SAINSBURY CENTRE
for MENTAL HEALTH

removing barriers achieving change

39: Mental health care and the criminal justice system

Summary

The population in custody has soared in the last decade and a significant proportion of those who end up in the criminal justice system have a mental health problem.

Responsibility for prison health care lies with the NHS. It aims to give prisoners access to the same quality and range of health services as the general public receives in the community. This is an enormous challenge. Many prisoners have a combination of mental health problems, substance misuse and personality disorder, as well as a range of other issues to deal with.

Overcrowding and a lack of staff skilled in identifying and managing mental health problems are major problems that need to be addressed. There is growing evidence that prisons are not effective at reducing offending and that the costs, both financial and social, of containing people in prison without access to appropriate health care are too high.

The resettlement experience of most prisoners is poor with most receiving little meaningful help on leaving prison. It is vital that, upon leaving prison, people are well supported and linked in to community services and that support is available in the community.

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

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Mental health in prisons

England and Wales together have one of the highest rates of imprisonment in Western Europe. In May 2009, 82,900 people were in prison (MoJ, 2009a) and this is forecast to rise to over 100,000 by 2014 (Carter, 2007).

Up to 90% of prisoners have some form of mental health problem (Singleton *et al.*, 1998) and 10% of male and 30% of female prisoners have previously experienced a psychiatric acute admission to hospital (DH, 2007).

Most prisoners with mental health problems have common conditions, such as depression or anxiety. A smaller number have more severe conditions such as psychosis. Figure 1 shows the prevalence of mental health problems in prisons compared to the general population.

Rates of self harm and attempted suicide in prison are high. A total of 61 prison suicides (MoJ, 2009b) and 23,026 self-harm incidents (House of Commons, 2009a) were recorded in 2008. Women represent 5% of the prison population, but account for over half of all reported self-harm incidents (HMIP, 2009).

Not everyone enters prison with a mental health problem: for some, being in prison will lead them to develop depression or anxiety (JCHR, 2004).

Ethnicity

People from Black and minority ethnic (BME) communities represent about 10% of the UK population (ONS, 2001) but in prison this rises to 26%, a significant proportion of whom are foreign nationals (MoJ, 2008). There are high rates of suicide among foreign nationals: 25% of all prison suicides in 2007/8 (HMIP, 2009). Some Black communities are also over-represented in secure mental health forensic hospitals (Rutherford & Duggan, 2007). While the rate of diagnosed mental health problems in prison is lower in BME people than among the white population, this may reflect lower levels of identification and referral (Durcan & Knowles, 2006).

Women

Of the 82,900 people in prison on 31 May 2009, 4,300 were females (MoJ, 2009a). A study of 500 women prisoners found that "women in custody are five times more likely to have a mental health concern than women in the general population" (University of Oxford, cited in Prison Reform Trust, 2008).

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 recommended completely replacing the women's prison estate and creating better alternatives (Home Office, 2007).

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

	Prevalence among prisoners (16 years+)	Prevalence in general population (16-64 years)
Psychosis	8%	0.5%
Personality disorder	66%	5.3%
Depression, anxiety etc	45%	13.8%
Drug dependency	45%	5.2%
Alcohol dependency	30%	11.5%
	Source: Singleton *et al.* (1998)	Source: Singleton *et al.* (2000)

Young people

At the end of May 2009, there were 2,100 young people aged 15-17 years and 9,600 aged 18-21 years in custody (MoJ, 2009a). The majority are held in Young Offender Institutions.

Young people in custody have an even greater prevalence of poor mental health, with 95% of 16 to 20 year olds having at least one mental health problem and 80% having more than one (Lader *et al.*, 2000). Few have any qualifications with up to three-quarters having experienced exclusion from school (Harrington & Bailey, 2005).

Many young people had traumatic experiences, such as bereavement, sexual abuse or violence in the home, prior to their incarceration. Young males are 18 times more likely to commit suicide in custody than in the community (Prison Reform Trust, 2007).

Imprisonment for Public Protection (IPP)

On 30 April 2009, there were 5,246 prisoners subject to the indeterminate sentence of Imprisonment for Public Protection (IPP). One hundred and four IPP prisoners were being detained in secure psychiatric hospitals (House of Commons, 2009b).

IPP is an 'indeterminate' sentence given to offenders who are identified by the courts as 'dangerous' but whose offences do not carry a life sentence. The Government forecasts that the number of IPP prisoners will rise to 12,000 by 2014 (MoJ, 2007).

Levels of mental illness and complex need are far higher among IPP prisoners than among the general prison population. Nearly one in five IPP prisoners has previously received mental health treatment, while one in ten is receiving mental health treatment in prison and one in five is on mental health medication.

IPP prisoners must often complete a number of Offender Behaviour Programmes in order to be considered eligible for release. There is evidence that prisoners whom staff consider to be unsuitable to participate because of mental illness or emotional instability are often excluded from taking part in these programmes (Sainsbury Centre, 2008a).

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 (SEU, 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 (SEU, 2002).

It is estimated that being in work reduces the risk of re-offending by between a third and a half (SEU, 2002). But 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.

There is anecdotal evidence that some prisoners with mental health problems are particularly disadvantaged as they are being excluded from employment resettlement programmes in prison.

Mental health care in prison

Responsibility for prison health care was fully transferred from HM Prison Service to the NHS in April 2006. The Government 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" (DH & HMPS, 2001).

Inreach teams

Specialist mental health inreach teams were introduced to work with prisoners with severe and enduring mental illnesses. This has led to an improvement in mental health care in some prisons (Durcan, 2008) but the picture is mixed. Recent evidence suggests that there are wide regional variations in funding for inreach services and that overall funding is no more than one-third of what is needed to offer an equivalent service to that available outside prison (Sainsbury Centre, 2008b).

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

There has been no implementation guidance for inreach teams or for 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 allied health professionals, most teams are mainly made up of nurses, with varying degrees of medical support.

The role of inreach teams is often restricted by frequent movement within the prison population. On average there were more than 6,000 inter-prison transfers per month between April 2007 and February 2008 (House of Commons, 2008).

The range of interventions offered by inreach teams can often be very limited. Teams in London reported that their work was restricted to assessment, mental health monitoring and medication management, but with considerable effort going into liaison with services outside the prison (Durcan & Knowles, 2006). But a study of five prisons in the West Midlands found that prisoners using inreach services felt better prepared for their release than on previous occasions (Durcan, 2008).

Identifying mental health problems

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 undergo multiple assessments, with considerable overlap between each.

Most inreach teams are not involved in the medical screening of new arrivals to prison. In some prisons a mental health nurse carries out this screening but in many cases it is done by staff who do not have mental health training (Edgar & Rickford, 2009).

Reception itself can be a chaotic process in which large numbers of people arrive at one time. Records of previous mental health care often do not accompany prisoners when they are transferred from other prisons. As a result, prisoners with mental health problems have often not been identified at this crucial time (Durcan, 2008).

Transfer to NHS care

Some prisons have 24-hour health care facilities which include inpatient units. These can be used for any medical need, but their use tends to be dominated by prisoners with mental health problems. There is also evidence that some prisoners with serious mental health problems are placed in segregation units, because 'ordinary location' is considered to be too stressful (Edgar & Rickford, 2009; Durcan, 2008).

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.

The population in secure adult forensic hospitals reached 3,906 in December 2007 (MoJ, 2009c). Transfer from prison to a secure hospital is often a very slow process. The Government instigated a pilot project to bring waiting times down to 14 days, but often it takes several months for a transfer to take place. The Government-commissioned Bradley Report has recently called for this waiting time limit to be applied nationally.

Primary mental health care

Primary care for prisoners with common mental health problems such as depression, anxiety, emotional distress and adjustment problems is variable (Prison Health APPG, 2006). Many prisoners have experienced trauma and abuse (Durcan, 2008) and need psychological therapy.

Some prisons are served by prison doctors and others by a local GP practice. While a majority of prison doctors work with prisoners with mental health problems, most do not receive any training in psychiatry (Pearce *et al.*, 2004). 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.

Sainsbury Centre recommends that each prison be given its own GP practice and a national body be established to monitor standards. Clearer incentives should also be given to practices outside prison to improve care for former prisoners (Sainsbury Centre, 2007).

Dual diagnosis

It is estimated that a large proportion of prisoners have both mental health and substance misuse problems (Brooker *et al.*, 2002). However, there is big gap in 'dual diagnosis' services in prisons. Up to 70% of inreach team clients have substance misuse needs, but only around one in ten teams has a specialist dual diagnosis service (HMIP, 2009).

There are poor links between substance misuse services, such as Counselling, Assessment, Referral, Advice and Throughcare (CARAT) teams, and mental health services in prisons. They often refer prisoners onto each other, rather than seeking to work together (Durcan & Knowles, 2006; Durcan, 2008). The Integrated Drug Treatment System (IDTS) is being rolled out across prisons to improve the quality of substance misuse treatment. It is unclear at this point whether it will help to create a more integrated service for people with both mental health and substance misuse problems.

Nearly one in five of the men entering local prisons admits to having an alcohol problem. The provision of alcohol services in adult prisons is variable: some have appointed dedicated alcohol workers, but most CARAT teams do not work with prisoners who have alcohol problems unless they also use street drugs (HMIP, 2009).

Personality disorders

It is estimated that 66% of prisoners have a personality disorder (Singleton et al., 1998). Personality disorders are not classed as mental illness but are described by psychiatrists as aspects of an individual's personality that make it difficult for them to live with themselves or other people. The majority of prisoners with personality disorder receive little in the way of support targeted to their needs (Durcan, 2008).

Alternatives to imprisonment

Custody and court diversion schemes were introduced to ensure that people with mental health problems who come into contact with the police and courts are identified and directed towards more appropriate care. There is evidence that where such services are working well they can be effective (Nacro, 2005; Sainsbury Centre, 2009a), but too often they are unable to have a major impact on the system.

Diversion

In the absence of a clear national policy framework, diversion services have developed piecemeal. Many schemes are insecurely funded. Some areas have no diversion arrangements at all. Others have only minimal coverage (Healthcare Commission / HMIP, 2009). It is estimated that just one-fifth of the potential national caseload is seen and even cases of severe mental illness are often missed because many schemes rely on police or court staff to identify individuals who may need support (Sainsbury Centre, 2009a).

Around 15% of incidents with which the police deal have some kind of mental health dimension. Yet police officers rarely have mental health training and there are few opportunities to divert people from police stations to health and social care services (Bather, Fitzpatrick & Rutherford, 2008). In 2009 work began in six Department of Health pilot sites to see how children and young people with mental health, learning disabilities and other difficulties such as family conflict, homelessness or drug and alcohol misuse can get the help they need as soon as they come into contact with the police.

The Bradley Report has called for criminal justice mental health teams to be set up across England to divert people from police stations and courts to more appropriate care (Bradley, 2009).

Community sentences

For people with mental health problems who cannot be entirely diverted away from a criminal justice sanction, a community sentence with a Mental Health Treatment Requirement (MHTR) can be a viable alternative to a short prison sentence. At present it is little used by the

courts because it is poorly understood, subject to lengthy delays and there is no procedure for ensuring that support is available from local community mental health services (Sainsbury Centre, 2009b).

There is a particularly strong case for diverting offenders away from short sentences in prison towards effective treatment in the community. It is estimated that this will lead to savings in crime-related costs of over £20,000 per case (Sainsbury Centre, 2009a).

Care after release

The resettlement experience of most prisoners is poor with most receiving little meaningful help on leaving prison. Prisoners with mental health problems are particularly vulnerable. Many have no permanent residence arranged on release which makes it harder for them to keep in touch with services (Sainsbury Centre, 2008c).

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

There is poor continuity of care both into and out of prison (Sainsbury, 2008c). The Government proposes that all prisoners with severe and enduring mental health problems should be linked into the care programme approach (CPA) system, which is used for planning care in the community, but there are reports that community mental health services are reluctant to accept responsibility for released prisoners (Sainsbury Centre, 2008b; Durcan & Knowles, 2006).

Conclusion

The introduction of mental health inreach teams has led to an improvement in mental health care in some prisons but the picture is mixed. There is still little provision for the vast majority of prisoners who have common mental health problems such as depression and other

problems normally supported by primary care outside prison. Many opportunities to divert offenders with mental health problems to more appropriate care in the community are being missed. Too little is being done to help released prisoners to make continuing use of community mental health services.

There is an urgent need to improve mental health care for all offenders. People with mental health problems need to have access to mental health treatment and support at all stages of the criminal justice system. This can be achieved by better services in the community to stop people being imprisoned, where there are safe alternatives outside prison, and investment in improved prison mental health care.

The Bradley Report has set the Government an ambitious agenda to make these improvements. We believe that if the report's recommendations are implemented in full, they will go a long way to improve the health of a very disadvantaged group of people, to make communities safer and to save significant sums of public money.

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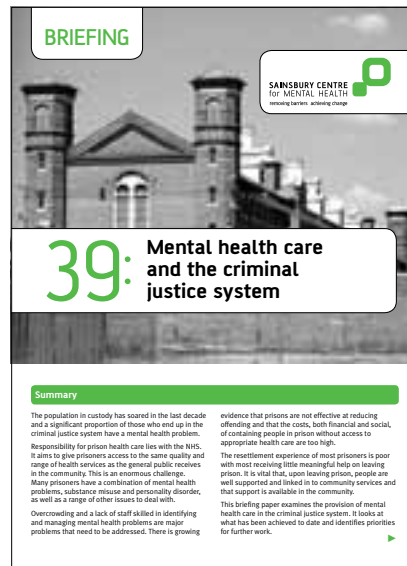
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