

Prison mental health: vision and reality



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Introduction

It is now almost a decade since the government introduced the principle of 'equivalence' into prison health care in England and Wales and set the stage for the NHS to take responsibility for achieving it (DH, 2001).

The principle of equivalence means that prisoners should receive the same quality of care for their health as they would receive outside prison. It does not mean that health care will be identical to that outside but that services will aim to achieve the same quality of care as the prisoner receives elsewhere.

The need for better mental health care in prisons has been evident for some time. Reports throughout the last two decades have shown that prisoners have dramatically higher rates of the whole range of mental health problems compared to the general population. Not only is prison itself a risk factor for emotional distress but the prison population is comprised disproportionately of people from disadvantaged backgrounds with a history of trauma, loss and low resilience to distress (Durcan, 2008).

With high levels of mental ill health in prison, the last decade has witnessed the creation of new inreach teams in every establishment in England. These new teams were designed to be broadly equivalent to the community mental health teams that operate outside and to incorporate within them the outreach and crisis resolution functions of the specialist teams that were set up across the

country following the publication of the National Service Framework for Mental Health (DH, 1999).

This publication aims to examine what has been achieved in prison mental health over recent years from a number of different personal perspectives and individual observations of working in England. It looks at the specific achievements of inreach teams and of efforts to divert offenders from custody. It also looks more broadly at the rapid growth of the prison population during the same period and the treatment of offenders with mental health problems outside as well as inside prison.

Louis Appleby sets out the principles that should underpin offender mental health policy and practice and examines how far we have travelled in the last decade towards those ends. He concludes that the health and criminal justice systems have developed improved responses to mental ill health among offenders, for example through better screening on reception to prison, drug treatment and suicide prevention. But, he argues, 'changing only one part of the offender health care pathway will merely expose other weak points in the system' and with the development of inreach the shortcomings of prison primary care and diversion from custody have been held in stark relief. Nonetheless, Appleby

concludes that we do now have a broad consensus about what needs to be done to make the whole system work better and a 'momentum to bring it about'. Such windows of opportunity do not appear very often, and grasping it while it exists will be vital.

Paula May and Calum Meiklejohn write from the perspective of working currently in a prison mental health services. They describe the journey the mental health service at HMP Bristol has taken over the past five years and what challenges lie ahead for prison mental health care.

The creation of prison inreach, they argue, saw the NHS 'parachute in' mental health provision to a new and difficult environment. The service inevitably had to adapt to the reality of its environment, for example by separating assessments and emergencies from planned work with the team's clients to avoid the former becoming the team's sole function. May and Meiklejohn also conclude that one of the biggest challenges facing inreach teams is not from within the prison but in the attitude of mental health services outside to working with offenders. Again, it is how the whole system, not just individual parts of it, works that determines how effective prison mental health services can be in supporting people in their treatment and recovery.

Kimmitt Edgar examines the way in which attitudes about mental illness and those experiencing distress

inform how they are managed by the health and justice systems. Public understanding of mental ill health is still very mixed and often quite different to reality, as a result of which 'divisive images of mental health problems lead to contradictory solutions'. So we are at one and the same time developing more compassionate and better resourced responses to mental ill health while also becoming 'ever-more coercive' towards people who are seen as a threat.

Edgar argues that some groups are particularly vulnerable to poor treatment within the criminal justice system, such as women and people with learning difficulties. Better management of the recent convergence between mental health and criminal justice, he argues, will be vital to ensure that the two services do not compound the disadvantage those groups experience.

Ian Cummins, finally, examines what the exponential growth of the prison population tells us about our society and how an understanding of why it has happened is essential to any effort to address it. He cites the widely held 'Penrose hypothesis' that the prison population has grown in response to the closure of the long stay 'asylums': that there is a 'static proportion of any population that will need or be deemed to need some form of institutional control'.

He argues that there are, however, serious problems with this approach. It assumes, for example, that

mental illness and offending are inextricably linked and is not supported by the evidence of any clear link between rates of crime and rates of imprisonment. In its place, we need to examine what it is mental health services should offer people experiencing mental distress. And this means we need 'to do things differently', using the recommendations of the *Bradley Report* (2009) as a starting point.

All four contributions make it clear that while a great deal has been achieved to mitigate mental distress among the prison population over the past decade, fundamental changes are needed both to reduce the size of that population and the proportion of people within it who have mental health problems. We need to develop 'whole system' responses that acknowledge that most prisoners are incarcerated for short periods at a time: that almost all return to their communities and need care and support that continues 'through the gates' and addresses the things that concern them most in life.

Prisons will never be free of mental ill health. No matter how well we divert people with mental health problems from custody, we still need to ensure that prison mental health care works for those who need it and supports them in their recovery journeys. After a decade of growth in public services, we face a new decade of contraction and retrenchment. Yet as the contributions to this volume show, we can

improve the way offenders with mental health problems are supported, inside and outside prison, not through adding extra investment onto an unreformed system but by looking at how it all works and reinvesting resources towards more effective interventions that are in everyone's interests.

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Authors' biographies

Louis Appleby

Louis Appleby has recently been appointed as Department of Health National Clinical Director for Health and Criminal Justice and is Professor of Psychiatry at the University of Manchester. The aim of his new post is to reduce mental illness in prisons and improve collaboration between mental health services and the criminal justice system. In his previous role as National Director for Mental Health in England he played a central role in plans to reform mental health services, bringing in a range of new services including home treatment, early intervention and assertive outreach teams, and mental health legislation. He led numerous initiatives including to reduce suicides and improve the physical environment of mental health wards.

Since 1996 he has been Professor of Psychiatry at the University of Manchester and since 1991 a consultant psychiatrist in Manchester. He was awarded a CBE for services to medicine in the 2006 New Year Honours.

Paula May

Paula May qualified from Hereford and Worcester College of Nursing in 1995. She has worked across a wide range of areas including inpatient services, high secure forensic settings, PTSD (post-traumatic stress disorder) units and also with the third sector.

Paula managed the court assessment and referral service Avon and Wiltshire in Mental Health Partnership NHS Trust from 2007 to 2009 whilst it was involved in the national pilot around court reports with offender health and Her Majesty's Courts Service (HMCS).

More recently she has undertaken specific pieces of work reviewing the mental health service in Horfield prison in her current role as development manager.

Calum Meiklejohn

Calum has been a registered mental nurse since 1985, and has worked as a clinician and manager in secure mental health services for most of his continuous career in the NHS.

Since 1998 he has been actively working in prison mental health. Calum completed his original MSc research in a remand prison, looking at the attitudes and beliefs of prison staff towards mentally ill prisoners. Since 2005 he has been involved in developing mental health services in prisons and courts in the south west of England.

Calum is Chair of the RCN Nursing in Criminal Justice Services Forum. As an experienced clinician and manager in the delivery of mental health to the Criminal Justice Liaison Services, he is well qualified to represent RCN members on the national level.

The delivery of health to the criminal justice services is developing and nurses working in criminal justice services require a forum to represent them. The RCN forum is proactive in representing issues raised by members and advocating nursing issues to wider stakeholders involved in policy and practice issues.

Kimmett Edgar

Dr Kimmett Edgar, Head of Research at the Prison Reform Trust, has been a prisons researcher since the 1980s, having previously worked as a Research Officer at the Oxford Centre for Criminological Research. He has published books on prison violence and on restorative justice in prison. He has written Home Office reports on racist incidents in prison and mandatory drug testing. At the Prison Reform Trust, his publications cover mental health, women on remand, and prison councils.

Kimmett Edgar is a member of the Northern Ireland Ministerial Forum on Safer Custody, the HMPS Grendon Research Advisory Group, and the steering group for *Back on Track*, a project using restorative justice with excluded school students. He is Quaker Representative to the UN Commission on Crime Prevention and Criminal Justice, and a former chair of the Alternatives to Violence Project. He sits on the Executive Board of the Restorative Justice Consortium.

Ian Cummins

Ian Cummins is a senior lecturer in social work in the School of Social Work, Psychology and Public Health at the University of Salford. He has worked as a probation officer and approved social worker. His research interests are in the areas of forensic mental health services with an emphasis on policing and mental illness. He has carried out research with police forces exploring ways to improve the mental health awareness of officers. He has published several journal articles based on this work. Ian is also a member of NACRO's National Mental Health Reference group. He regularly presents at NACRO and other conferences.

Offender health: reform is gathering pace

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At the heart of offender health care lies an indisputable fact: people with acute severe mental illness should not be in prison. No matter how much better prisons become at providing for mental ill health in the broader sense – and they have greatly improved in recent years – they are not the right place, clinically or ethically, for psychosis. Our best figures on mental disorder in prison are still those that came out of the 1997 psychiatric morbidity survey in England and Wales (Singleton et al, 1998). It found functional psychosis in seven per cent of male sentenced prisoners, 10 per cent of males on remand and 14 per cent of female prisoners – these figures are several times higher than the equivalent findings for the general population.

The same study reported that more than 90 per cent of prisoners had a mental health problem of some kind and that more than 70 per cent of both male and female sentenced prisoners had at least two mental disorders. Sixty-four per cent of sentenced male prisoners and 50 per cent of

female prisoners had a personality disorder. A decade later, in 2008, a Ministry of Justice survey gave similar figures. It also found that 69 per cent of prisoners had used illicit drugs in the year before custody, and that 31 per cent had used heroin. In the four weeks before custody 36 per cent had been drinking heavily.

The relationship between the mental health of offenders and their risk of offending and re-offending is, however, more complex than these figures imply. For many, mental disorder is associated with poor social circumstances and a lack of social supports. Those with 'lower level' individual needs may also have chaotic lifestyles. They are frequently unemployed or homeless. They may have been poorly educated or victims of abuse. It is their combination of problems that keeps their prospects poor and their risk of offending high.

Unpicking the web of relationships between mental health, social adversity and addictions presents policy makers, the NHS and criminal justice agencies with a number of challenges: identifying people with mental health problems early in the criminal justice pathway and providing alternatives to custodial sentences ensuring that people with severe mental illness receive appropriate care providing an equivalent level of mental health care for prisoners compared to services available in the community contributing to inter-agency action to reduce re-offending.

Governments from the 1990s onwards have attempted to tackle these challenges and there have been significant changes in the way that mental health care is delivered, most notably:

- the introduction of criminal justice liaison and diversion services
- health screening on reception: all new offenders entering prison, either on remand or sentenced, have an initial health assessment to ensure that any immediate health needs are identified on the first night. A comprehensive health assessment should be completed within a week of admission into custody
- mental health inreach – mental health treatment within prisons: most prisons now have access to mental health inreach teams. People with an identified mental health problem are referred for specialist assessment, treatment and, if needed, referral to inpatient care
- transfer to hospital: improvements have occurred in the process and speed by which, under S47 and S48 of the Mental Health Act 1983, severely mentally ill prisoners are transferred to hospital accommodation. In 2008, 75 per cent more prisoners, with mental illness too severe for prison, were transferred to hospital than in 2000 – up to 937 from 537. In the quarter ending March 2010, 25 prisoners were waiting in excess of 12 weeks for transfer, a lower figure than in previous years
- suicide prevention: in 2002, the Department of Health (DH) launched its *National Suicide Prevention Strategy for England*; prisoners were

- included as one of five high-risk groups within the population. The Safer Custody initiative, a partnership between the National Offender Management Service and DH, aims to improve safety and the management of suicide risk in prisons. The number of self-inflicted deaths fell from over 90 deaths per year in 2002-4 to 60 per year in 2008-9
- treatment of drug dependence: from 2006-7, a new integrated mode of assessment and treatment has led to a step change in clinical management of drug misuse throughout the adult prison estate. In 2008-09, 64,767 prisoners received an intervention – 45,135 received detoxification and 19,632 received a maintenance prescription for opiate dependence
- support for older prisoners: an older prisoners' action group has been established to improve the well-being of older and disabled offenders, and training has been delivered to prison staff
- information systems: rollout of the national clinical IT system for prisons *SystemOne* gives clinicians round-the-clock access to prisoners' medical records. In January 2010, 87 prisons had adopted the system. The aim is that it will be universal by the end of 2010.

It was against this backdrop that Lord Bradley was commissioned to consider the experience of people with mental health problems or learning disabilities in the criminal justice system, to examine how the various agencies currently work and how they should work in the future. Several reports had covered this territory before and the *Bradley Report*

(2009) did not attempt to re-invent a familiar wheel. It listed the changes that most people in the field knew to be necessary and set them in a new context – the modern NHS driven by commissioning, multi-agency working, and care pathways based on patient experience.

The *Bradley Report* put forward wide-ranging recommendations about training, the development of liaison and diversion services, information technology, public health, practice in courts and police stations, sentencing and research. It described models of good practice nationally and internationally and called on the NHS, National Offender Management Service (NOMS), the police, the judiciary and the third sector to respond. It acknowledged that services would have to be redesigned and reshaped from existing resources as the current system wastes money.

Liaison and diversion services are key to the proposed transformation. Court diversion services were first introduced in the 1990s but initially evolved in an uncoordinated way leading to wide variations in size, type of services offered, effectiveness and availability. There are currently around 130 diversion services. Some are well-developed, taking the form of multi-disciplinary teams that provide mental health assessment to both police custody suites and courts. Others are limited, relying on a single dedicated individual providing services to courts on set days. The task is now to show that there are savings for the NHS

and the criminal justice system where effective liaison and diversion services are in place, to collect evidence on which models of diversion are most successful, and to describe how diversion fits with other NHS and local authority services. All health and criminal justice partners will be encouraged to invest and evaluate.

However, changing only one part of the offender health care pathway will merely expose other weak points in the system. That is the experience of prison inreach teams whose excellent work has exposed the lack of satisfactory primary mental health care in many prisons. Without good primary care, or a form of specialist mental health service focussing mainly on severe mental illness, inreach teams receive referrals for people who could be treated without specialist input or who need a behavioural programme to address longstanding difficulties in personality or emotional control. Conversely, some people who do need specialist treatment for mental illness are never detected and go untreated. Just as good inreach requires effective primary mental health care, good diversion highlights the need for skilled and accessible community services.

In the end, mental health reforms are about workforce roles and this one is no different. The mental health care of offenders is not the exclusive responsibility of forensic psychiatrists, though their leadership is vital. Many of the patients in our clinics and CPA meetings have a history of

offending or are at risk of offending. Community mental health teams have always practised in offender health, although at times this went unacknowledged. In future, as we work across previous agency boundaries and health care moves towards care in the community, this will be more explicit.

Mental health staff will also have a role in ensuring that prison and probation staff have the skills needed to recognise and assess mental disorder and suicide risk. Good progress has been made in this area with over 17,000 prison officers receiving mental health training between 2006 and 2009. The recently published training framework will promote consistency in content but allow flexibility for local adaptation.

Any strengthening of diversion or transfer, any improvements to joint working between health and criminal justice, any new roles or new skills, rely on robust and well-informed commissioning. The Department of Health will soon be issuing generic offender health commissioning guidance that will in time be augmented by more specific advice about each stage of the care pathway. It is commissioners, who can calculate the costs of poor offender health in their localities, who can put arrangements in place for care in the community on release from prison, who can turn research evidence and clinical guidelines into better outcomes for patients – though the good commissioner will always consult local clinicians to get this right.

Commissioning, workforce reform, evidence, outcome measurement – these are the foundations on which better care is built. Offender health also has two crucial current assets that should overcome the tight budgets that will be a fact of NHS life in the next few years – a consensus about what is needed and, vitally, a momentum to bring it about.

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Prison mental health: representation and reality

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In 2003 mental health services to prisons were generally inreach where local mental health trusts or service providers supplied mental health practitioners to prisons (usually remand locals) to identify prisoners who were eligible for a Care Programme Approach (CPA) (Meiklejohn et al, 2004). In 2006 Primary Care Trusts (PCT) began commissioning mental health services which heralded a new approach to developing a comprehensive mental health service in local remand prisons.

Commissioning

Key changes to the local mental health offender care pathway have been achieved through negotiations with local PCT commissioners. A key document is the *Offender Health Care Pathway* (DH and NIMHE, 2005). This policy document was used to help develop a new scheme for the local courts around Her Majesty's Prison Service (HMP) Bristol – Court Assessment and Referral Service (CARS).

The rationale was that mental health practitioners should conduct an early assessment of an offender, divert the offender to a mental health service if needed, and where appropriate, ensure that information is shared across the offender health care pathway.

Another challenge was to ensure that the services were 'mainstream services' and not forensic mental health services. Traditionally, prison mental health services were provided by local forensic services. The majority of the mental health need in prisons is primary and secondary. Developments of mental health services to prisons and courts have been in primary and secondary service provision, with an emphasis on ensuring that mainstream services accept appropriate responsibility, especially in CPA cases.

HMP Bristol Service Model

The community mental health team at HMP Bristol started as an inreach team in 2003, and operated outside the prison walls. The inreach team became based within the prison in 2007. The rationale for this change was to develop joint partnerships with other services such as 'counselling, assessment, referral, advice and through care' (CARAT), offender management unit (OMU), primary care and safer custody. The prison team consisted of a team leader and two mental health practitioners.

In 2008/2009, the prison mental health team was transferred to Avon and Wiltshire Mental Health Partnership NHS Trust. During this process and

through planned changes to the service provision, the team grew significantly.

The Community Mental Health Teams (CMHT) model at HMP Bristol now consists of:

- one band 7 team leader
- one band 7 independent nurse prescriber
- two band 6 practitioners
- two band 5 practitioners
- one consultant psychiatrist
- counsellors
- one full time administrator.

In addition to the community service provided in prison wings, the team also supplied the prison with an inpatient facility.

The initial model in operation at HMP Bristol involved sorting mentally ill prisoners into groups based on their need for or likely benefit from immediate mental health treatment on arrival (triaging). All referrals were discussed at a team meeting. Following triage, prisoners were allocated to a team member's caseload, and reviewed according to their treatment and care requirements. The underlying philosophy is based on the CMHT model which envisages the prison wings as the community and the inpatient unit as a mental health inpatient acute facility. In this model, the CMHT is the hub which joins all of these services together. The intent was to combine inpatient and community care, with the wing (community) team and the inpatient team working together. The service was based on an integrated care pathway model where individuals needing mental

health care could be picked up initially via screening at the local courts. The care pathway between the courts in Bristol and HMP Bristol is particularly cohesive as HMP Bristol is the local remand prison serving the courts in Avon and Wiltshire. This makes the service model clear and contained.

Review of Community Mental Health Teams (HMP) Bristol

A clinical review of the prison mental health service was undertaken in March 2010. The outcomes and recommendations of the clinical review clearly identified the challenges and the journey that has been undertaken at HMP Bristol. Key publications were reviewed including the *Bradley Report* (DH, 2009), *Improving health, supporting justice* (DH, 2009) and *From the inside; experiences of prison mental health care* (SCMH, 2008)

Key points to the review are:

- 1) **The lack of cohesion between inpatients and the community part of the team**

Historically, the inpatient unit at HMP Bristol was run by the prison with a mixture of health care officers and nursing staff employed by the prison. A review of the health care officer role at HMP Bristol in April 2009 concluded that prisons should no longer employ health care staff in the inpatient department. All clinical work was to be undertaken by the mental health trust employees. The prison would continue to provide a discipline presence at all times in the inpatient unit, as it was still deemed

a residential unit of the prison and cares for some very challenging and at times, disturbed and violent individuals. The inpatient unit accommodates a large number of lodgers who are predominantly awaiting places on the safer custody unit. The 20 inpatient cells are included on the certified nominal accommodation role for the prison. As long as this remains, the admitting rights lie with the prison governor.

2) A need to define the function and purpose of the prison inpatient unit

Historically the inpatient unit would have become overloaded with mentally ill prisoners waiting for transfer to medium secure units or specialist hospitals. The 14-day prison transfer pilot in 2009 defined clear targets for the identification and transfer of prisoners with acute mental illness. This has reduced the need for prison mental health beds as prisoners with acute symptoms requiring hospital treatment are transferred to a hospital bed within 14 days. In Bristol, we have transferred prisoners to psychiatric intensive care unit beds where appropriate. The 14-day target is within the new prison health performance and quality indicators (PHPQI) which each prison's performance is audited against annually. The Department of Health is producing a new national policy on 14-day transfer. Inpatient is not a mental health facility and a challenge for a mental health provider is to provide the evidence to support this. In the coming months we will be reviewing all admissions to the prison inpatient unit against an acute mental health/PICU admission criteria.

It was clearly identified that Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) had significant difficulty retaining registered mental nurses (RMN) in the inpatient unit. One reason was that there are very few RMN specific roles within the unit. A majority of the roles for the RMNs are task orientated within the prison regime and medication specific with little scope for the development of the environment or therapeutic services. For some prisoners within the prison system there is a need for containment and observation, or sanctuary, away from the main wings, for a given period of time. The inpatient unit to date provides this function for prisoners. What we will be doing in the coming months is to define whether prisoners who require sanctuary should be provided through an inpatient service by a mental health trust.

Wing work in crisis

It was identified that mental health teams are constantly responding to emergencies, including, perceived mental health emergencies out on the wings. This created the atmosphere of a fire-fighting type service, rather than a planned or systemised service. One of the most contentious issues within the staff base was the process of working 'out on the wings'. There appeared to be a lack of systemised structures in which to operate. Confidentiality is an issue if a room is not available for an assessment to take place. Further guidance from the trust health and safety teams is required to enable practitioners to construct safe and practicable ways of working within this complex environment.

To address the above it was recommended that the CMHT model should include a practitioner who is allocated the role of duty worker on a daily basis. The practitioner will respond to requests for assessments and implement these assessments as they come in, negating the need for a triage function to run separately. They would also act as a single point of co-ordinating contact for all queries and referrals that come in on that day. The duty worker would clear their caseload for the day to allow the other practitioners within the team clear time and space to plan their work. The duty worker system means that a dedicated crisis service is built into the service model.

The use of CPA

There is ambiguity regarding practitioners' views of what constitutes primary and secondary care in the complex prison population. Practitioners were at times unclear about the realistic working of the CPA process and their responsibilities in managing complex caseloads. Many cases do not meet the thresholds for CPA within the prison systems and often only need brief solution-focussed interactions. Further guidance is needed from the trust CPA leads to enable the team to work through these challenges and reach clear guidelines.

Public protection and Multi-Agency Public Protection Arrangements (MAPPA)

A more systemised process is needed to facilitate clear liaison of MAPPA and public protection issues,

both within the prison and the general community. The operational workings between the mental health team and Offender Management Unit (OMU) were not clearly defined at this point. A process for public protection and MAPPA systems will be implemented in conjunction with the offender management partnership agencies.

Health care governance

The definition of integrated governance is unclear and further clarity is needed by AWP and its partners within prison management. AWP met with the prison ombudsman and the primary care trust to encourage discussion about systems to reduce post incident reporting and encourage multi organisation learning within the prison. AWP welcome the recommendations set out by the Care Quality Commission (CQC) and Her Majesty's Inspectorate of Prisons (HMIP) in the paper *Commissioning health care in prisons 2008/2009* (2010) that PCTs must provide a lead in developing clinical governance in the prisons that they have commissioning responsibility for. Another recent development is the requirement for health care providers to register their services with the (CQC). The CQC has standards that mental health providers are rightly expected to meet. The authors are not clear what this means for providers of mental health services to prisons, especially inpatient facilities.

Summary

There is no defined model for the provision of prison mental health services. Our work to date has proved to us that working in prison mental health teams is very challenging, particularly because it is often isolated from mainstream health. Although prisons are unique environments, the answers to many challenges lie within the mainstream services. It is important that wider mental health services be involved in the development of our work.

To attempt to manage the issues raised in this paper, service providers must have robust integrated governance structures in place. All stakeholders within the prison need to work in partnership, following a clearly defined mental health care pathway. To enable cohesive care pathways it is advisable to have diversion schemes in local courts, as set out in the *Bradley Report*. This will allow for the early identification of mental health care needs and the referral of individuals to the appropriate services as they progress along the criminal justice pathway.

The journey over the last five years of developing prison mental health has been made up of three distinct phases: the development of inreach teams where mental health parachuted into prisons; PCT commissioning mental health services; and a whole systems approach to prison mental health. We are now in the third phase where the aspirations and collective ideals are equally matched to the reality of providing health care within the prison environment. A lack of understanding and motivation from some of our NHS Mental Health Trust colleagues regarding mental health care in the prison environment remains a challenge.

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Recognising mental health: balancing risk and care

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Public institutions, such as health services and criminal justice agencies, often find it difficult to honour the individuality of people. A person's mental health can change considerably over time, yet an offender can be stuck with the label 'mentally disordered' throughout their contact with the criminal justice system. A person's capacity for responsibility – the extent to which someone is able to make decisions in the knowledge of right and wrong – also varies. Courts distinguish between those who are, and who are not legally responsible – with little room for responding sensitively to someone whose capacity is limitedⁱ.

There is a gap between government policies and structures, with their categories and distinct pathways, and persons, whose lives transcend the 'boxes' imposed by institutions. When that gap is bridged, it is by professionals exercising discretion as they try to apply the policy to the person in front of them.

Public attitudes may influence professionals' use of discretion in at least two ways. First, the professional is also a member of the public and susceptible to many of the same influences (e.g. media). Second, government policies, which shape the functions of health and justice, can also be influenced by what the government believes to be the concerns of the public at large.

The Department of Health (DH) survey, *Attitudes to Mental Illness* (TNS-BMRB, 2010) shows how mental illness is linked, in public perceptions, with stigma and risk on one hand, and tolerance and compassion on the other. The survey measured fear of mental illness. Fewer than six in ten people agreed with the statement that, "people with mental illness are far less of a danger than most people suppose".

There was a significant increase from 29 per cent in 2003 to 36 per cent in 2010 of those who believed that mental illness indicated "someone prone to violence". So while most agree that mentally ill people are not as dangerous as people suppose, over a third of the public equates mental illness with "someone prone to violence".

A factsheet published online by the mental health charity Mind cites evidence from Clark and Rowe that psychiatrists were more likely to diagnose someone as suffering from schizophrenia if the patient had a history of violence (Clark and Rowe, 2006). This suggests that even the definitions of some mental health problems are influenced by the stereotypes held by the public. For example, personality disorder has been defined thus:

"people with antisocial personality disorder exhibit traits of impulsivity, high negative emotionality, low conscientiousness and associated behaviours including irresponsible and exploitative behaviour, recklessness and deceitfulness..." (www.patient.co.uk).

When presented with a description of a mental health problem, the test should be: is this profile likely to increase, or decrease empathy for this person? The policy implications of such a

judgemental definition as this are more exclusion, coercion, and discrimination.

Standard 1 of *The National Service Framework for Mental Health* states:

"health and social services should... combat discrimination against individuals and groups with mental health problems, and promote their social inclusion" (Department of Health, 1999: page 14).

The campaign, *Time to Change*, established by the charities Mind and Rethink, has targeted stereotypes of mental illness, because stigma leads to discrimination; discrimination is linked to social exclusion; and isolation exacerbates certain mental health problems, thus setting up a destructive cycleⁱⁱ.

The *Bradley Report* was commissioned to consider the extent to which offenders with mental health problems or learning disabilities could be diverted from prison to appropriate services. Over a year on from the *Bradley Report*, discussions about mental health and criminal justice are still polarised: one side highlights an individual's mental health problems; the other is focused on the dangers posed by people with mental illness.

Polarised images of mental health problems also lead to contradictory 'solutions': the former asking for more resources for mental health treatment and support; the latter requiring ever-more coercive management of people defined as a threat. Therapeutic interests, meeting offenders' needs for mental health care and/or support with learning disabilities, compete with the risk averse interests in labelling them dangerous, excluding them from the

public, and applying custody until professionals are convinced they are safe to release.

Current arrangements do not provide a healthy balance between therapeutic interests and public protection, or even suggest what a healthy balance would look like.

- The number of people received into prison under sentence in 2008 to serve twelve months or less was over 65,000ⁱⁱⁱ.
- Around 70 per cent of women entering custody require clinical detoxification^{iv}.
- Revolving Doors Agency has estimated that 60,000 people who have mental health problems enter prison every year^v.

For most people, time in prison is more likely to aggravate than resolve any existing mental health problem. We also know that diversion away from the criminal justice system and to mental health treatment works. Dr David James' study of a court diversion process found that it achieved double benefits: providing therapeutic outcomes for the person's mental health problems and reducing the rates of reoffending among those who were diverted away from criminal justice (James et al, 2002).

Despite the evidence that people respond better to mental health care in the community, despite the clear evidence that increased use of diversion away from prison would be in the public interest, the over-use of prison for people with common mental illness continues unabated. The system is out of balance: it prioritises risk so that large numbers of vulnerable people are being defined – unnecessarily – as dangerous. It is also out of balance in that there is a lack of care, therapy and support that

people need in the community in order to improve their mental health and stop offending.

What is not so obvious is that the opposite set of responses can be equally degrading. The therapeutic model too often presumes that the patient should not be trusted to make decisions. The premise is that mental health care's purpose is to 'do things for' the vulnerable person. When diversion means that the person's liberty is at the discretion of professionals in mental health care, the patient may find that they are no better off than prisoners serving indeterminate sentences. The offender is passed from one coercive and stigmatising system to another.

Attempts to implement the *Bradley Report* reforms will be strengthened if they can balance (and moderate) these two interests. Fortunately, there are some models that demonstrate that it's possible.

Circles of support and accountability^{vi} work with high-risk sex offenders on release from prison. A circle is made up of volunteers who meet the offender before his release, and then provide informal support during his resettlement. The purpose of the group is to provide both help and monitoring. The support can include advice about housing, employment, finances, and other concerns. Accountability refers to an explicit agreement that the circle will maintain communication with probation services and police and inform the authorities of concerns they might have about the core member's behaviour.

The circles provide encouraging signs of reducing

re-offending by high-risk sex offenders:

"at their heart, circles are about including, rather than excluding: they provide a real and meaningful community for a group that has previously been only stigmatised and marginalised." (Wilson, 2006).

People with learning disabilities are disadvantaged by the criminal justice system. The Prison Reform Trust's programme, *No One Knows*, revealed that from arrest through to resettlement, criminal justice processes often neglect their particular needs and discriminate against them (Talbot, 2008: page 75). *No One Knows* showed that prison is an inappropriate place for the vast majority of people with learning disabilities. Many offenders with learning disabilities would be able to manage on community orders if they could receive special support.

Are learning disabled offenders being denied the opportunity to take up community orders – and receiving custodial sentences – because their disability makes it difficult for them to keep to the conditions? *No One Knows* cited cases in which a learning disabled offender was recalled to prison for breaking his curfew, though no one had checked to confirm that he could tell time. A former offender said that no one had explained to him that a failure to pay a court fine was imprisonable and he was not aware that he could be sent to prison for that offence. Schemes for people with learning disabilities, like the charity KeyRing provide, enabling community support, can offset many of the disadvantages imposed on them by the criminal justice system. Offenders who have

a learning disability can be held accountable for criminal actions without discriminating against them if the support is in place to ensure that they are not disadvantaged due to their disability.

Services that work with women offenders add to the knowledge about balancing public protection with support. Interventions that work best acknowledge and address the prior victimisation which women offenders have experienced:

"it is clear that the majority of women in prison have experienced some form of abuse, and that a history of abuse is one factor amongst others contributing to the risk of offending and of a range of associated problems, including drug and alcohol problems, mental health problems and self harm" (Home Office and Prison Service, 2003).

The risk of re-offending is closely tied to the woman's experience of being victimised by others. Addressing the prior victimisation is not intended to let an offender off the hook. Rather, it creates a mutual obligation, between the offender and the state, to work on the consequences of that abuse for her behaviour. In short, helping her to resolve the damage caused by being abused is very likely to prevent further offending.

Rumgay (2004) has concluded that women offenders seem to be unusually receptive to these approaches, which recognise their prior victimisation, yet expect them to make amends, in some way, for the harm they have caused others:

"if we are bound to hold the victimised offender

morally accountable and capable of personal responsibility, then we may demand that such responsibility be exercised in tackling the psychological, social and economic legacy of victimisation and thereby changing the conditions in which offending has emerged as an adaptive solution" (Rumgay, 2004: page 15)

This principle, balancing sensitivity to the vulnerabilities of offenders with their obligations not to re-offend, also seems to work with some of the most dangerous offenders in the prison system. That Grendon's therapeutic regime reduces the risk of reoffending is well-established:

"therapeutic communities within the prison offer intensive group psychotherapy and social therapy. This core therapy is complemented by activities such as art therapy, psychodrama and cognitive behavioural groups. There is a strong emphasis on multidisciplinary working and each team consists of forensic psychologist, prison officers, probation officer and psychodynamic psychotherapist. The focus of much of the work is upon disordered relationships, which often arise from intolerable and uncontainable feelings, and the outcome of violence or other offending. Through exploring the past and present, clients can begin to make sense of their cycles of being abused and abusing and through forming reparative relationships with staff over a period of years the energy for violence can be ameliorated" (NIMHE, 2003: page 19)

There is a substantial risk in encouraging health providers to make themselves aware of the potential danger a patient might pose to the

public, or in efforts to make prisons more therapeutic environments for mental health. Asking either department to take on the other's functions adds to the pressures experienced by offenders. It might be fair to require an offender to meet the requirements imposed by the courts, or to expect a mentally ill person to comply with the treatment provided by mental health services. But holding the same person accountable to both is likely to create unreasonable demands. The hybrid order, by which an offender can be sentenced to hospital for mental health treatment and given a prison sentence, is a clear example.

The institutional response to the twin demands of risk management and addressing therapeutic needs is joined up services of health and criminal justice, a process termed 'convergence'.

Among the drawbacks of convergence are:

- prison 'hospitals' are a contradiction in terms, as the impact of imprisonment is anti-therapeutic
- labelling the person as both an offender and mentally ill will stigmatise them more
- an increase in preventive detention is unjust, in that prolonged custody is arbitrary; and it is inefficient, in that the vast expenditure on indeterminate sentences and the *Dangerous People with Severe Personality Disorder Programme* (DSPD) programme are not justified by convincing evidence of their impact on re-offending
- risk management and public protection dominate the treatment of mentally ill offenders, as, for example, mental health needs are presumed to signal criminogenic factors

- the over-representation of people from black and minority ethnic (BME) groups in both mental health secure care and prisons suggests that further convergence could contribute to institutional racism. (Rutherford, 2010).

As Rutherford argues, convergence has potential benefits in both mental health and criminal justice. But to achieve these, it is vital that the joined up work is properly managed.

Achieving a better balance will require a shift in resources, through justice reinvestment. The Revolving Doors Agency estimated in 2007 that five per cent of the budget for criminal justice could be transferred to health to double the money primary care trusts have to spend on mental health (Revolving Doors Agency, 2007: page 3).

Finally, balancing the patients' needs for mental health support with reasonable precautions against their risk to others requires systematic service user engagement. A study of BME patients' experiences of mental health care concluded with a call on service providers to listen more carefully to the perceptions of the service user:

"service users and carers repeatedly ask to be treated 'with respect and dignity' and they demand better information about services with less coercion, less reliance upon medication and other physical treatments and more choice. In this they concur with the views of many other service users and carers who have commented on their experience of mental health services. They wish to be treated and respected as individuals." (Centre for Mental Health, 2002: page 6).

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ⁱ "The criminal law is an unsophisticated instrument for determining blame. Apart from the specific defences of insanity and diminished responsibility, there is no specified way in which defences are framed which make allowances for the state of mind for a person who commits a criminal act. It must therefore be acknowledged that the criminal law may operate unfairly in relation to people labelled as mentally disordered offenders." Mind, cited in SCMH, Rutherford, page 39.

ⁱⁱ *Time to Change* is England's most ambitious programme to end the discrimination faced by people with mental health problems, and improve the nation's wellbeing. www.time-to-change.org.uk

ⁱⁱⁱ Ministry of Justice (2009) *Offender Management Caseload Statistics 2008*, Table 6.1, page 51.

^{iv} Prison Reform Trust (2009) *Bromley Briefings*, June 2009, page 43, London: Prison Reform Trust.

^v Revolving Doors Agency (2007) *Prisons: Britain's "Social Dustbins"*, by J Corner, E Jones and R Honeyman, London: Revolving Doors Agency, page 1.

^{vi} www.circles-uk.org.uk

The relationship between mental institution beds, prison population and crime rate

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Lionel Penrose (1898-1972) made an enormous contribution to the development of medical genetics, particularly in the study of Down's Syndrome (Harris, 1974). In addition, he was also concerned with the nature of the services provided for the mentally ill and those with learning disabilities. In this essay, I will explore his famous hypothesis regarding the use of prison and psychiatric care in the light of recent developments in both policy areas.

Penrose (1939 and 1943) put forward the intriguing hypothesis that there is a fluid relationship between the use of psychiatric inpatient beds and the use of custodial sentences. The 1939 paper was based on the analysis of statistics from European countries and argues that there was an inverse relationship between the provision of mental hospitals and the rate of serious crime in the countries studied – as one increases, the other decreases.

The 1943 paper was a study of the rates of hospital admission in different states in the USA and the numbers in state prisons. Later in his work, he argued that a measurable index of the state of development of a country could be obtained by dividing the total number of people in mental hospitals and similar institutions by the number of people in prison. Penrose's work in this area

concludes that society responds to challenging or bizarre behaviour in one of two ways – either by the use of the criminal justice system or the mental health system. The system with the greater capacity at the time takes on this role.

The problem raised by the use of the criminal justice system as a response to mental illness is not a new one. Howard (1780) noted that there were a number of "idiots and lunatics" in prison. He also argued that they did not receive appropriate care and if they did they "...might be restored to their senses and usefulness in life." Stone (1982) argues that this is a problem all urban societies have faced in one form or another. In addition, he suggests that it is one that has never been solved.

The justification for the development of community based mental health services is based on moral and clinical arguments. It is a combination of idealistic and pragmatic approaches. The idealism can be seen in the human rights arguments that were put forward. Community based services, it was argued, would be by definition more humane. Lamb and Bachrach (2001) argue that this was based on a moral argument with little evidence to support it. Clearly, the supporters of community based mental health services did not argue that asylums should be replaced by jails.

Deinstitutionalisation, a progressive policy aimed at reducing the civic and social isolation of the mentally ill, did not achieve its aims. Wolff (2005) and Moon (2000) argue that asylums have been replaced by a fragmented and dislocated world of bedsits, housing projects, day centres or increasingly, prisons and the criminal justice system. This shift has been termed 'transinstitutionalisation'.

This incorporates the ideas that individuals live in a community but have little interaction with other citizens and major social interactions are with professionals paid to visit them.

Other social outcomes such as physical health, which can be used as measures of citizenship or social inclusion, are also very poor indicators. Kelly (2005) uses the term 'structural violence', originally from liberation theology to highlight the impact of a range of factors including health, mental health status and poverty that impact on the mentally ill.

The response of successive governments since 1983 to the developing crisis in the provision of mental health services has been to focus on the legislative and policy framework.

The policy of deinstitutionalisation is followed across the world (Hicking, 1994; Mizuno et al, 2005; Ravelli, 2006). The World Health Organization (2001) highlights that long-term facilities are still the most common form of service provision – 38 per cent of countries worldwide have no community-based mental health services, whereas there has been a shift in service provision in North America and Europe towards this policy. At the same time, there has been a clear shift towards a more punitive prison policy. As Wacquant (2009) argues, throughout the industrialised world there has been a large prison building programme and investment in the criminal justice system. It should be noted that this process has been overseen by governments, particularly in the UK and USA with a commitment to reducing both the role of the state and public spending. Gunn (2000) and Kelly (2007) found that the reduction in the number of psychiatric beds in the UK occurred at the same

time as the rise in the prison population, as Penrose predicted. The clash of the two policies outlined above – hospital closure and prison expansion – at first seems to provide evidence to support Penrose; they also create significant challenges for all those working in these fields. As Lord Bradley (2009) has highlighted there is a need for all staff working in agencies in the criminal justice system to receive training in relation to mental health issues.

Large and Nielessen (2009) undertook a review of Penrose's original hypothesis using data from 158 countries. They suggest one of the main features of Penrose's argument is that there is a unchanging proportion of any population that will need, or be deemed to need, some form of institutional control. They concluded that though there was a positive correlation between prison and psychiatric populations in low and middle income countries, there was no such relationship in high income countries.

It is clear that in the UK, the prison population has risen significantly over the past 25 years. I remember working as a probation officer in the mid-1980s when there were great concerns that the prison population would break the 45,000 barrier. Wacquant (2009) argues that prison policy has replaced welfare services as a means of responding to the needs of marginalised individuals and communities. Successive governments of differing political persuasions have been seemingly addicted to the expansion of the use of custody despite its well-documented failings to achieve its avowed aims. In addition, as Barr (2001) demonstrates, the 'zero tolerance' approach widely adopted in the privatising and policing of public space results in more mentally ill people being drawn into conflict with various public authorities.

Discussion

It is possible to explore Penrose's hypothesis as a statistical argument about the use of two distinct institutional processes – prison custody and psychiatric care – and the investigation of the relationship between the two. I would argue that there are a number of dangers in this approach. It equates, however unintentionally, crime and mental illness. In addition, it fails to explore the reasons behind the changes in patterns of use of the two institutions. As Garland (2001) suggests, the increase in the use of prison continues despite the general reduction in the crime rate. Therefore, it is part of a wider change in society and government attitudes rather than simply a response to crime. The changes in the use of institutional psychiatric care are the result of a combination of social attitudes, improved medical and treatment approaches, recognition of the cost of in-patient treatment and recognition that citizens should not lose their civic and human rights because of mental ill-health.

The moral force of Penrose's arguments can perhaps be located in his Quaker beliefs. In a similar vein, in 1994 the Mental Health Foundation published *Finding a place*. This was the result of a general inquiry into the failings of mental health policy in the late 1980s/early 1990s that ultimately led to the *Ritchie Inquiry*. The messages of this report are very relevant to this discussion. Instead of starting from an organisational or service structure perspective, the report adopts a values one. It asks the fundamental questions:

- what are the underpinning beliefs, on which, mental health services should be based?
- what is it that mental health services should seek to provide for those experiencing acute distress?

The answer is, in many ways, disarmingly straightforward: an appropriate place to live, an adequate income, employment and other activity, respect, trust, help and support. These reflect civic and human values of support and respect that should be at the core of public services – whatever their configuration.

The range of service initiatives that have been developed to address the mental health needs of those in our prisons are to be welcomed. However, these new ways of working should not obscure the fact that as a society we have become over-reliant on the use of prisons. As a result of this and other policies discussed above, the distinction between some areas of the criminal justice system and mental health services are increasingly blurred. All too often, policy decisions in this area are presented as if there is no alternative. The force of Penrose's initial papers today is the clear view that we, as a society, have a choice to do things differently. I would argue that the message of the *Bradley Report* is that this is a choice that we should exercise.

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