

## Grasping the nettle of mental illness in prisons

The UK Government has pledged to reduce prison numbers by diverting mentally ill individuals away from the criminal justice system and into the health-care system. Talha Burki reports.

In May, 2010, the number of prisoners in England and Wales stood at 84 982, an increase of 60% since 1995. Nowhere in western Europe jails more of its citizens, nor a higher proportion of its population.

Last month, Chancellor George Osborne announced the measures by which the UK Government aims to cut public spending by some £80 billion over the next 4 years. The Ministry of Justice has had its budget trimmed by about a quarter, in light of which it pledged to reduce prison numbers by 3000 by 2014. Part of this will be delivered by diverting mentally disordered individuals away from the criminal justice system into the health-care system, predominantly in the community, although some cases will require a secure ward. In fact, this is a policy supported by UK Governments dating back to the 1990s, but its implementation has been inconsistent and lacklustre. This looks likely to change. There is a cross-party consensus on the issue, commitment from the upper echelons of the Cabinet, and a forthcoming Health and Criminal Justice Programme, central to which is diversion.

"We need a system which takes out the people who shouldn't be in prison at the earliest possible time, and also provides better mental health support for those who are properly placed in the criminal justice system but who require some kind of health intervention", explains Louis Appleby, Clinical Director of the Health and Criminal Justice Programme. Diversion schemes work by assessing the mental health needs of offenders in custody or at court, and moving those with sufficiently pronounced mental disorders to services where their needs are adequately addressed. This could entail using the provisions of the Mental

Health Act (1983) to place them in a psychiatric hospital.

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"The Government committed in its Spending Review to look at options to invest in mental health liaison services at police stations and courts, which intervene at an early stage to divert offenders with mental health problems away from the justice system and into treatment", Care Services Minister Paul Burstow told *The Lancet*. There is evidence to suggest that this not only provides therapeutic benefit for the offender, but reduces rates of reoffending. A study commissioned by the Home Office found that offenders who had been diverted by the courts were reconvicted at about half the rate of prisoners who were released from prison, at 2 years after discharge.

Juliet Lyon (Prison Reform Trust, London, UK) talks of the growing network of community-based centres for female offenders. "They're

tremendously impressive, and they can demonstrate improvements in health and well-being and reductions in reoffending", she told *The Lancet*. "They're a better way to go than prison for the majority of non-violent female offenders." There has been a rapid increase in the number of female prisoners over the past decade or so and they now make up about 6% of the prison population, yet account for more than half the cases of self-harm. About 70% of female offenders need clinical detoxification when they enter custody.

In England and Wales, it is NHS Primary Care Trusts that commission health services for those incarcerated in the penal system. Internationally, this is uncommon: in most countries, responsibility lies with the Ministry of Justice or Interior Ministry, and in these departments prisoner health is not usually a priority. "The NHS taking responsibility is a great leap forward", affirms Ian Cummings, senior lecturer in social work at the University of Salford, Manchester, UK.

"There's no question that there have been vast improvements over the last few years", adds Andrew



The burden of mental illness in the prison population is extremely high

Forrester, forensic psychiatrist at HMP Brixton. The handover to the NHS was completed in 2006; a few years earlier the Department of Health agreed on the principle of equivalence: prisoners should receive the same quality of care as those in the outside community. The Safer Custody Initiative seems to be paying dividends, with suicides down by a third since 2004, although it is possibly too early to call this a trend, and in 2000, a network of mental health in-reach teams was established, initially conceived as roughly analogous to community mental health teams, with a remit to attend to prisoners with severe and enduring mental illness.

"They were swamped by the need they discovered", explains Forrester. The Bradley Report (2009), which forms the basis for the Health and Criminal Justice Programme, noted that the teams "have moved away from their original intention of serving those with serious mental illness...[they have] broadened to include a whole range of mental health problems, including those not receiving appropriate services from the treatment avenues".

There are few data for the burden of mental illness in the prison population, but the data that are available suggest that 66% of prisoners have a personality disorder, 45% are dependent on drugs, 30% dependent on alcohol, and 45% have a neurotic disorder. Perhaps 10% of prisoners have some form of psychosis. Between 20–30% of prisoners are thought to have a learning disability that adversely affects their ability to cope within the criminal justice system. Needless to say, the aforementioned data are several times higher than the equivalent values for the general public. Personality disorder, for example, affects 5–3% of the wider population. The Bradley Report goes on to say that 85% of in-reach team leaders asserted that they did not have the staff to meet the demand for their services.

"The health-care needs of prisoners are generally very high", explains Cummings. "People with mental health issues are often drawn into the criminal justice system, and once you're in, it's very difficult to get out". It's a longstanding problem. In 1780, English philanthropist John Howard bemoaned the fact that the country's prisons were full of "idiots and lunatics". Cummings cites Lionel Penrose's hypothesis that the prison population is inversely related to the number of available psychiatric beds. Lyon mentions that some courts elect to send an offender to prison if there are not sufficient community alternatives.

In the case of serious mental illness, things seem to be fairly straightforward, a matter of identifying these individuals and removing them to a psychiatric hospital. "No-one's saying prison is the right place for someone with psychosis", says Appleby. But the system does not always work. The Bradley Report states that the "vast majority of prisoners with serious mental illness are not identified by in-reach teams". Even after a prisoner is marked for transfer, "there's research showing that prisoners don't move in a timely manner", Forrester told *The Lancet*. "In London you might have to wait 90–100 days for a bed". If there's no treatment during this time, and prisons are not permitted to treat inmates under compulsion, then an individual's condition could worsen. There are cases in which a prisoner awaiting transfer has committed suicide.

"The prison environment has no therapeutic aims", points out Cummings. He adds that even if the prison population were halved, caregivers would still find it difficult to meet the mental health needs of those incarcerated. It is difficult to ensure continuity of care—prisoners are often suddenly moved to distant institutions—and, besides, security is the paramount consideration of the prison authorities.

"The single thing that would make the most difference is if police stations and courts had diversion and liaison schemes and ready access to a mental health nurse or team", said Lyon. The Bradley Report made a similar recommendation, stressing the importance of early intervention. If there is concern that a person under arrest might not have the mental capacity to comprehend his situation, the police are required to request the attendance of an "appropriate adult". This does not always happen, however, and even when it does there are often questions over the suitability of the chosen adult; the role can be fulfilled by volunteers rather than trained professionals. There have been cases in which the appropriate adults themselves have learning difficulties. All of which could serve to trap mentally ill individuals within the criminal justice system.

As things stand, there is huge variation in diversion services. "Our overall aim is to strengthen diversion nationally. We need to think about how it works best and look at how good the evidence is on making savings within the system", noted Appleby. He emphasises the importance of providing clinical justification for such services as well as the health economic benefits. Risk to the public will remain a key consideration, and it is individuals whose mental illness and substance abuse—dual diagnosis is very common—are fuelling low-level criminal behaviour who are likely to form the majority of those diverted.

"We're still very far from the Bradley model", cautions Forrester. He believes there is still discrimination against offenders within health care. "And we haven't even begun to have the debate on where best to spend the money" he said. "Why are we spending all this money after the event? Why not spend it on prevention, on children and adolescents who present with conduct disorder?"

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