Mental health care and treatment in prisons: a new paradigm to support best practice

Stone walls do not a prison make,
Nor iron bars a cage;
Minds innocent and quiet take
That for an hermitage.

R. Lovelace's 17th century poem *To Althea, from Prison* alludes to the ability of a "quiet" mind to transcend the imposition implied by institutions which deprive people of their liberty. But our prisons are not full of "minds innocent and quiet"; rather they are overloaded by minds troubled by the experience of mental illness[1]. There is a need to reach into prisons to address mental health needs, but "stone walls" and "iron bars" constitute barriers to this intent. Systems designed to care for and treat mental illness struggle in institutions designed to punish, deter and incapacitate.

Yet people are sent to prison *as* punishment, not *for* punishment, which requires us to understand how humane treatment can be delivered in such environments. The existence of various international human rights instruments (such as the International Covenant on Civil and Political Rights, and the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment) are necessary, but not sufficient by themselves, to ensure appropriate and humane care for some of the most vulnerable members of our citizenry[2].

Worldwide more than 10 million people are held in penal institutions at any given time and more than 30 million people pass through prisons each year, with some regions experiencing prison growth well above population growth. There is an elevated risk of all-cause mortality, including suicide, for prisoners in custody[3] and for ex-prisoners soon after release[4]. We therefore have a collective interest in ensuring that health related need is identified and effective care is delivered during incarceration and the critical period of transition to community life.

Research in this area has yielded increasing clarity about the central issues that need to be addressed to provide a comprehensive model of care for mentally unwell prisoners. First, the prison must screen for mental illness, at reception and at other critical times. At least five such screening instruments have been developed[5]. However, additional triage and case-finding measures are needed to ensure comprehensive case identification.

Once need is identified, hospital transfer may be required for the most unwell. Mental health legislation needs to accommodate such transfers. For others, prison-based care is often delivered through mental health in-reach teams, which have become increasingly systematic in creating care and treatment pathways for prisoners with serious mental illness, including contribution to release processes to enable sustained clinical involvement on release[6].

Systems of prison mental health care are not bereft of innovation. Multi-disciplinary teams can address complex mental health and social care needs and include cultural expertise in jurisdictions where indigenous populations or ethnic minorities are over-represented in prisoner populations[6]. Release planning constitutes an opportunity for "critical time intervention", focusing on ensuring continuity of care across a range of providers as the prisoner transitions through the gate[7]. The evidence for the success of such endeavours is gaining momentum, with indications of the positive impact of systematic prison in-reach models of care on detecting those requiring assistance[8] and improving post-release engagement with mental health services[4].

Modern prison outcomes are increasingly focused on reducing reoffending post release, and to this end we share a common purpose in the ultimate release of a rehabilitated prisoner whose mental health and addictions needs have been met. Yet, the pathway to this collective goal is far too often reliant on the goodwill of individual custodial staff or the ability of prison mental health in-reach teams to navigate the institutional barriers imposed when "safety and security" are prioritized over human suffering. Our social institutions are being challenged to re-think this siloed mentality. Whether change ultimately comes from legal challenges to human rights violations, or a pragmatic neoliberal emphasis on fiscal constraint, the shift is toward interagency collaboration. This is coupled with a person-centred approach with institutions re-focusing on the people they serve, rather than the self-perpetuating demands of the institution itself.

In courts, such transformation is spear-headed by the principles of "therapeutic jurisprudence", which invite legal systems to view their processes through a therapeutic lens. It is recognized that addictions, mental illness and social care needs (such as family support, housing and employment) are inextricably linked to rates of crime, to the extent that traditional adversarial courts have become revolving doors for offenders whose criminal behaviour arises from psychosocial challenges. The advent has been the proliferation of "solutions-focused" courts, which use the leverage of the legal process to encourage people to address the causes of offending and actively involve social agencies that can assist[9].

A paradigm shift is especially evident in youth justice custodial services. Research shows that justice-involved youth are exposed to high rates of trauma. Childhood physical, sexual and psychological abuse has negative consequences on subsequent life trajectories, leading to an increased likelihood of mental illness and ongoing involvement in the justice system[10]. Under a trauma-informed model of care, young people are held accountable for their offending behaviour, but all parties involved recognize and respond to the impact of trauma on

development, behaviour and identity. A trauma-informed model of care is one in which custodial services act in collaboration with families and wider social networks to facilitate and support the recovery and resilience of young people.

There are signs of change also in the adult corrections sector. Psychologically informed planned environments (PIPEs)[11] and therapeutic communities that target specific behaviours, such as drug and alcohol abuse and violent behaviour, are attempting to bridge gaps between therapy and custody. Rehabilitation has become a stronger emphasis in many prisons, with some approaches using the therapeutic alliance and recognition of strengths to bring about "recovery" to offenders. Yet, what is lacking is a penal paradigm that articulates the integration of therapy and custody. If a punishment paradigm is allowed to prevail, more damage is inevitable – to individual prisoners, to their family and loved ones, and to the communities from which they have come and to which they return on release.

The collective challenge for all stakeholders is to help transform toxic penal environments into true recovery opportunities. In this endeavour, there may be much to borrow from the way in which some secure forensic hospitals have blended care and custodial drivers to promote the recovery of this most vulnerable part of our community.

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