

UNMET MENTAL HEALTH NEEDS IN PRISON:

A report based on a survey of Independent Monitoring Boards
in England and Wales

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There is no more distressing a mismatch in our criminal justice system than mental illness and prison. Would anybody prescribe for a mentally ill person the kind of environment that a prison needs to be, let alone the kind of environment that actually exists in our oldest and most unsuitable prisons? Yet this mismatch is what tens of thousands of prisoners experience.

Peter Selby

President of the National Council for Independent Monitoring Boards

In June 2008, the Prison Reform Trust worked with the National Council for Independent Monitoring Boards to gather members' views on mental health in prisons. This report builds on their uniquely independent perspective to reveal the extent to which mental health needs in prison are being neglected.

In September 2008, Michael Spurr, Operational Head of HM Prison Service, told Today that 10% of the prison population was seriously mentally ill. The scale of the problem indicates a failure of care in the community and a breakdown of court diversion schemes.

Of the 41 boards who provided information about diversion, over half felt that they frequently saw prisoners who were too ill to be in prison.

Other prisoners have a history of enduring mental illness and engage in persistent, low-level offending. There is evidence that it would be far more effective to refer them to mental health support in the community. People with learning disabilities should be referred to social care services.

Many prisons lack the resources they would need to conduct full psychiatric assessments of those they receive. Boards observed that when mentally ill people first arrive in custody, there is often a lack of information about their medical history accompanying them. As a result, assessments frequently have to rely on the prisoner's own accounts. Further, too few prisons can draw on the expertise of specialist trained staff who can accurately assess mental health problems.

When sent to prison, many people who have serious mental illnesses end up on segregation units, because normal location is far too stressful. This means that they are subjected to an impoverished regime, as one board chair wrote.

I have become increasingly concerned at the number of prisoners with mental health problems who are being moved from one Segregation Unit to another either because they are not suitable for normal location or because they refuse to locate anywhere except the "Block".

Dealing with seriously mentally ill prisoners places intolerable strains on prison staff, who often lack relevant training. Although wing staff do their best to work with mentally ill prisoners, they often lack basic knowledge about mental illness and cannot provide the appropriate care.

From the IMB's point of view, every board member could give numerous examples of prisoners that we have met during applications, during the IMB Induction talk, during observations of adjudications etc, where we felt that the prisoner had some type of mental health issue. We normally do not know if that prisoner is receiving treatment, but our feeling is that there is a problem here which is larger than current clinical definitions embrace.

In theory, prisoners who are identified as seriously mentally ill should be promptly transferred to appropriate NHS care. Just over half of the chairs of IMBs who responded stated that they were aware of serious delays in arranging for transfers.

IMB chairs also reported concerns about the number of prisoners with learning disabilities who face a more restrictive regime.

Learning disabilities pose a great challenge to wing and other staff and mental health needs may not be detected in the general run of the prison. As board members we are not automatically informed of people with such needs.

Many prisons lack any means of identifying people who have learning disabilities, and often their disabilities restrict their capacity to engage fully with the regime.

The principle of equivalence, to which the government is committed, holds that people in prison should have access to an equal standard of healthcare as the community. The shift of prison healthcare to Primary Care Trusts has improved the service, but there is still a huge gap between the resources and the levels of need for mental healthcare. Only one in six of the IMBs rated the resources available for mental health care in their prison as good or adequate.

There remains an underlying and unresolved ethical dilemma about holding people with mental health illnesses in closed conditions, where providing treatment and support for them, which is similar to that available in the community, is almost impossible.

The survey also gathered evidence that the needs of particular groups were not receiving adequate attention. For example, the mental health problems of older prisoners are sometimes overlooked.

This board is concerned that elderly prisoners with complex mental health and physical needs are being held in the Healthcare Centre of the prison which has neither the appropriate facilities and equipment nor sufficiently trained staff to respond to their needs.

Other boards described the harm done to women with mental health problems when they are sent to prison. Even a short time inside can exacerbate a woman's social circumstances. If abuse, self-harm, or depression is linked to her offending, it is very likely that her condition will worsen while she is inside. The Corston report made a powerful case for a drastic reduction in the numbers of women sent to prison. While the Government has accepted 40 of 43 of Baroness Corston's recommendations, implementation remains slow.

The co-ordination required between services for substance misusers and mental health in-reach teams is often poor, with the consequence that people with mental ill health and drug problems are often not provided with an integrated service.

Of the 57 boards who provided information, not one stated that families were always involved in decisions about mental health care as a matter of principle. One chair spoke for many boards in stating that families were 'peripheral' to decision-making about a prisoner's mental health.

Prisoners with mental health needs often face a combination of problems after release. They might need a tailored package of accommodation, drug misuse services, health care and support for physical and mental illness, and social services. When vulnerable people are released from prison with no after-care arrangements in place, the predictable outcome is that the person is often returned to face a subsequent prison sentence. Fewer than one in five boards felt that their prison made links with support in the community in good time prior to release to provide continuity of mental health care.

Remanded prisoners who were released directly from court were particularly likely to fall through the net. It appears that many people in this situation were released with no mental health plan, no support, and no links set up.

The IMBs described a range of measures taken in prisons to work more effectively with people who have a mental illness:

In HMP Holloway, a multi-disciplinary Learning Disability Steering Group had been formed and had developed an action plan.

In HMP Stafford the HOPIN (Help Other Prisoners In Need) service, enables experienced prisoners to help other prisoners in a whole range of areas both at induction and during their time on the wings.

At HMP Chelmsford, a multi-agency group draws up a mental health pathway to structure the interventions and key links for prisoners with mental health needs, from reception into prison to care and support after release.

In HMP Channings Wood, a project set up by Mind, provides help to prisoners whose mental health needs fall below the eligibility criteria for secondary care.

HMP Dorchester, a multi-agency team prepares for the release of prisoners, to ensure they have continuous GP care, access to housing support, and mental health care.

Recommendations

Examining the wide-ranging evidence provided by these boards, the Prison Reform Trust recommends:

- The Equality and Human Rights Commission should investigate compliance with the Disability Discrimination Act (DDA) by all criminal justice services. NOMS should also initiate an internal review of compliance with the DDA. Work to comply fully with the DDA would highlight the need for far more efficient mechanisms for diverting mentally ill people from the criminal justice system.
- The new Care Quality Commission should monitor the extent to which equivalence in mental health care is being achieved in prisons. This could be conducted jointly with the Inspectorate of Prisons.

Diversion

- A national network of court and police diversion and liaison schemes should be established, with performance targets and sustainable funding.
- Police, court officials, and magistrates should have regular training in understanding mental illness and learning disabilities.

- Local mental health and social care services should be required to provide full and current information to courts about the resources and services in their areas.
- The ‘appropriate adult’ in police stations and courts must be fully resourced so that they can work with duty social workers to facilitate referrals to mental health services and social care.

Transfers out of prison under the Mental Health Act

- Under current policy (DOH Guidance 2007 page 7), when a prisoner is assessed as needing a transfer and is then moved to a different prison, they must be re-assessed before the transfer can take place. The policy causes unnecessary delay and should be reviewed.
- A more efficient structure is needed to resolve disputes between Primary Care Trusts (PCTs) over which is the responsible commissioner for a prisoner’s mental health care.

Treatment of mentally ill people in prison

- Every prison should have learning disability specialists, providing a better assessment service, improved conditions and treatment, and follow-up support.
- When prisoners do not attend mental health care appointments, reasons for non-attendance should be rigorously explored, and then remedied.
- The Prison Service Order on segregation (1700) which permits the use of segregation for people at risk of self-harm ‘in exceptional circumstances’ should be tightened to eliminate the current over-use of segregation units for prisoners with serious mental health problems.
- Patient involvement, and engaging prisoners’ families in treatment planning, should be high priorities for mental health inreach services.
- Every prison should expand its links to voluntary organisations outside, in particular, with black and minority ethnic groups. Mental health inreach teams should also ensure that they maintain links with the PCT’s community development workers.

- Performance measures and standards should be introduced to assess PCTs on the adequacy of prison mental health care.
- Each prison should have a full complement of staff in mental health teams equivalent to the norms that would apply in the community for the prevalence and caseload of psychiatric morbidity.

Resettlement

- More should be done to provide specialist mental health and social support for people released on licence to ensure that will not be returned to prison for breaching their conditions.
- Prison resettlement units and probation staff should alert local authorities to their duties to assess the needs of vulnerable prisoners at an early stage well before they are released from prison. Prison Service Orders give guidance on this but need to be reinforced by training and support for prison officers acting as advocates for vulnerable prisoners.
- Prior to release, arrangements should be made for any prisoner needing continuing mental health care to establish registration

with a GP, suitable accommodation, and a commitment from the relevant local mental health care services to provide support.

- Under current rules of residence, prisoners with mental health needs eligible for the care programme approach are not the responsibility of their 'home' PCT until they are released. When prisoners are held away from their home area, any care planning that occurs will be carried out by the area in which the prison is situated. The result can be delay and confusion and often no support for prisoner released with mental health problems. Guidance on the rules of residence need to be clarified to ensure that support services, to which vulnerable prisoners are legally entitled, are provided in a timely way.