



HM CHIEF INSPECTOR OF PRISONS FOR SCOTLAND

Out of Sight

Severe and Enduring Mental Health Problems in Scotland's Prisons

SUMMARY OF MAIN FINDINGS

FOCUS

1. This was a thematic inspection focusing on “severe and enduring” mental health problems of prisoners in Scotland. This includes prisoners with a formal diagnosis of a severe and enduring mental health problem, and those who have not been diagnosed, but whose behaviour indicates that they experience such problems, or who suffer substantial disability as a result of their problems.
2. Examples of the types of behaviour covered by the inspection include substantial confusion or depression; inability to make informed, consistent decisions, or to cope independently; inability to sustain relationships; and behaviour which poses a significant risk of injury to self or others (including self-neglect).

AIMS

3. The aims of the inspection were to examine:
 - The scale of severe and enduring mental health problems in Scotland.
 - The processes involved.
 - The impact on the prison.
 - Issues on release.
 - Prison-based and community interventions.
 - Reasons for use of prison for people with severe mental health problems.

FINDINGS

Prevalence

4. A very large proportion of prisoners have some form of mental health problem. Of these, only a small proportion have severe and enduring mental health problems. At least 315 prisoners with severe and enduring mental health issues were identified by prisons (not counting Polmont). A further eight prisoners were identified who were, at the time, undergoing assessment in a hospitality facility. Excluding Polmont, this represents around 4.5% of all prisoners. This is a much higher proportion than in the population as a whole.
5. The number of prisoners with severe and enduring mental health problems appears to be rising, although it was not clear if the numbers themselves are increasing, or if the visibility of mental health problems is increasing. Whatever the reason for the changing patterns, there is an increasing requirement for prisons to respond to these issues.
6. The most common types of severe and enduring mental health problems in Scottish prisons are schizophrenia and bi-polar affective disorder. There is also a significant number of prisoners with a personality disorder. The majority of prisoners with mental health problems also have substance misuse issues.

Impact

7. Prisoners with severe and enduring mental health problems have an impact on the general running of an establishment, with this group seen as being both resource-intensive and a cause of disruption. There is also an impact on prison staff, in terms of the physical and emotional demands of being required to manage difficult behaviour and respond to complex needs. This is exacerbated by a lack of training and guidance.

8. The impact on other prisoners is general disruption; disproportionate use of staff time; less access to facilities; and a charged atmosphere.

9. The fact and nature of imprisonment itself does real harm to people with severe and enduring mental health problems.

10. These impacts are exacerbated by overcrowding.

Identification

11. Reception and induction processes can provide the first opportunity to identify mental health needs. During a sentence, the main ways of identifying mental health problems are through observation by prison staff, other workers, prisoners, and through self-referral.

12. There are a number of gaps in the identification of mental health problems and needs. These include: problems with the transfer of information from courts and the community; difficulties for prisoners in disclosing issues; problems with processes and operational issues; and problems with staff being able to identify issues. These difficulties can mean that some prisoners with severe and enduring mental health problems may not access assessment and referral.

Treatment, Interventions and Support

13. Once prisoners have been identified as having severe and enduring mental health problems which do not require transfer to hospital, the treatment which they receive in prisons generally includes: medication; access to a psychiatrist; and input from a mental health nurse. There was little evidence of input from community-based mental health and other relevant organisations focusing on mental health during sentences.

14. Segregation units and separate cells are used at times, with difficulties faced in making distinctions between mental health and behavioural or management problems.

The use of segregation as a response to mental illness is wrong. Mechanical restraints are used very rarely in prison and are never used in hospitals.

15. There has been a growing emphasis generally on the involvement of prisoners in identifying their own needs and participating in their own care, but this remains limited and variable.

16. The provision of advocacy support varies. In some prisons, there was no provision, or it was virtually non-existent. Prisoners generally had no awareness of their right to access advocacy support under the Mental Health (Care and Treatment) (Scotland) Act 2003.

17. The issue of transfer between prisons can impact upon treatment, intervention and support, and most prisoners would not be transferred to another prison solely on the basis of their difficult behaviour.

18. A number of concerns were expressed with aspects of existing provision including variations and gaps in practice and treatment; issues with medication; issues with the use of segregation; a lack of an holistic approach; a lack of day care facilities; a lack of "talking treatments"; the removal of in-patient facilities; and issues relating to overcrowding, staffing, information and other resources.

Referral, Assessment and Transfer to Hospital

19. Prisoners diagnosed with severe and enduring mental illness and requiring transfer to hospital may wait longer than similar people in the community.

- 20.** The referral, assessment and transfer processes are generally appropriate. However, a small number of issues were identified relating to referral – some to the assessment, diagnosis or admission of prisoners for assessment in prison; difficulties in diagnosis; some tension and variation in views of the appropriate level of security for some patients; and some issues related to the transfer process such as a lack of information and practical difficulties such as the provision of nurse escorts and timing of delivery of prisoners to hospitals.
- 21.** In most hospitals, the number of prisoners forms a very small proportion of the total number of patients, although this is larger in the medium and high secure facilities. These patients have access to a range of treatment, interventions and support, which are generally the same as that available to any other patient, but in the main are not available in prisons.
- 22.** Hospitals generally are clear that patients would be involved in identifying their needs and planning their care. Unlike prison, advocacy is available in all of the hospitals visited, and some hospitals have an advocacy service on-site.

Preparation for Release and Release to the Community

- 23.** Prisoners face a range of issues prior to release, and accessing support is very important. Some work is being carried out in prisons to assist prisoners in preparing for their release and in accessing support, but the nature of this varies, particularly in relation to the level of formalised planning undertaken. A more systematic, formal, process for making arrangements to prepare people for return to the community and to ensure that their care continues is in place in hospitals. This generally involves a relatively formal discharge planning process, which includes relevant staff in identifying all of a patient's needs.

- 24.** In many cases, prisoners being released from prison have to approach organisations in the community at their own instigation, with limited external support available, although a small number of initiatives were identified.

25. Some prisoners with severe and enduring mental health problems are released from prison with few if any links to continuing support in the community, and without any arrangements for the continuation of any work which had started in prison.

- 26.** There are some specific gaps in preparation for release such as a lack of focus on throughcare specifically for prisoners with severe and enduring mental health problems and the lack of an holistic approach. Some prisoners do not engage with pre- and post-release planning, in some cases arising from a fear that disclosure of needs may delay their release date.

27. There is a number of perceived difficulties in securing access to services upon release, such as GP services, hospital services, housing services, and issues for some specific groups. There are difficulties in gaining access to an in-patient bed when this is required. There are also issues relating to geographical variations and capacity of services, as well as a lack of communication between agencies.

- 28.** Some of the problems experienced on release relate to aspects of prisoners' lives in the community: chaotic lifestyles; drug and alcohol use; lack of access to economic and social participation; and stigma. These may also impact on their likelihood of being able to access support services.

Resources

- 29.** The level and nature of health care staff, and particularly mental health specialist staff varies widely across prisons. Generally, nursing teams are available on a weekly basis, although there is little or no mental health nursing cover on-site overnight or at weekends.
- 30.** Some prisons have a psychologist in post, some do not. Psychologists are more likely to work on programmes than directly with prisoners with severe and enduring mental health problems. Most prisons have access to a psychiatrist, although for a relatively small number of hours.

31. Overall, there is concern about the level of specialist staffing resources available, the number of competing priorities, and the extent to which existing arrangements have sufficient resilience to cope with, for example, a member of staff leaving, or periods of sickness.

32. In all prisons, residential and operational staff have a less well-defined, but still important, and increasing role, to play in relation to prisoners with severe and enduring mental health problems. A number of concerns were raised that staff: lack specific training; may lack confidence; may feel that they have not had sufficient guidance; may have insufficient time to interact with prisoners; and may lack information about the prisoners' problems and the impact of any steps they take in working with them.

33. Health care beds have been phased out in virtually all prisons, which has given rise to concerns both within prisons, and among NHS staff. This means that more prisoners who might have been located in these beds are now located in halls, and it makes observation of their behaviour more difficult. Some of the conditions in which interviews and assessments have to take place are inappropriate.

Joint Working

- 34.** The main mechanism for joint working within the prison is the Multi Disciplinary Mental Health Team.
- 35.** Relationships between hospitals and prisons largely relate to the transfer of individual prisoners. There are also examples of joint working groups of which both prison and NHS staff are members. Generally, relationships are good, although in some cases, it is clear that, at least in part, these could be more effective. There are examples of a lack of understanding of each other's roles and constraints. Some psychiatrists considered that they were not afforded sufficient cooperation, or adequate facilities, by some prisons.
- 36.** There are few difficulties relating to sharing information about prisoners on transfer to hospital, in part because hospital based psychiatrists may be involved with the prisoner prior to transfer, in some cases for an extended period, and do not, therefore, require access to case notes.

IMPROVEMENTS IN RECENT YEARS

37. There is some positive work taking place with prisoners with severe and enduring mental health problems, despite some of the difficulties and constraints. There have been developments to the services available in prisons, in terms of the basic care provided, the overall approach to mental health, and conditions for prisoners. There have also been changes in local and regional secure mental health facilities, in terms of the composition of the overall forensic estate.

38. Progress has been made in terms of throughcare, and in the development of improved communication with external organisations.

39. The level of understanding of mental health issues in prisons has increased, and the knowledge and awareness amongst some officers has also increased.

40. The stigma associated with mental health problems has reduced, both inside and outside prison, but it still remains a major problem.

The Use of Prison

41. Prison is not the most appropriate environment for people with severe and enduring mental health problems. Their primary need is their mental health and the appropriate place to address this is in a hospital.



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