

Mental health care in prisons[†]

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Over 200 years ago John Howard, the prison reformer, noted the very high number of people with mental illnesses in prison and the poor care they received there: 'many of the bridewells are crowded and offensive, because the rooms which were designed for prisoners are occupied by lunatics'; 'No care is taken of them, although it is probable that by medicines, and proper regimen, some of them might be restored to their senses, and usefulness in life' (Howard, 1784). The first full survey of the mental health of prisoners in England and Wales undertaken by the Office for National Statistics showed that psychiatric morbidity remains far more common among prisoners than among the general population (Singleton *et al*, 1998). Only one prisoner in ten showed no evidence of any mental disorder and no more than two out of ten had only one disorder. Ten per cent of men on remand and 14% of all female prisoners had shown signs of psychotic illness in the year prior to interview in prison compared with 0.4% in the general household population (Meltzer *et al*, 1994), and 59% of remanded men and 76% of remanded women had a neurotic disorder. Over a quarter of female remand prisoners reported attempting suicide in the preceding year and 2% of both male and female remand prisoners reported having attempted suicide in the week before interview. Fifty-eight per cent of men and 36% of women on remand met the criteria for previous hazardous drinking, and 66% of remanded women had misused drugs in the year prior to entry into prison. Comorbidity was the norm; seven out of ten prisoners had more than one disorder, and those with functional psychosis were likely to have three or four other disorders.

Reasons for this high prevalence are discussed by Reed (2002); they include higher risk of arrest for people with mental disorder alleged to have offended, inadequate coverage by court assessment schemes, too few National Health Service (NHS) psychiatric beds, and poor identification during reception into prison.

HEALTH CARE IN PRISONS

Earlier work by John Howard led in 1774 to the requirement for all prisons to appoint a surgeon or apothecary, and prisons can rightly claim to have the oldest civilian medical service. *Amour propre* flowing from this contributed to prison health care being omitted from the NHS at its establishment in 1948, but more recently the increasing involvement of the NHS in prison health care has culminated in an announcement that responsibility will be transferred to the Department of Health from April 2003, with primary care trusts becoming responsible for the commissioning and provision of health services to prisoners in their areas. This is welcome news.

Prison health care has aimed to provide a service broadly equivalent to that of the NHS in both scope and quality (Home Office, 1990), but despite good-quality care in some prisons – mainly smaller and long-term institutions – failure to achieve equivalence has been recorded in relation to both health care generally (Reed & Lyne, 1997) and mental health care in particular (Gunn *et al*, 1991; Health Advisory Committee for the Prison Service, 1997; Reed & Lyne, 2000).

Prison mental health care policy and practice

Neither staffing nor policy in prisons was geared to the provision of NHS equivalent care. Until June 1999, doctors recruited to work in prisons were required only to be

'registered medical practitioners' rather than having appropriate specialist training. A quarter of the nursing workforce comprises health care officers, many of whom have only limited nurse training. Reports on both prison nursing (Department of Health, 2000) and doctors working in prisons (Department of Health, 2001a) form a basis for matching staffing, in the long term, more closely to patient needs.

Health care workers in prisons have had little in the way of guidance on policy or practice in caring for prisoners with mental illnesses. A welcome consequence of the cooperation between the Department of Health and the Prison Service has been the publication for the first time of a strategy for mental health services in prison (Department of Health, 2001b), based on the National Service Framework for mental health. Equally welcome is the adaptation by Paton & Jenkins (2002) of the World Health Organization's guidelines on mental health in primary care, which, if effectively used throughout the Prison Service, would transform primary mental health care in prisons from its present low base.

Patients needing transfer to NHS mental health facilities

Earthrowl *et al* (2003, this issue) draw attention to a major problem facing prisons: the presence of many inmates with acute and severe mental illness who require NHS in-patient care but whose transfer cannot be arranged expeditiously. This is a problem which is, very largely, not caused by the prisons, and its solution rests more with the NHS than with the Prison Service. Some of these severely ill patients have not been identified by the prisons and are on general location in prison wings (Birmingham *et al*, 1998). Her Majesty's Inspectorate found one prisoner on general location, clearly experiencing hallucinations and delusions, who had not left his cell or washed for several weeks. Officers thought that he was 'acting up' to stay in his single cell. Even when a prisoner has been identified as being severely ill, care can be grossly inadequate – epitomised by a patient whom HM Inspectorate of Prisons found nursed in a health care centre with no furniture or bedding because the prison had 'run out of supplies'.

Transfers to the NHS of prisoners with serious mental illness are often delayed for months, or even years. A recent audit report (Isherwood & Parrott, 2002) confirms that

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lengthy delays continue despite increased numbers of transfers, and it remains to be seen what impact is produced by the recent requirement to report to the Department of Health delays of more than 3 months from acceptance. Consequently such patients accumulate in prison health care centres. One patient, HM Inspectorate found, was still waiting for admission to a high-security hospital 5 years after transfer had been recommended by a special hospital consultant. If the figures from an unpublished survey of in-patient units in prisons in West Midlands and Trent NHS regions (A. Reed, personal communication, 2002) are extrapolated nationwide, then there are likely to be up to 500 patients in prison health care centres sufficiently ill to require NHS admission.

Many reasons have been suggested for these delays. Reports of concern that the Home Office will insist on an inappropriate level of security in the NHS, a reluctance to accept those with dual diagnosis, or a fear that transferred prisoners bring a 'prison culture' with them, are anecdotal only and have never been raised with HM Inspectorate by prison staff and visiting psychiatrists. Rather, the principal problem causing delay in transfer reported to the Inspectorate is a shortage of secure psychiatric beds. A further reason given us for delay in transfer is a belief that, whatever the deficiencies in prison health care, patients with serious mental illnesses are safe in a prison health care centre. This is not true. Over 14% of all suicides in prison take place in the health care centre (HM Inspectorate of Prisons, 1999), and Dooley (1990) has shown that mental illness, as distinct from guilt at their offence or inability to cope with the pressures of imprisonment, was the main motivation for 22% of all those who committed suicide in prison. An unpublished Prison Service study of deaths in prison by suicide between January 1992 and October 1993 showed that three patients had committed suicide while awaiting transfer to NHS psychiatric care (M. Piper, personal communication, 2002).

Earthrowl *et al* (2003, this issue) propose a policy and protocol for extending treatment of non-consenting patients in prison beyond emergencies, and it has been suggested (Wilson & Forrester, 2002) that the current practice of restricting to emergencies the compulsory treatment of patients who do not consent may be based on a misunderstanding of common law.

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However, treatment without consent in prison means that patients would be given psychotropic medication while in the care of a service that is not staffed, trained or equipped to meet all their needs. For instance, they would not necessarily be under the care of a fully trained psychiatrist; nurses trained in mental health would be in the minority; multi-disciplinary care teams would virtually always not be in place; and staffing levels would make it likely that the patients would be locked in their rooms for by far the greater part of the day. One of the suggested revisions to mental health law would make such treatment legal, but would it make it ethical and compatible with human rights law?

Aside from these risks for individual patients, there is a real danger that if treatment without consent became common in prisons, the need to ensure that there were sufficient NHS psychiatric beds to allow prompt admission of all who needed in-patient care would slip even further down the priority list both of individual services and of the Department of Health.

HEALTH BENEFITS FROM ADMISSION TO PRISON

Admission to prison offers a unique opportunity to assess and to start to meet the health care needs of a population with high levels of physical and psychiatric morbidity, many of whom rarely come into contact with the NHS. Drug and alcohol problems can be addressed, blood-borne viral infections identified and treated, dental health improved, and mental health problems assessed and treatment started. However, prisons are not hospitals, and (unlike prisoners with serious physical illness) many prisoners with serious mental illnesses requiring NHS in-patient care remain in prison. A senior medical officer in prison summed up the situation neatly: 'I have always found it strange that a patient [in prison] suffering from a medical emergency can be in the nearby general hospital within 30 minutes, but if they are floridly psychotic it takes 30 days at least to find an appropriate disposal.'

DECLARATION OF INTEREST

None.

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