the current situation is the dreadful fact that prison needs have, for years, not figured in NHS budgeting. As a result no additional places in secure accommodation were added to cater for the numbers who really ought to be treated there, rather than in prison. Since 2003 the NHS has tried to improve matters, with individual mental health trusts being contracted to provide services in individual prisons. At last Ministers have begun to realise that prison conditions, particularly being locked in cells for the majority of every 24 hours with nothing to do, is the very worst form of treatment for those suffering from many forms of mental health problem. This merely results in the person affected being made worse, which in turn impacts on communities when they leave prison. Prison health is a public health issue, a fact that is emphasised by the figures in the ONS 1998 report.

Therefore, I was delighted when the Sainsbury Centre for Mental Health, one of the most highly regarded research organisations in the country, decided to turn its attentions to the problem. I say this because it is able to bring to bear experience and analysis of many aspects of mental health treatment and needs around the country, and apply them to prisons, in which the Government is anxious to claim that 'equivalence' is the standard sought. This means that, instead of treating prisons as a unique problem, Graham Durcan and his team were able to compare what they found in the five prisons with current practices in the community and define what changes need to be made to bring them into line.

In other words, he has been able to advise on how prisons might be part of, rather than apart from, common practice. In doing so he has, inevitably, identified gaps in the current situation in prisons, which should give cause for concern to those responsible for filling them, as well as providing practical advice in determining how that might be done.

I could not commend *From the Inside* more highly to all those concerned with the problem. Sadly prisons are, all too often, used as repositories for those who are neglected and rejected by other services in the community. This is not a fit and proper task for prisons and the needs of these neglected people have, until now, been too often ignored. Therefore, because they form such a significant part of current prison populations, their particular needs must be catered for. That is why, in addition to advice on treating more acute conditions, I am delighted to see concentration on such vital issues as staff awareness, the improvement of screening, the development of a 'stepped care' approach to managing needs and greater concentration on the basics of resettlement such as housing.

I hope that, as with the 1998 ONS report, Graham Durcan's Sainsbury Centre report becomes recognised as seminal, and a universal guide book on what must be done as matters of urgency, humanity and public good.

# Executive summary

The prison population of England and Wales now exceeds 80,000 and is set to rise to beyond 100,000 within a decade.

The majority of prisoners have mental health problems. Many also have a complex mix of other issues including substance misuse, poverty and a history of abuse.

Few previous attempts have been made to listen to the views of prisoners about their mental health and mental health services in prison. We interviewed 98 prisoners and 75 staff in five West Midlands prisons to find out more about mental health care inside and outside prison.

We found that being in prison may in itself damage mental health: for example because of separation from family, bullying and a lack of someone to trust. Self-harm and worries about children are particularly serious problems for women prisoners.

Prisoners' lives before prison were frequently chaotic. Abuse and homelessness were commonplace. Many had previous contact with mental health services but had not been followed up and had lost touch.

Arrival at a new prison is a stressful process. Screening for mental health problems is poor yet reception is often the only occasion where this happens for many prisoners.

Having something to do is vital for prisoners. For those with mental health problems, a lack of meaningful daytime activity and limited opportunities for exercise are major concerns.

Prison health care departments offer very limited support for prisoners' mental health. Nursing staff with mental health training rarely practise those skills.

Mental health inreach teams, however, are making a difference to the prisoners they support. Prisoners in contact with inreach services told us they were more confident about their future and thought they were less likely to re-offend because of the practical help the team offered.

The major barriers to change in prison mental health care are:

- Custom and practice prevent staff working flexibly or using their skills appropriately with prisoners;
- Inflexible appointment systems;
- A lack of understanding between different services within the prison;
- A lack of attention to resettlement.

Prisoners with mental health problems told us what they felt they needed:

- 'Someone to talk to' about their feelings and problems;
- Better planning for their release;
- 'Something to do' during the day: meaningful activity, including work and exercise;
- Help in a crisis;
- Access to psychological therapy and advice about medication.

We recommend:

1. Integration between agencies working in prisons on health, mental health, substance use and resettlement.
2. Investment in mental health awareness training for all prison staff.
3. Better care for prisoners with 'mild to moderate' mental health problems, including a new 'primary mental health practitioner' role.
4. A major rethink of mental health screening.
5. The development of a 'stepped care' approach to manage mental health according to the severity of a prisoner's needs.
6. Intensive outreach to prison wings to replace inappropriate use of prison health care beds for people in a mental health crisis.
7. A greater priority given to resettlement, focusing on the 'basics' of housing, employment and drugs.
8. Research to understand the impact of psychological trauma on prisoners and the development of services to support them.
9. Listening to prisoners' own views about the support they get and how it could be improved.

# Introduction

England and Wales together have the highest imprisonment rate in Western Europe. The population in our prisons exceeded 80,000 in 2007 (NOMS, 2007a) and has remained above this level ever since (e.g. Ministry of Justice / NOMS, 2008). It is expected to rise beyond 100,000 by 2014 (Carter, 2007). The majority of these prisoners need support for their mental health and experience high levels of mental distress.

The Government has acknowledged the need to improve mental health care in prisons 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 inreach 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 be supported by primary care in the community.

In the summer of 2006 the Sainsbury Centre for Mental Health conducted a review of five prisons in the West Midlands to assess the provision of and need for mental health care. Each of the prisons was served by a well-established mental health inreach team. The review included interviews with 173 people who were either imprisoned in, worked in, managed, commissioned or provided services for the five prisons. Additional information was drawn from statistical data, audits of case notes and in the region of 150 hours of observing the daily routines within the five establishments.

This report primarily draws from the interviews and in particular from the conversations the Sainsbury Centre team had with 98 prisoners drawn from all five establishments. These interviews sought details of the prisoners' lives up to that point, including their history of offending, life in prison, use of mental health services and the problems they experienced both inside and outside prison. We also asked for their views on how a mental health service in a prison could meet their needs. For most, this was the first time they had been asked to share their experiences, concerns and views.

The prisoners interviewed included both males and females between 15 to 60 years. Some prisoners were remanded, others sentenced and some were facing lengthy sentences. They included people with histories of severe and enduring mental illness and others with more moderate mental health difficulties. Some were experiencing marked mental health problems at the time of the interview. But regardless of their mental wellbeing, their age, sentence status or gender, there was remarkable consistency about the nature of their needs and their experiences.

The five prisons were:

- A male young offenders institute (YOI) and juvenile unit serving sentenced and remanded young adults (18-21 years) and juveniles (15-17 years) with a total population of around 500;

- A semi-open women's resettlement prison with a small young offenders' unit and a total population of approximately 300;
- A contracted-out category B male training prison and its separate therapeutic community with a population over 800;
- Two male category C training prisons, each with over 600 inmates. One devotes half of its beds to *'vulnerable' prisoners'.

* A 'vulnerable' prisoner is one who would be vulnerable to abuse, exploitation and / or violent assault, if housed with the general prisoner population. Most commonly these are sexual offenders, those who have committed crimes against children, but also can include former police and prison officers, those with learning difficulty / disability, prisoners with marked mental illness and some offenders with personality disorders. These prisoners tend to be housed separately from the general prison population in a separate wing and movements from this wing will generally be coordinated to avoid contact with other prisoners.

The total population of the five prisons was almost 3,000 prisoners. The different categories of men's prisons currently in operation in England and Wales are shown in Box 1. Prisons for juveniles and women are not categorised in the same way but also vary in their purpose and security level.

**Box 1: Prison types and categories**

**Local prisons** are for unconvicted and short-term prisoners.

**High security** (formerly known as 'dispersal') prisons are for high security prisoners.

**Training prisons** are for long-term prisoners who do not need the highest security.

**Open prisons** are for prisoners not believed to be a risk to the public or in danger of escaping.

**Category A:** prisoners whose escape would be highly dangerous to the public, police or security of the State and for whom the aim must be to make escape impossible.

**Category B:** prisoners who do not need the highest conditions of security but for whom escape must be made very difficult.

**Category C:** prisoners who cannot be trusted in open conditions but who do not have the ability or resources to make a determined escape attempt.

**Category D:** prisoners who can reasonably be trusted to serve their sentences in open conditions.

Taken from the *Liberty Guide to Human Rights*

(http://www.yourrights.org.uk/your-rights/chapters/the-rights-of-prisoners/classification-and-categorisation/classification-categorisation-and-allocation.shtml)

## Interviews with prisoners and staff

The interviews took place over 300 hours. Around half this time was spent interviewing prisoners, all identified as having mental health problems but not all receiving any help with these.

It was intended that up to 20 prisoners from each prison (i.e. up to 100 in total) would be interviewed and that these would be a mix of those who had common mental health problems and severe / enduring mental health problems. In the event 98 interviews took place, 60 adult males (over the age of 21), 19 women and 19 young men and in each establishment around half were on mental health inreach team caseloads.

We also interviewed a range of other individuals through one-to-one and some group interviews. These included:

- Local primary care trust (PCT) commissioners;
- Senior and operational NHS trust managers;
- Senior local authority managers;
- Senior prison management and staff from each establishment (governors, health care managers, chaplains and other key prison staff including those who work in the residential and work / education areas of the prisons);
- Health care practitioners, including senior clinicians, nursing staff and primary care practitioners;
- Mental health staff working in prisons including: inreach team managers / leaders and staff, psychologists and psychiatrists;
- Non-statutory sector providers in the establishments.

Approximately 75 people took part in these interviews. It did not prove possible to include carers in this exercise.

The Sainsbury Centre guaranteed anonymity to all those it interviewed, providing that this did not contravene the law, individual safety or security. Additionally, we agreed with the local research ethics committee that we would not use any direct quotes from prisoners. This was to protect vulnerable individuals and to ensure that no individual prisoner could be identified from the material in this report.

## Non-participant observation

Observation had not been intended originally as one of the formal data collection methods. However, the research team had considerable opportunity to observe the day-to-day activities, running and management of all of the health care departments and to a lesser degree other parts of the prison such as segregation units and ordinary residential locations (prison wings). So early in the exercise, the research team began taking detailed notes of their observations.