MENTALLY DISORDERED PRISONERS

Adrian Grounds

THE WOOLF REPORT RECOMMENDATIONS

The Woolf Inquiry into the prison disturbances of April 1990 (Woolf, 1991) overlapped with the most major review for twenty years of services for mentally disordered offenders in England. This Review of Services for Mentally Disordered Offenders and Others Requiring Similar Services was established jointly by the Department of Health and Home Office in November 1990. In November 1991 the first set of reports from this review were published for consultation (Department of Health/Home Office 1991a, b, c, d), and a second group of reports was published in June 1992 (Department of Health/Home Office 1992a, b). The Final Summary Report was published in November, 1992 (Department of Health/Home Office 1992c). The conclusions of the Woolf Inquiry in relation to mentally disordered offenders prefigured many of the ideas which have since been developed at length in the Department of Health/Home Office review.

The Woolf Report discusses mentally disordered prisoners in the context of its broader recommendations about limiting the role of the Prison Service. Co-operation between agencies, including the Department of Health, is urged in order to divert remand prisoners and offenders from prison custody, so as to reduce the prison population ‘to an unavoidable minimum’ (Woolf, 1991, para. 10.70). In the interest of avoiding remands in custody, the Report recommends the establishment of further bail information and public interest case-assessment schemes, bail hostels, and specialist hostels for people with mental disorder and those with drug or alcohol related problems. The mentally disordered are included as a specific group, alongside young offenders and fine defaulters, as a category for whom the use of imprisonment should be minimised.

In the main section of the Report dealing with mentally disordered offenders (paras. 10.115-10.140) there are two main themes. First, initiatives to minimise the number of mentally disordered people remanded in custody are endorsed. Second, the responsibility to care for each person and, in particular, the responsibility to care for people with a handicap (learning difficulties) is devolved from the criminal justice system to the mental health or social services. The Home Office and the Department of Health are urged to summarise the legal and practical issues arising from the criminal justice system’s devolution of responsibility for mentally disordered people to the health or social services.

However the Woolf Report also envisaged alternatives, and there were significant external pressures to make recognition of the Woolf Report recommendations.

The Government committed itself to adopting the Woolf Report recommendations and proceeded to establish the Woolf Inquiry into the prison disturbances of April 1990. The Woolf Report was silent on the discharge of mentally disordered prisoners and the establishment of the Department of Health and Home Office review, and whenever possible the mentally disordered prisoner should be discharged to health or social services. The mentally disordered offender should be treated as a patient, with a health or social services hospital should be sought for remanded mentally disordered offenders. The mentally disordered are included as a specific group, alongside young offenders and fine defaulters, as a category for whom the use of imprisonment should be minimised.

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are endorsed. Second, the Prison Department is urged to recognise a special responsibility to the mentally disordered who remain accommodated in prison and, in particular, specific attention should be paid to those with mental handicap (learning disability). The Report welcomed the guidance given by the Home Office to courts, prisons, police and the probation service, summarising the legal powers available to divert mentally disordered offenders from the criminal justice system; and the Report also commended the experimental schemes which were then becoming established to provide a rapid psychiatric assessment service to magistrates' courts.

However the Report was also realistic in acknowledging that the provision of alternative facilities was inadequate and noted that this was also recognised by the Government.

The Government recognise that action is needed substantially to improve the present situation.

(para. 10.117)

The Department of Health accepts that, although expanded and developed in recent years, the services that are at present available for the mentally disordered do not work as well as they should in meeting requests for treatment from the Courts and the Prison Service. Nor do they result in the most appropriate placement of offenders.

(para. 10.121)

Following the Woolf Report, the Government published its White Paper Custody, Care and Justice in September 1991 (Home Office 1991a). In one important respect the White Paper lacked the realistic and balanced approach that characterised the Woolf recommendations concerning mentally disordered prisoners. The White Paper endorsed the view that whenever possible mentally disordered offenders should be diverted to health or social services, and prisoners requiring psychiatric treatment in hospital should be transferred as rapidly as possible. However, the White Paper was silent in response to the Woolf proposals that the Prison Department should recognise its special responsibility towards the mentally disordered offenders who are accommodated in custody, and that it should ensure that clearer and more specific attention is paid to mentally handicapped prisoners.

The remainder of this chapter will discuss the problems of providing for mentally disordered offenders as highlighted in the Woolf Inquiry, and the prospects for improvement.

HISTORICAL BACKGROUND

Our current difficulties need to be seen in historical context. The practice of remanding defendants in custody for pre-trial diagnosis had become
established in a number of London courts by the end of the nineteenth century, and medical remands in custody by magistrates steadily increased during following decades. They were given further impetus in the Criminal Justice Act 1948, which increased the powers of courts to obtain pre-trial and pre-sentence reports. The psychiatric assessment and care of remanded prisoners has traditionally formed a major component of the work of the Prison Medical Service and there has been a long-standing recognition that prison doctors should have training and expertise in psychiatry. However, at the same time this has been combined uneasily with the view that it is undesirable in principle that the mentally disordered should be remanded in custody and their diversion from prison should be the aim.

The difficulty experienced by psychiatric hospitals in coping with mentally disordered offenders also has a long history, and is not merely a recent phenomenon resulting from the advent of community care. This is well illustrated in the evidence given to a Commission of Inquiry established by the Home Secretary in 1880 to enquire into the subject of criminal lunacy (Criminal Lunacy (Departmental) Commission 1882). The Commissioners heard a number of graphic accounts of the objections raised by asylum superintendents to the admission of criminal patients. For example, in giving evidence on 5 August 1880, Dr R. M. Gover, Medical Inspector of Government Prisons, was asked if he was aware of any grievances arising from the detention of lunatics who were dangerous or who exhibited criminal tendencies. He told the Commission:

I have several friends among the medical superintendents of lunatic asylums and they express themselves unanimously upon that point.

They have pointed out to me the extreme inconvenience and in some cases the disastrous effects of the presence of criminal patients among the ordinary patients.

(para. 806)

Likewise, the Honourable Francis Scott, Chairman of the Brookwood, Surrey, Asylum, on being asked whether provision for dangerous lunatics had been included when his asylum was built, replied: ‘Certainly not, and as long as I am Chairman I will endeavour to avoid that’ (para. 1892). Dangerous lunatics, he argued, are expensive: ‘If you have a person requiring a constant attendant to look after him to see that he does not attack others, he is both a dangerous man and an expensive man, and these are both material ingredients’ (para. 1848).

The main developments during the last two decades in psychiatric and legal provisions for mentally disordered offenders may be traced back to the report of the Butler Committee (Home Office/Department of Health and Social Security 1975). The Committee drew attention to the problems faced by courts in obtaining hospital orders for mentally disordered offenders who could not be looked after in local hospitals and who, in consequence, the Committee recommended that government for a modest number of psychiatric services (Home Office/Department of Social Security 1974). Recognising that the disposal could be so damaged, the Committee recommended that there should be discharge. The Honourable Francis Scott, Chairman of the Brookwood, Surrey, Asylum, on being asked whether provision for dangerous lunatics had been included when his asylum was built, replied: ‘Certainly not, and as long as I am Chairman I will endeavour to avoid that’ (para. 1892). Dangerous lunatics, he argued, are expensive: ‘If you have a person requiring a constant attendant to look after him to see that he does not attack others, he is both a dangerous man and an expensive man, and these are both material ingredients’ (para. 1848).

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consequence, were being sentenced to imprisonment. In order to ease both this problem and the problem of overcrowding in special hospitals, the Committee recommended as a matter of urgency that regional units offering a medium level of security should be established with central government funding (Home Office/Department of Health and Social Security 1974). The Committee recommended the development of psychiatric services both in the Health Service and within the prisons, recognising that there may be exceptional circumstances in which a penal disposal could be preferred to a hospital disposal (para. 3.23). New community provision, in particular residential provision, was recommended, together with the retention of the 'asylum' role of local hospitals.

Hospitals...have a role in the continuing care of those who cannot be discharged into the community without serious risk of relapse through self-neglect, ... The re-introduction to some extent of a sanctuary role would particularly serve those people who are already so damaged that they are unable to take advantage of the rehabilitation measures which hospitals normally pursue.

(para. 6.6)

The Committee also recommended changes in criminal proceedings. There should be more consideration of non-prosecution of the mentally disordered and new powers to remand to hospital for assessment and treatment before trial.

Many of the principal recommendations of the Butler Report have been implemented in the ensuing years, albeit slowly and partially, but their impact has been limited. Regional secure units have been established, but neither the target of 2,000 beds recommended by the Butler Committee, nor the more modest number of 1,000 beds recommended by the Glancy Committee (Department of Health and Social Security 1974) has been met. The current (January 1992) level of provision in England and Wales is approximately 600 beds.

In 1984 new powers for courts to remand mentally disordered defendants to hospital for reports or for treatment came into operation, but their use has been low. The total number of remands to hospital for assessment and treatment has currently reached a plateau of about 300 per year, approximately one-twentieth of the number remanded to prison for medical reports.

In 1987 a further report on mentally disordered offenders in the prison system in England and Wales was produced by an interdepartmental working group of Home Office and DHSS officials (Home Office/Department of Health and Social Security 1987). The working group recommended that further research should be carried out to assess the extent of mental disorder amongst the sentenced and remand populations, that transfer to hospital of mentally disordered inmates should be expedited more rapidly and that health authorities should continue to develop a comprehensive range of provision for mentally disordered offenders. By the time this
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A report was published, evidence of a new gap in secure provision was becoming clear and the working group advised: 'the approach to secure provision has to be further diversified with complementary non-RSU [Regional Secure Unit] facilities, including a range of local hospital accommodation' (para. 8.3).

Despite these various initiatives, concern about mentally disordered prisoners has grown rather than diminished. In contrast to the rather bland conclusions of the interdepartmental working group (Home Office/Department of Health and Social Security 1987), others have expressed more outraged concern about the unacceptable suffering of seriously mentally ill remanded prisoners. The House of Commons Social Services Committee (House of Commons 1986) advised urgent action to transfer ill prisoners. Coid (1988a, 1988b) described rejection by psychiatric services of chronically disabled men remanded in custody and the Chief Inspector of Prisons has drawn attention to the heavy psychiatric workload and poor facilities at HMP Brixton (Home Office 1990b).

Finally, as described above, a further, comprehensive Department of Health and Home Office Review of services for mentally disordered offenders was established in November 1990. Its content will be further discussed below.

LEGAL AVENUES

The difficulties in achieving the transfer of mentally disordered prisoners to NHS psychiatric services are not due to a lack of legal avenues for transfer. The police have powers to take a mentally disordered person who appears to be in immediate need of care and control to a place of safety, which can include a psychiatric hospital (Mental Health Act 1983 s. 136). Alternatively, if a mentally disordered suspect is taken into police custody a medical assessment can be requested with a view to transfer to hospital and this may provide an alternative to prosecution. Courts can remand to hospital for reports instead of remanding in custody (Mental Health Act 1983 s. 36). Powers to remand to hospital for treatment (Mental Health Act 1983 s. 37), and the probation order with a condition of medical treatment, which may be as an in-patient or an out-patient. This order requires the individual's consent.

Although there are deficiencies in some of these legal powers, the difficulties in achieving diversion mainly arise for other reasons. These will be considered in the light of some recent research on mentally disordered prisoners among the remand and sentenced populations.

Research attention to the withdrawal of consultants who had admitted them during the treatment of seriously mentally ill remanded or sentenced psychotic ill prisoners, and there was a widespread concern, and some outrage, about the suffering of psychotic and mentally ill prisoners during their care' (para. 8.3).

However, referring referred to as 'hospital order', diagnosis was provided. Grounds, Janes and Earley (1992) had similarly carried out an prospective medical assessment of the need for hospital disposal. They found that with any evidence of psychiatrist services, there was always a need to transfer the prisoner. The sample who were not transferred showed needs for care and treatment. Predominantly, high proportion were homeless. Most of the sample referred to the higher courts were accepted following forensic psychiatric assessment. Among those who were not referred, 96% of the sample received prison sentences. Most of these sentences were not associated with hospital order. When prison sentences were given, a person's illness or circumstances was taken into consideration. A flexible range of disposals is now available (Criminal Procedure (Insanity and Unfitness to Plead) Act 1991). At the sentencing stage two specific medical disposals are available: the hospital order (Mental Health Act 1983 s. 37), and the probation order with a condition of medical treatment, which may be as an in-patient or an out-patient. This order requires the individual's consent.

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Remand prisoners

Research carried out at HMP Winchester by Coid (1988a, b) drew attention to the difficulty in securing psychiatric care from NHS consultants when mentally disordered remanded prisoners were referred to them during the remand period. The men rejected for treatment had been remanded on minor charges and were described as typically having chronic psychotic illnesses and socially disorganised lives. Coid's paper argued there was a failure by psychiatric services to look after the people concerned, and he noted: 'During this study I was distressed to see how psychotic and helpless men were ignored by the hospital responsible for their care' (1988a, p. 1782).

However, the commonest reasons cited by NHS psychiatrists for rejecting referred men were that hospital treatment was not appropriate or the diagnosis was disputed. A recent research project carried out at the Institute of Criminology, Cambridge, and the Institute of Psychiatry, London, (Dell, Grounds, James and Robertson 1991; Robertson, Dell, Grounds and James 1992) had similar findings but interpreted them differently. The study was carried out at three prisons, Brixton, Holloway and Risley, and entailed a prospective follow-up of 951 cases from reception in custody to court disposal. The sample consisted of three overlapping groups: first, people with any evidence of past or present psychotic illness, or who were recognised as mentally handicapped; second, all cases referred to outside psychiatric services; and third, all those remanded for psychiatric reports. The sample therefore represented those with conditions which caused, or showed need to cause, some psychiatric intervention in the remand process. Predominantly they were people charged with minor offences and a high proportion (40 per cent in the London samples) were effectively homeless. Most of the people with histories of psychotic disorders were referred to outside psychiatrists. Of these different proportions were accepted following referral. In the Holloway sample, 57 of the 95 women with psychotic disorders (60 per cent) were accepted, and in the Brixton sample 96 out of the 336 men with psychotic disorders (29 per cent) were accepted. Amongst the psychotic men who were rejected for admission or who were not referred, most received non-custodial disposals. If they did receive prison sentences most of these had been served whilst on remand. Most of these people were regarded by the courts as not meriting prison sentences and this, in itself, calls into question whether they should have been remanded into custody.

When prison doctors and visiting psychiatrists took different views about a person's illness and detainability these disagreements could relate to one or more of three issues. First, they sometimes reflected genuine diagnostic difficulties; second, they could reflect different opinions about what treatment was appropriate; third, they could reflect different definitions of the
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threshold of illness-severity that warrants hospital admission. When there was a disagreement between the prison doctor and the NHS psychiatrist, the prison doctor could seek a second opinion, but this would be at the cost of lengthening the prisoner’s period on remand.

The results of the study suggested that NHS psychiatrists may have been acting as gate-keepers, restricting admission to those whom they perceived as requiring in-patient treatment and likely to benefit from it. If this is the case, it indicates that those working in general psychiatric services may have a narrower view than practitioners in the criminal justice system about the criteria for hospital admission and the functions of psychiatric hospitals. In remanding for psychiatric reports, the courts appear to consider that psychiatric help was needed by a wider range of offenders than were regarded by psychiatric services as requiring psychiatric care. The contrast in expectations between courts and psychiatric services was most marked for those who had non-psychotic mental disorders, for example depression and personality disorders. In these cases requests for court medical reports did not usually result in medical disposals. People with personality disorders and mild degrees of mental handicap were unlikely to be seen by visiting psychiatrists as candidates for hospital care, and it may not be realistic to expect that appropriate help will be found as a result of remanding them in custody with requests for reports. People with primary problems of drug and alcohol dependence were also rarely referred to psychiatric services.

A commitment to a policy of diversion should not embrace the simple view that psychiatric hospitals and prisons have equivalent functions and that the hospital constitutes an alternative for the purposes of custody and social control. This may be the case in secure hospital settings for the period of time that someone is thought to require clinical assessment or treatment, but it is not likely to be the case in general psychiatric units. Fundamental differences of this kind in expectations of health and criminal justice agencies need to be recognised, and they may set limits to the degree to which diversion from custody can be achieved.

Sentenced prisoners

A substantial psychiatric study of the prevalence of psychiatric disorder and treatment need in the sentenced prison population has recently been completed by Gunn, Maden and Swinton (1991). A representative 5 per cent sample of the sentenced male prison population and a 21 per cent sample of the female sentenced population were identified. Based on the clinical interviews, the researchers estimated that 3 per cent of the sentenced prison population suffered from psychiatric disorders warranting transfer to hospital beds in the health service (ie. approximately 1,100 prisoners); that 10.5 per cent (approximately 4,000) required treatment of an
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...an 'outpatient' kind which could be provided in prison; and that 5.6 per cent (approximately 2,100) required more intensive psychological treatment in a therapeutic community setting, which also, in principle, could be provided within the prison system by means, for example, of an additional prison establishment like Grendon Underwood.

In their discussion, Gunn et al. (1991) urged the need for improvements in both the prisons and the National Health Service in order to meet the needs of mentally disordered sentenced prisoners. They emphasised the need for adequate funding for prison health services and adequate training for prison staff. In addition, the Prison Health Service should develop clear policies for the management of psychiatric problems, for example in having guidelines about the degree of mental disorder warranting hospital transfer and about the provision of drug and alcohol services. The authors remark on, 'the failure of the prison medical service to develop an explicit policy on the degree to which it will accept responsibility for managing psychiatric disorder' (Gunn et al. 1991, p 96). There should be a principle that inmates suffering from psychotic illnesses should not be contained in prison: as the authors point out, prison 'hospitals' lack the facilities of NHS hospitals.

In relation to the National Health Service, the research pointed to several needs: first, units providing long-term care in conditions of medium security; second, services providing rapid assessment and transfer of acutely ill prisoners; and third, improved district services for chronically ill patients who exhibit problems of social nuisance offending.

THE REED COMMITTEE

The joint Department of Health and Home Office Review of Services for Mentally Disordered Offenders and Others Requiring Similar Services was established in 1990 under the chairmanship of Dr John Reed. The main steering committee of the review delegated examination of specific topics to a series of advisory groups. These advisory groups considered hospital services, prisons, community services, staffing and training, services for people with special needs, research, academic developments and finance. The Final Summary Report from the steering committee has now been published (Department of Health/Home Office 1992c).

The reports have as their starting point a commendable set of aspirations. The policy aim expressed in the 1990 Home Office circular1 that the care and treatment of mentally disordered offenders is the responsibility of health and social services is endorsed, and, as far as possible, services should be provided in the community rather than in institutional settings, in the minimum level of security needed to protect the patient and others, as near as possible to the patient's home, and in a way that promotes rehabilitation and independence (Department of Health/Home Office 1991a).

The Report of the Finance Advisory Group (Department of Health/Home
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Office 1992a) recommends that district health authorities should be responsible for purchasing a comprehensive range of services for mentally disordered offenders, and that regional health authorities should set performance targets and monitor the achievements of districts in this regard. Regions should work within a framework of objectives set by the NHS Management Executive. However, the reports are less resolute and convincing in considering the financing of their proposals and the feasibility of achieving their recommendations. The reports recommend considerable expansion in services and manpower (Department of Health/Home Office 1992b), a likely doubling of medium secure provision (the exact level depending on the outcome of local needs assessments) (Department of Health/Home Office 1991c), and comprehensive availability of local police and court diversion schemes (Department of Health/Home Office 1991d). However, the funding recommendations of the Finance Advisory Group Report do not include earmarked central funding to enable the development of these services at local level. Without this, the prospects of achieving the goals set by the reports may be poor in the light of current constraints on finance for the health service. Ministers have welcomed the Final Summary Report but will decide in due course which recommendations to accept and when to implement them 'bearing in mind the resources available' (Department of Health/Home Office 1992c, p. iii).

The Report of the Prison Advisory Group (Department of Health/Home Office 1991b) made a number of positive recommendations for the improvement of services for mentally disordered prisoners. The Report advised that existing powers of courts to remand to prison for psychiatric reports should be examined with a view to amendment or appeal, a step which would be consistent with the principle that care should be provided by health and social services rather than in prison custody. The Report also recognised the need to facilitate more rapid transfers of the acutely ill from prison and advised that a statement of policy should be drawn up in relation to the care and treatment of mentally disordered prisoners, making clear the responsibilities of outside psychiatric services. However, the advisory group also recommended that prison governors should have responsibility for the provision of services for those with psychiatric needs included in their contracts with area managers. There was also endorsement for better discharge planning, involving continuing care for mentally disordered prisoners on release.

EFFICIENCY SCRUTINY OF THE PRISON MEDICAL SERVICE

The Reed Reports endorse the policy that psychiatric and other medical services should be contracted into prisons from the NHS. It is thought that this change should improve the quality of care and enable more rapid psychiatric assessments and continuity of care. This policy was the central recommend-
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dation of a Report on an Efficiency Scrutiny of the Prison Medical Service published
in July 1990 (Home Office 1990e). In Chapter 7 Roger Ralli describes the
purpose and outlines the main recommendations of the Efficiency Scrutiny Report. Its most significant recommendation was that the Prison Service
should become a purchaser, rather than a provider, of clinical services. Services should be provided through contracts for specialist care and primary
care, the latter being undertaken by general practitioners. The report estimated that provision of primary care from general practitioners would
result in a financial saving to the Prison Department, but the scrutiny team was unable to cost accurately the provision of specialist services.

The major failure of the report was in not examining thoroughly the feasibility of its proposals. Health authorities, health service managers and
their representative bodies do not appear in the list of those consulted by the scrutiny team. This is a remarkable omission in a report whose key
recommendation is that contracts should be established with them. In consequence there is no proper assessment of whether the resources and
manpower exist to deliver a contracted-in service.

The report also fails to address adequately the issue of clinical standards. The view taken in the Efficiency Scrutiny Report is that the provision of
health services through contracts will enable standards of care to be set and monitored, with the Prison Health Service Directorate and the Area Physician
contributing to this process (Home Office 1990e, para. 7.35). The report advises that there should be a clear ministerial commitment to a high
standard of health care in prisons and that a health advisory committee should be established to advise the Secretary of State and the Director of
the Prison Health Service. The committee would receive an annual report from the Health Director on the standards of health care provided.

However, such an arrangement would be unlikely to result in sufficiently close external scrutiny of standards and it is unfortunate that the scrutiny
team did not recommend that a body such as the Mental Health Act Commission, or the Hospital Advisory Service should have its remit
extended to cover prison hospitals, in view of the fact that these bodies have considerable expertise and experience in visiting secure hospital establish-
ments and bringing poor standards to light. The Mental Health Act Com-
mission, which has a duty to review the care of detained patients, argued in
evidence to the Woolf Inquiry that the Commission’s remit should be
extended to protect the rights and interests of mentally disordered
prisoners in prison hospitals. This recommendation was not included in
the Woolf proposals, nor in the Government’s White Paper, Custody, Care
and Justice (Home Office 1991a), despite further representations to the
Home Secretary by the Chairman of the Mental Health Act Commission
following publication of the Woolf Report (Department of Health 1991a).

Reliance has to be placed on such external investigatory bodies rather
than the courts to highlight unacceptable standards. In the case of Knight
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and Others v. The Home Office, which arose following the death by hanging of a mentally disordered prisoner at Brixton Prison, the High Court held that the standard of care required of the prison was not the same as that required of a psychiatric hospital. Hopes for remedies and more enlightened judgments from the European Commission or the European Court of Human Rights have to face the slowness and infrequency of successful proceedings (Harding 1989).

In response to the Report on an Efficiency Scrutiny of the Prison Medical Service, a joint Home Office and Department of Health working party was set up to examine the recommendations in more detail and, in August 1991, the Directorate of Prison Medical Services issued a consultation paper on contracting for prison health services (Home Office 1991m). Whilst accepting the broad recommendations of the scrutiny team, the working party considered that contracting-in of psychiatric services could not be implemented quickly. The proposal would have major manpower and training implications for NHS psychiatric services, and the bodies responsible for accrediting psychiatric training would have to be willing to approve training posts in prisons. The working party advocated 'a step by step approach' (Home Office 1991m, para. 3.20). It recommended the establishment of a small number of pilot schemes, commencing with remand prisoners, the first few of which should be established by the end of 1992.

There have also been external responses to the Efficiency Scrutiny Report. Some initial professional guidance has been issued by the Royal College of Psychiatrists (Royal College of Psychiatrists 1992), which has published an interim report on ethical issues concerning psychiatric care in prison. This commences with the explicit principle that prisoners have a right of access to medical and nursing care of the same standard as that available to other citizens. Medical and nursing staff also have a right to provide this standard of care. The report specifies that where a psychiatric team is responsible for a ward within a prison, admission and discharge decisions should be at the discretion of the psychiatrist. Medical records should be confidential, although prisoners have a right of access to their own health records under the Access to Health Records Act 1990. The report also emphasises that 'whistle-blowing' is not only allowable but may be a duty in situations which clinicians regard as damaging to the standards of care for their patients. As the first pilot schemes for contracting-in psychiatric services become established, it will be important to assess whether they are able to operate with the degree of autonomy envisaged in these recommendations. The Report of an Efficiency Scrutiny of the Prison Medical Service anticipated: 'a beneficial pressure from providers in stipulating the standards of the environment and nursing support to be made available by the Prison Service' (Home Office 1990e, para. 7.36). It is to be hoped that such pressure will be applied and will meet with success.
MENTALLY DISORDERED PRISONERS

FUTURE PROSPECTS

NHS services for mentally disordered offenders will have to survive and develop in the context of the reformed structure of the National Health Service (Department of Health 1989). These reforms introduced a separation between purchasing health authorities and provider units which are moving increasingly in the direction of becoming self-governing trusts. Under these arrangements it is the responsibility of district health authorities first, to identify health needs and priorities; and second, to purchase the range of services they consider to be required to serve the needs of their population. The future role of regional health authorities is uncertain and could contract so that they primarily become regulators of the NHS internal market. These changes could potentially have harmful consequences for forensic psychiatry services. These services are most wanted by the criminal justice agencies – prisons, courts and the probation service – but these agencies do not have significant powers to purchase medical and social care. Nor are there established structures enabling criminal justice agencies to influence the purchasing decisions of health authorities. Murphy (1992) has argued that two conditions need to be met if the NHS reforms are to benefit mentally abnormal offenders:

First, districts acquire the necessary knowledge and skill to develop a clear vision of future services for this group of patients; and, second, that regions take seriously their performance monitoring role and set ambitious targets for the service.

(p.23)

Regional health authorities must retain a pro-active role.

In two important respects the response of the Government and of the criminal justice system will also be crucial. First, the area criminal justice committees recommended in the Woolf Report should include health service representation, and this, in turn, should aim to achieve effective liaison and influence by local criminal justice agencies on health authority purchasers and managers of provider psychiatric units. Second, the ideal of community prisons described in the Woolf Report (Woolf 1991, paras. 11.49-11.68) must become a reality if NHS psychiatric services are to care more effectively for their local mentally disordered prisoners and if 'Care in the Community' is to make a significant contribution to resettlement.

NOTE

1 Home Office Circular 66/1990 Provision for Mentally Disordered Offenders.
Mentally disordered prisoners

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A report commissioned and published by the Home Office
CHAPTER 1
INTRODUCTION

This is the report of a study commissioned by the Home Office Research and Planning Unit and carried out by the Department of Forensic Psychiatry at the Institute of Psychiatry. The purposes of this study were:

1) To ascertain the nature and extent of psychiatric disorder and the need for psychiatric treatment within the sentenced prison population (of England and Wales).

2) To describe and comment upon existing arrangements for the management, care and treatment of mentally disordered prisoners, including the part played by non-medical regimes and prison hospitals.

3) To identify any therapeutic needs that are not being met, to estimate the short fall in provision and to suggest ways of meeting these needs.

Previous Studies of Psychiatric Morbidity in Sentenced Prisoners

1. Studies in the UK

Table 1.1 summarises the results of some previous surveys of psychiatric disorder amongst sentenced prisoners in the United Kingdom. Overall the findings are similar and can be summarised as follows:

i. Rates of psychosis resemble those found in the general population. In UK studies, the prevalence of psychosis is never above 3%.

ii. Alcoholism and personality disorder are the commonest diagnoses. Precise rates vary and reflect the use of different diagnostic criteria.

iii. Rates of mental handicap vary widely. Again, there is wide variation in diagnostic criteria.
Table 1.1: previous UK studies of the prevalence of psychiatric disorder in sentenced prisoners.

<table>
<thead>
<tr>
<th>MAIN AUTHOR</th>
<th>MENTAL ILLNESS</th>
<th>SUBSTANCE DEP/ABUSE</th>
<th>PERSONALITY DISORDERS</th>
<th>MENTAL HANDICAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROPER</td>
<td>Neurosis 12%</td>
<td></td>
<td>Psychopathy 8%</td>
<td>Intellectually defective 3%</td>
</tr>
<tr>
<td>1100 men</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GIBBENS</td>
<td>Psychosis 0.5%</td>
<td>&quot;Mentally abnormal&quot; 27%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>200 in Borstal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROBINSON</td>
<td>Positive psychiatric diagnosis 31%</td>
<td></td>
<td>Subnormal 24%</td>
<td></td>
</tr>
<tr>
<td>566 men</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BLUGLASS</td>
<td>Psychosis 2%</td>
<td>Alcoholism 11%</td>
<td>Alcoholism and personality disorder 75%</td>
<td>Subnormal 3%</td>
</tr>
<tr>
<td>300 men</td>
<td></td>
<td></td>
<td>Drug dependency 6%</td>
<td></td>
</tr>
<tr>
<td>FAULK</td>
<td>Psychosis 3%</td>
<td>Depression 1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>72 men</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GUNN</td>
<td>Psychoses 2%</td>
<td>Alcoholism 13%</td>
<td>Personality disorder 22%</td>
<td></td>
</tr>
<tr>
<td>629 men</td>
<td>Neurosis 9%</td>
<td>Drug dependency 3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

References to Table 1.1


Gibbens TCN. Psychiatric studies of Borstal lads. 1967 OUP: Maudsley Monograph No 11

Robinson CB, Patten JW & Kerr WS A psychiatric assessment of criminal offenders Med Sci Law 1965 5:140-146

Bluglass R A psychiatric study of Scottish convicted prisoners. 1966 Univ of St Andrews MD thesis

Faulk M A psychiatric study of men serving a sentence in Winchester Prison Med Sci Law 1976 16:244-261

2. American studies

A number of studies in American prisons have reported higher prevalence rates for some diagnoses and in particular for drug dependency. Direct comparison between American and UK studies is limited by variation in diagnostic practices and the different pattern of psychiatric and prison services.

The results of a 1976 study by Guze\(^1\) are consistent with the pattern described above. He diagnosed 78% of a male sample as sociopathic (personality disordered) but only 1% were found to be suffering from schizophrenia. Rates for other diagnoses were: alcoholism 54%, anxiety neurosis 12%, drug dependency 5% and subnormality 1%. The diagnoses were not mutually exclusive and the high rate of personality disorder resulted from the use of very loose criteria. A similar study of 66 female prisoners produced similar findings for most diagnoses but higher rates of drug dependency (26%) and subnormal intelligence (6%). The small sample size reduces the significance of the latter finding; it represents 4 subnormal women.

A 1977 study of 1400 inmates in the New York prison population\(^2\) reported current heroin abuse in 17%, alcohol dependence in 5% and a history of psychiatric hospitalisation in 7%.

A 1980 study of 174 inmates\(^3\) found a high rate of schizophrenia at 5%; the significance of this finding is uncertain because of the small sample size and the fact that it was a study of a single prison.

Limitations of Previous Studies

With so many studies in the past why is a further study necessary? One major reason is that all the studies described above are at least ten years old. The prison population has increased in this period and the number of mentally disordered people within it may have changed. In particular there has been concern that changing patterns of NHS psychiatric services have resulted in increasing numbers of mentally abnormal people going to prison.

In addition, there are methodological problems which limit the extent to which previous studies can be regarded as an accurate description of psychiatric disorder in the sentenced prison population of England and Wales.

1) Many are based on single prisons (usually local prisons) which are not representative of the entire prison estate.

2) Most samples were of consecutive receptions, introducing a bias towards prisoners serving short sentences. A cross-section of the prison population would include many more inmates serving long sentences.

3) Most studies make no comment on the suitability for treatment of individual subjects. This criticism is in many ways the most important. Treatment needs do not follow merely from the presence of a diagnosis and other factors such

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\(^1\) Guze SB. Criminality and Psychiatric Disorders 1976 New York: Oxford University Press


\(^3\) James JF, Gregory D, Jones RK & Rundell OH. Psychiatric morbidity in prisons. Hospital and Community Psychiatry 1980 31:674-7

-7477-
as motivation have to be taken into account. This criticism is particularly relevant to those disorders previously noted to be the most common in prison - personality disorder and substance dependency.

The earlier study from this department by Gunn et al addressed these problems by using a cross-sectional sample from an entire prison region and including measures of attitude towards treatment. Part of a census of sentenced men in the South East prison region, it was based on a questionnaire given to 811 men, validated by psychiatric interviews with 90 inmates. Two percent of men were suffering from psychosis; the commonest diagnoses were, again, personality disorder and alcoholism. From the questionnaire data, it was estimated that 31% of prisoners were likely to be psychiatric cases, both having a diagnosis and being suitable for treatment.

The present study can be seen as an expansion of this work. Sampling is extended to cover all prison regions and the female and youth custody populations. In addition, each identified case is assessed to decide upon the most appropriate treatment; this is used to estimate the treatment needs of the entire sentenced population. All subjects in the present study are assessed at interview by a psychiatrist.

Medical Services for Prisoners.

A further reason for the present study is that none of the previous surveys have looked in detail at medical services for mentally disordered prisoners. The "oldest civilian medical service" began with an Act of Parliament in 1774, in response to the threat of typhus spreading from prisons to surrounding communities. Since then, the work of the service has been concerned increasingly with psychiatric rather than physical disease.

There has been increasing criticism of the continued separation of the Prison Medical Service from the NHS. Proposed improvements in the relationship between the two services have ranged from recommendations that links between the two services should be much closer, to the suggestion that the Prison Medical Service should be abolished and all services provided by the NHS.

A recent report recommends fundamental changes in the way in which health care is delivered to prisoners. Rational planning of services for mentally disordered prisoners depends on a knowledge of existing facilities and the identification of the unmet treatment needs. These are the second and third objectives of our study.

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5 Report of House of Commons Social Services Committee 1986 London:HMSO
6 Royal College of Psychiatrists. Evidence to the prison services enquiry. Bull Royal Coll of Psychiatrists, May 1979 81-4
7 Report on an efficiency scrutiny of the Prison Medical Service
Design of the Study

The present study is based on a large representative cross-sectional sample of sentenced prisoners in England and Wales. Subjects are given a diagnosis, their treatment needs assessed and current treatment described. Interviews with doctors and other prison staff are used to build up a description of the treatment facilities generally available to the mentally disordered in prison.

As in previous studies, a psychiatric interview leads to a standard psychiatric diagnosis. The fact of our subjects being criminals, being in prison or being convicted of particular offences was not in itself indicative of any diagnosis. Our knowledge of the nature of the individual's offence was information that played a part in the assessment procedure but diagnoses were not made on offence alone.

In assessing treatment needs, ratings were made by applying the same principles we would use when assessing a patient in a more orthodox psychiatric setting. The aim was to replicate psychiatric assessment in a clinic or hospital; the full range of treatment options was considered. Treatment recommendations did not take into account the treatment available at the prison where the subject was held. The description and assessment of existing facilities for treatment formed a separate part of the study.

Limitations of the study

It is important to note that the study was confined to sentenced prisoners. Fine defaulters and remand prisoners were excluded. Approximately one quarter of people in prison are awaiting trial or sentence. This group contains a proportion of individuals who have been remanded specifically because of mental abnormality. Surveys of individual remand prisons have revealed high levels of psychiatric illness. Whilst an examination of the sentencing process in relation to mentally disordered remand prisoners has been commissioned by the Home Office and is being undertaken by the Institute of Criminology, there remains a gap in our knowledge of the prevalence of psychiatric disorder in remand prisoners. There is an urgent need for a study in this area, which has relevance for both the Home Office and the Dept. of Health.

Chapters 2 and 3 cover the methodology of the study. The general characteristics of the sample are given in Chapter 4. Chapters 5, 6 and 7 report the nature and extent of psychiatric disorder and the need for psychiatric treatment in the prison population. Chapter 8 describes the existing arrangements for psychiatric treatment and Chapter 9 describes the unmet need for treatment and the services required to meet this need.

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CHAPTER 5
DIAGNOSIS

Primary Diagnosis

Table 5.1 shows the frequency of the primary diagnoses in the three samples. In this and the following tables ICD-9 diagnoses have been combined to create diagnostic groups. These diagnostic groups are defined below.

- Psychoses combines schizophrenia (ICD 295), affective psychoses (296) and paranoid psychoses (297).
- Neuroses combines neurotic disorders (300) and adjustment reaction (309).
- Substance dependency/abuse combines alcohol dependency/abuse (303 and 305.0), drug dependency/abuse (304 and 305.3 - 305.9) and pathological gambling.
- Organic disorders combines epilepsy (345), anoxic brain damage (348.1) and mental disorders following organic brain damage (310) with mild mental retardation (317).
- Diagnosis uncertain was used in subjects where it was thought probable that an ICD diagnosis could be made but lack of time prevented full diagnostic assessment. They were given codes 666.6 and 888.8 during the assessment (see Appendix B).

Additional Diagnoses

Seventy-two adult men received a second diagnosis and 14 received a third. Thirty three women received a second diagnosis and 3 received a third. Thirty six male youths received a second diagnosis and 6 received a third. Multiple diagnoses were usually combinations of substance dependency/abuse with personality disorder and neurosis. The overall numbers of specific diagnoses (combining primary with additional diagnoses) are shown in Table 5.2. This table demonstrate in particular the high prevalence of personality disorders and of substance dependency/abuse in the samples. The total numbers of specific diagnoses are of course higher than those shown in Table 5.1 although the total number of subjects who have a diagnosis is unchanged.

Population Prevalence Rates

Based on these findings, estimates have been made of the prevalence of psychiatric disorders in the total sentenced prison population. Tables 5.3, 5.4 and 5.5 show the prevalence of the various psychiatric disorders (expressed as a percentage) in the three samples. This is followed by the 95% confidence interval (CI) for the population1. The confidence interval figures show the imprecision inherent in estimating population figures from a sample. There is a 95% confidence that the population figure (i.e. the prevalence of a particular disorder amongst the population of sentenced prisoners) will lie within the indicated range. In some instances small numbers and percentages make the use of confidence intervals inappropriate and in the tables this is indicated by "N/A". Estimates here are less accurate.

The estimated number of subjects with each diagnosis in the prison population (the "pop est") has been calculated by multiplying the prevalence of each diagnosis

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1 A finite population correction has been made for the female results as described in V. Barnett, Elements of sampling theory 1974.

-7480-
by the prison population. A range of likely values for the number of cases in the population (the "CI") has been calculated by multiplying the upper and lower confidence interval figures by the prison population. The numbers from the three groups have been combined in Table 5.6 to show an estimate of the total number of people with psychiatric disorder amongst all sentenced prisoners.

Comparison with Previous Studies

a. Psychotic disorders

The prevalence of psychotic disorders found in this study is very similar to that reported in earlier studies (see Chapter 1). It seems likely that the prevalence of these disorders has not changed markedly over the intervening years. The prevalence of schizophrenia at 1.5% (95% confidence interval 0.9% - 2.1%) is higher than the rate of between 0.2% and 0.5% found in community studies.

b. Personality disorders

The prevalence of personality disorders is lower than that reported in the studies listed in Chapter 1. This reflects differing diagnostic criteria. Chapter 3 describes the principles on which personality disorders were diagnosed. It can be restated that the diagnosis was made in those subjects who met explicit criteria for the disorder but that this information was often lacking because of shortage of time and lack of background information. Our impression is that a substantial minority of our sample would have meet the diagnostic criteria for personality disorder if we had taken more time for assessment - this would have required a one hour interview per subject. We suspect that the great majority of the extra subjects picked up by this method would not see themselves as abnormal or requiring treatment. Such an exercise would be costly and would not in the end produce much helpful information in determining treatment needs. The information needed to determine unmet needs is not that of knowing how many subjects meet the diagnostic criteria but knowing how many of those with a personality disorder want to have psychiatric treatment - this information is given in the next chapter.

c. Alcohol dependency/abuse

Our figures for the prevalence of alcohol dependency/abuse are lower than those reported for alcoholism in the studies listed in Chapter 1. The criteria for "alcoholism" in these studies are not always specified and direct comparison is not possible. Searching for the precise number of subjects with an alcohol disorder, however defined, is not the prime purpose of the study. There is no clear line between normal and abnormal drinking. If we had used different criteria - for example including all those who drank above the recommended guidelines - we could have produced different results for the prevalence of this diagnosis. We have used our criteria as a means of identifying a group for whom treatment for an drink problem might be appropriate. Again the important information is knowing how many of these subjects want to have psychiatric treatment.

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Diagnosis 40

d. Drug dependency/abuse

Drug dependency was diagnosed on the basis of daily use of drugs of dependency during the six month period prior to the index offence. The figures do not include cannabis users. Unlike the situation with alcohol dependency/abuse there the use of differing criteria would have had little effect on the prevalence of this disorder because there is a much clearer line between normal and abnormal drug use. Comparison with earlier studies is appropriate for this diagnosis.

The figures are greater than those reported in earlier studies. Drug dependency/abuse is now the commonest single diagnosis amongst sentenced prisoners. This reflects a rise in the prevalence of this disorder in the UK. This change is discussed in Chapter 8.

Table 5.1: frequency of primary diagnoses in adult males, male youths and females.

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>ADULT MALES n = 1365</th>
<th>MALE YOUTHS n = 404</th>
<th>FEMALES n = 273</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSYCHOSES</td>
<td>33 2.4</td>
<td>1 0.2</td>
<td>3 1.1</td>
</tr>
<tr>
<td>SCHIZOPHRENIA</td>
<td>20 1.5</td>
<td>1 0.2</td>
<td>3 1.1</td>
</tr>
<tr>
<td>AFFECTIVE</td>
<td>7 0.5</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>PARANOID</td>
<td>6 0.4</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>NEUROSES</td>
<td>71 5.2</td>
<td>18 4.5</td>
<td>36 13.2</td>
</tr>
<tr>
<td>NEUROTIC DISORDERS</td>
<td>49 3.6</td>
<td>12 3.0</td>
<td>21 7.7</td>
</tr>
<tr>
<td>ADJUSTMENT REACTION</td>
<td>22 1.6</td>
<td>6 1.5</td>
<td>15 5.5</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>99 7.3</td>
<td>46 11.4</td>
<td>23 8.4</td>
</tr>
<tr>
<td>SEXUAL DEVIATIONS</td>
<td>33 2.4</td>
<td>1 0.2</td>
<td>0 0</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>275 20.1</td>
<td>64 15.8</td>
<td>79 28.9</td>
</tr>
<tr>
<td>ALCOHOL</td>
<td>118 8.6</td>
<td>35 8.7</td>
<td>12 4.4</td>
</tr>
<tr>
<td>DRUGS</td>
<td>138 10.1</td>
<td>25 6.2</td>
<td>66 24.2</td>
</tr>
<tr>
<td>PATHOLOGICAL GAMBLING</td>
<td>19 1.4</td>
<td>4 1.0</td>
<td>1 0.4</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>12 0.9</td>
<td>2 0.5</td>
<td>7 2.6</td>
</tr>
<tr>
<td>EPILEPSY/ORGANIC</td>
<td>7 0.5</td>
<td>1 0.2</td>
<td>1 0.4</td>
</tr>
<tr>
<td>MENTAL RETARDATION</td>
<td>5 0.4</td>
<td>1 0.2</td>
<td>6 2.2</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>18 1.3</td>
<td>2 0.5</td>
<td>5 1.8</td>
</tr>
<tr>
<td>NO DIAGNOSIS</td>
<td>824 60.4</td>
<td>270 66.8</td>
<td>120 44.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1365 100</td>
<td>404 100</td>
<td>273 100</td>
</tr>
</tbody>
</table>
Table 5.2: number of specific diagnoses in samples of adult males, male youths and females.

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>ADULT MALES n = 1365</th>
<th>MALE YOUTHS n = 404</th>
<th>FEMALES n = 273</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSYCHOSES</td>
<td>33 2.4</td>
<td>1 0.2</td>
<td>3 1.1</td>
</tr>
<tr>
<td>NEUROSES</td>
<td>79 5.8</td>
<td>23 5.7</td>
<td>42 15.4</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>120 8.8</td>
<td>57 14.1</td>
<td>44 16.1</td>
</tr>
<tr>
<td>SEXUAL DEVIATIONS</td>
<td>37 2.7</td>
<td>1 0.2</td>
<td>0 0</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>310 22.7</td>
<td>75 18.6</td>
<td>84 30.8</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>13 1.0</td>
<td>2 0.5</td>
<td>7 2.6</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>18 1.3</td>
<td>2 0.5</td>
<td>5 1.8</td>
</tr>
</tbody>
</table>

Table 5.3: estimated prevalence of psychiatric disorder in sentenced adult males by diagnostic group (for sample n = 1365 for population n = 28970)

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>SAMPLE %</th>
<th>95% CI FOR POPULATION</th>
<th>POP EST</th>
<th>(CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSYCHOSES</td>
<td>2.4</td>
<td>(1.6 - 3.2)</td>
<td>695</td>
<td>(460 - 930)</td>
</tr>
<tr>
<td>NEUROSES</td>
<td>5.2</td>
<td>(4.2 - 6.4)</td>
<td>1506</td>
<td>(1165 - 1848)</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>7.3</td>
<td>(5.9 - 8.7)</td>
<td>2115</td>
<td>(1715 - 2515)</td>
</tr>
<tr>
<td>SEXUAL DEVIATIONS</td>
<td>2.4</td>
<td>(1.6 - 3.2)</td>
<td>695</td>
<td>(460 - 930)</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>20.1</td>
<td>(18.0 - 22.2)</td>
<td>5823</td>
<td>(5207 - 6439)</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>0.9</td>
<td>N/A</td>
<td>261</td>
<td>N/A</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>1.3</td>
<td>N/A</td>
<td>377</td>
<td>N/A</td>
</tr>
<tr>
<td>TOTAL (ANY DIAGNOSIS)</td>
<td>39.6</td>
<td>(37.0 - 42.2)</td>
<td>11472</td>
<td>10720 - 12224</td>
</tr>
</tbody>
</table>
Table 5.4: estimated prevalence of psychiatric disorder in sentenced male youths by diagnostic group (for sample n = 404 for population n = 7692)

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>SAMPLE %</th>
<th>95% CI FOR POPULATION</th>
<th>POP EST</th>
<th>(CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSYCHOSES</td>
<td>0.2</td>
<td>N/A</td>
<td>15</td>
<td>N/A</td>
</tr>
<tr>
<td>NEUROSES</td>
<td>4.5</td>
<td>(2.5 - 6.5)</td>
<td>346</td>
<td>(191 - 502)</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>11.4</td>
<td>(8.3 - 14.5)</td>
<td>877</td>
<td>(639 - 1115)</td>
</tr>
<tr>
<td>SEXUAL DEVIATIONS</td>
<td>0.2</td>
<td>N/A</td>
<td>15</td>
<td>N/A</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>15.8</td>
<td>(12.2 - 19.4)</td>
<td>1215</td>
<td>(942 - 1489)</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>0.5</td>
<td>N/A</td>
<td>38</td>
<td>N/A</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>0.5</td>
<td>N/A</td>
<td>38</td>
<td>N/A</td>
</tr>
<tr>
<td>TOTAL (ANY DIAGNOSIS)</td>
<td>33.2</td>
<td>(28.6 - 37.8)</td>
<td>2554</td>
<td>(2201 - 2907)</td>
</tr>
</tbody>
</table>

Table 5.5: estimated prevalence of psychiatric disorder in sentenced females by diagnostic group (for sample n = 273 for population n = 1235).

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>SAMPLE %</th>
<th>95% CI FOR POPULATION</th>
<th>POP EST</th>
<th>(CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSYCHOSES</td>
<td>1.1</td>
<td>N/A</td>
<td>14</td>
<td>N/A</td>
</tr>
<tr>
<td>NEUROSES</td>
<td>13.2</td>
<td>(9.7 - 16.7)</td>
<td>163</td>
<td>(120 - 207)</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>8.4</td>
<td>(5.5 - 11.3)</td>
<td>104</td>
<td>(68 - 139)</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>28.9</td>
<td>(24.2 - 33.6)</td>
<td>389</td>
<td>(325 - 453)</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>2.6</td>
<td>N/A</td>
<td>32</td>
<td>N/A</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>1.8</td>
<td>N/A</td>
<td>22</td>
<td>N/A</td>
</tr>
<tr>
<td>TOTAL (ANY DIAGNOSIS)</td>
<td>56.0</td>
<td>(50.8 - 61.2)</td>
<td>692</td>
<td>(628 - 755)</td>
</tr>
</tbody>
</table>
Diagnosis 43

Table 5.6: estimated prevalence of psychiatric disorder amongst all sentenced prisoners by diagnostic group.

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>NUMBER</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSYCHOSIS</td>
<td>724</td>
<td>1.9%</td>
</tr>
<tr>
<td>NEUROTIC DISORDERS</td>
<td>2015</td>
<td>5.3%</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>3096</td>
<td>8.2%</td>
</tr>
<tr>
<td>SEXUAL DEVIATIONS</td>
<td>710</td>
<td>1.9%</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>7427</td>
<td>19.6%</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>331</td>
<td>0.9%</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>437</td>
<td>1.2%</td>
</tr>
<tr>
<td>TOTAL (ANY DIAGNOSIS)</td>
<td>14718</td>
<td>38.8%</td>
</tr>
</tbody>
</table>

n = 37897
CHAPTER 6
TREATMENT

Treatment Needs

Table 6.1 shows the interviewer's treatment plan for each of the adult male subjects by diagnostic group. The diagnosis shown is the primary diagnosis for each case.

In 48 subjects our judgement was that these individuals should not be in prison at all and should instead be transferred to hospital. These "hospital cases" are described more fully in Chapter 7.

In 80 subjects our judgement was that the individuals should be in a "therapeutic community".

In 140 subjects there was a need for psychiatric treatment which could be met by the prison medical service within the prison.

In 205 subjects no treatment recommendation was made even though the subject had a diagnosis - these were subjects who expressed no wish for treatment and where compulsory treatment would not be applicable. This was a common rating in subjects with personality disorders and substance dependency/abuse.

In 68 subjects the best treatment was unclear as the short time available for interview in complex cases left the rater having doubts about diagnosis or the subjects' motivation. In such individuals it is suggested that further assessment would allow the individual to be placed in one of the other categories above.

Current Treatment

Current treatment was recorded during the interview. In reporting the findings here all inmates who said that they were being prescribed psychotropic drugs (any prescribed drug prescribed to treat mental disorders ie antidepressants, anxiolytic drugs and sleeping tablets) were rated as receiving out-patient treatment. Subjects seeing a visiting psychiatrist for supportive psychotherapy or having any form of regular treatment from a psychologist have been rated as having psychological treatment. Many subjects had been seen for a single assessment interview - this was not rated as treatment. The nature of the sample meant that subjects could not possibly be currently receiving some of the recommended treatments. Clearly no subject within the sample could be in an NHS hospital or therapeutic community except the two subjects from the Annex at Wormwood Scrubs.

Table 6.2 shows the treatment currently being received by all adult males by primary diagnostic group. Tables 6.3 and 6.4 show the interviewer's treatment plan and the treatment currently being received by male youths. Tables 6.5 and 6.6 show the interviewer's treatment plan and the treatment currently being received by women.
Meaning of abbreviations in tables:
"None" no psychiatric/psychological treatment
"OP" seeing prison doctor, prescribed medication
"Psychther" psychological treatment, counselling or psychotherapy from a doctor or psychologist
"Pris Ho" in prison hospital
"Pris care" is combined from "OP", "Psychther" and "Pris Ho"
"Ther comm" therapeutic community treatment
"IP NHS" admission to a NHS psychiatric facility
"Fur ass" further assessment

Treatment Needs in Population

Based on these findings, estimates have been made of the prevalence of treatment needs in the total sentenced prison population. Tables 6.7, 6.8, and 6.9 show the prevalence of treatment needs (expressed as a percentage) in the three samples. This is followed by the 95% confidence interval (CI) for the population where the number and prevalence of diagnoses makes this appropriate. The estimated number of people needing treatment in the prison population (the "pop est") has been calculated by multiplying up the prevalence of each treatment need by the prison population. The numbers from the three groups have been combined in Table 6.10 to show an estimate of the total number of people with psychiatric treatment needs amongst all sentenced prisoners.

Comparing Treatment Needs With Current Treatment

It is possible to make a comparison between the treatment received (actual treatment) and the recommended treatment (ideal treatment). The following tables do this for all subjects combined (adult males, male youths and women). The following tables establish the medical treatment being given within the prison to those who should have been in hospital or therapeutic communities and establish to what extent those who needed psychiatric treatment that could be received within prison were in fact receiving such care.

a. Psychotic disorders

Table 6.11 shows the treatment currently being received by all subjects with a diagnosis of psychosis compared with our recommended treatment. All these subjects with a psychosis were rated as needing some form of treatment. In most subjects the ideal treatment required admission to a NHS psychiatric bed. These subjects are more fully described in Chapter 7. Two subjects had in fact been accepted and were awaiting transfer. All others can be regarded as having unmet treatment needs. In four subjects of psychosis management within the prison was thought to be sufficient. These were two subjects with depressive psychoses who had not been treated but had almost recovered. It was thought that these two might well have been hospital cases earlier in their illness but that treatment in the prison would now be sufficient. The other two were subjects with paranoid psychoses whose delusions appeared to be
solely related to prison life and who were not getting into any difficulty as a result of their delusions.

While remaining in prison the best possible treatment for subjects with a psychosis would include admission to the prison hospital and this happened to one third of these subjects (13/37). Nine subjects were receiving no medical care - these had not been detected. The remaining subjects were in touch with the prison doctor and being assessed or receiving a prescription of neuroleptic drugs.

b. Neurotic disorders

Table 6.12 shows the treatment currently being received by all subjects with a diagnosis of neurosis compared with recommended treatment. Most subjects with neurotic disorder stated that they wanted treatment. In most instances they can be managed within the prison with medication and supportive psychotherapy. A few subjects needed transfer to an NHS hospital - in particular those subjects with depression where suicidal thoughts are prominent. These subjects are described in Chapter 7. Other than this small group such subjects do not make great demands on treatment resources yet very few of them were receiving any treatment.

Case history: a 25 year old serving 5 years for theft and conspiracy. There was no past psychiatric history. His marriage had recently broken down and he was uncertain of the whereabouts of his two children and unable to obtain any information since his wife had broken off contact. He had coped with previous sentences without problems but found his present situation intolerable. Mental state examination revealed a tearful man reporting anxious ruminations on his plight and a pessimistic view of his life and future. He reported frequent suicidal thoughts, although he had made no specific plans. Sleep was poor with early morning waking. A diagnosis of neurotic depression was made. The most appropriate treatment would be supportive psychotherapy and possibly the prescription of medication.

Out of 125 subjects with neurotic disorder, 114 were rated as needing psychiatric treatment and 29 of these were already receiving treatment. Our assessment included a judgement as to whether or not current treatment was appropriate to the patient’s needs. In 22 of these cases, treatment was judged to be adequate and this figure represents approximately 18% of all those with a diagnosis of neurotic disorder. The seven cases who were receiving treatment which did not adequately meet their needs included the five subjects who were rated as requiring transfer to a psychiatric hospital. These were people who had not responded to medication and supportive psychotherapy in prison and were felt to represent a significant suicide risk.

c. Other disorders

Most subjects with neurotic disorders can be treated within the prison. Subjects with alcohol or drug dependency, personality or sexual disorder who are strongly motivated for treatment need to have their treatment in special settings. The findings for actual treatment received for subjects with each of the individual diagnoses above and from the three groups (adult male, male youths and females) are similar. Subjects from these diagnostic groups have been combined in Table 6.13 to show the actual treatment they were getting. Two men were in a therapeutic community - the Annex at Wormwood Scrubs.
Of the 620 subjects with one of the above diagnoses, no treatment recommendation was made in 279 subjects - this was mostly due to lack of motivation for treatment. Most of this group were having no medical treatment. A small number of subjects rated as needing no treatment are recorded as actually receiving treatment in this table. This is a result of the way information has been combined. Everyone receiving a prescription for a psychotropic drug has been recorded as having "OP" care. Thus subjects were found who did not want any psychiatric treatment for their primary disorder and were receiving sleeping tablets. Also 4 subjects with a diagnosis of drug dependency who were not motivated for treatment were located in prison hospitals. They were not receiving any form of psychiatric treatment.

The remaining 341 were rated as needing some form of treatment and the table compares ideal with actual treatment for this group. 269 of these were receiving no form of psychiatric treatment at all. Of the remaining 72 who were receiving some form of psychiatric treatment we rated whether the treatment they were receiving to be appropriate to their needs. We judged that 34 of these subjects were receiving appropriate treatment. This figure of 34 represents approximately 10% of all those with diagnoses of personality disorders, sexual deviations and substance abuse/dependency who needed treatment. The remaining 38 (again approximately 10% of all those in this group with treatment needs) were receiving some treatment but it did not adequately meet their needs.
Table 6.1: adult males - ideal treatment plan for all subjects by diagnostic group (n = 1365).

<table>
<thead>
<tr>
<th>DIAGNOSTIC GROUP</th>
<th>NONE</th>
<th>PRIS</th>
<th>THER</th>
<th>COMM</th>
<th>NHS</th>
<th>FUR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>824</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>824</td>
</tr>
<tr>
<td>PSYCHOSIS</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>29</td>
<td>0</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>NEUROSIS</td>
<td>4</td>
<td>63</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>71</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>25</td>
<td>19</td>
<td>31</td>
<td>4</td>
<td>20</td>
<td>0</td>
<td>99</td>
</tr>
<tr>
<td>SEXUAL DEVIATIONS</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>9</td>
<td>5</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>168</td>
<td>46</td>
<td>38</td>
<td>0</td>
<td>23</td>
<td>0</td>
<td>275</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1029</td>
<td>140</td>
<td>80</td>
<td>48</td>
<td>68</td>
<td>0</td>
<td>1365</td>
</tr>
<tr>
<td>(<strong>%</strong>*)</td>
<td>(76)</td>
<td>(10)</td>
<td>(6)</td>
<td>(4)</td>
<td>(5)</td>
<td>(0)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

Table 6.2: adult males - current treatment by diagnostic group (n = 1365).

<table>
<thead>
<tr>
<th>DIAGNOSTIC GROUP</th>
<th>NONE</th>
<th>OP</th>
<th>PRIS transcripts HO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>824</td>
<td>0</td>
<td>0</td>
<td>824</td>
</tr>
<tr>
<td>PSYCHOSIS</td>
<td>9</td>
<td>14</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>NEUROSIS</td>
<td>55</td>
<td>15</td>
<td>1</td>
<td>71</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>76</td>
<td>18</td>
<td>5</td>
<td>99</td>
</tr>
<tr>
<td>SEXUAL DEVIATIONS</td>
<td>26</td>
<td>6</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>255</td>
<td>15</td>
<td>5</td>
<td>275</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>16</td>
<td>1</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1271</td>
<td>70</td>
<td>24</td>
<td>1365</td>
</tr>
</tbody>
</table>
Table 6.3: male youths - ideal treatment by diagnostic group (n = 404)

<table>
<thead>
<tr>
<th>DIAGNOSTIC GROUP</th>
<th>NONE</th>
<th>PRIS CARE</th>
<th>THER COMM</th>
<th>NHS</th>
<th>FUR ASS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>270</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSYCHOSIS</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>NEUROSIS</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEXUAL DEVIATIONS</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>323</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6.4: male youths - current treatment by diagnostic group (n = 404).

<table>
<thead>
<tr>
<th>DIAGNOSTIC GROUP</th>
<th>NONE</th>
<th>OP</th>
<th>PRIS HO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>270</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSYCHOSIS</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NEUROSIS</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEXUAL DEVIATIONS</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>389</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6.5: females - ideal treatment by diagnostic group (n = 273)

<table>
<thead>
<tr>
<th>DIAGNOSTIC GROUP</th>
<th>NONE</th>
<th>PRIS CARE</th>
<th>THER COMM</th>
<th>NHS</th>
<th>FUR ASS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>120</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>120</td>
</tr>
<tr>
<td>PSYCHOSIS</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>NEUROSIS</td>
<td>2</td>
<td>31</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>36</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>1</td>
<td>10</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>33</td>
<td>18</td>
<td>16</td>
<td>0</td>
<td>12</td>
<td>79</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>156</td>
<td>60</td>
<td>20</td>
<td>11</td>
<td>26</td>
<td>273</td>
</tr>
</tbody>
</table>

(%) (57) (22) (7) (4) (9) (100)

Table 6.6: females - current treatment by diagnostic group (n = 273)

<table>
<thead>
<tr>
<th>DIAGNOSTIC GROUP</th>
<th>NONE</th>
<th>OP</th>
<th>PRIS HO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>120</td>
<td>0</td>
<td>0</td>
<td>120</td>
</tr>
<tr>
<td>PSYCHOSIS</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>NEUROSIS</td>
<td>26</td>
<td>8</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>PERSONALITY DISORDERS</td>
<td>14</td>
<td>7</td>
<td>2</td>
<td>23</td>
</tr>
<tr>
<td>SUBSTANCE DEP/ABUSE</td>
<td>63</td>
<td>11</td>
<td>5</td>
<td>79</td>
</tr>
<tr>
<td>ORGANIC DISORDERS</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>DIAGNOSIS UNCERTAIN</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>231</td>
<td>32</td>
<td>11</td>
<td>273</td>
</tr>
</tbody>
</table>
Table 6.7: treatment needs in population of sentenced adult males (for sample n = 1365 for population n = 28970)

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>SAMPLE %</th>
<th>95% CI FOR POPULATION</th>
<th>POP EST</th>
<th>(CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP PRISON SUPPORT</td>
<td>10.2</td>
<td>(8.6 - 11.8)</td>
<td>2995</td>
<td>(2490 - 3420)</td>
</tr>
<tr>
<td>THERAPEUTIC COMMUNITY</td>
<td>5.9</td>
<td>(4.6 - 7.2)</td>
<td>1709</td>
<td>(1347 - 2071)</td>
</tr>
<tr>
<td>IP NHS</td>
<td>3.5</td>
<td>(2.5 - 4.5)</td>
<td>1014</td>
<td>(732 - 1296)</td>
</tr>
<tr>
<td>FURTHER ASSESSMENT</td>
<td>5.0</td>
<td>(3.8 - 6.2)</td>
<td>1448</td>
<td>(1114 - 1783)</td>
</tr>
</tbody>
</table>

Table 6.8: treatment needs in population of sentenced male youths (for sample n = 404 for population n = 7692)

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>SAMPLE %</th>
<th>95% CI FOR POPULATION</th>
<th>POP EST</th>
<th>(CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP PRISON SUPPORT</td>
<td>9.2</td>
<td>(6.4 - 12.0)</td>
<td>708</td>
<td>(491 - 924)</td>
</tr>
<tr>
<td>THERAPEUTIC COMMUNITY</td>
<td>4.0</td>
<td>(2.1 - 5.9)</td>
<td>308</td>
<td>(161 - 455)</td>
</tr>
<tr>
<td>IP NHS</td>
<td>1.0</td>
<td>N/A</td>
<td>77</td>
<td>N/A</td>
</tr>
<tr>
<td>FURTHER ASSESSMENT</td>
<td>5.4</td>
<td>(3.2 - 7.6)</td>
<td>415</td>
<td>(246 - 585)</td>
</tr>
</tbody>
</table>

Table 6.9: treatment needs in population of sentenced women (for sample n = 273 for population n = 1235)

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>SAMPLE %</th>
<th>95% CI FOR POPULATION</th>
<th>POP EST</th>
<th>(CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OP PRISON SUPPORT</td>
<td>22.3</td>
<td>(18.0 - 26.6)</td>
<td>275</td>
<td>(222 - 329)</td>
</tr>
<tr>
<td>THERAPEUTIC COMMUNITY</td>
<td>7.3</td>
<td>(4.6 - 10.0)</td>
<td>90</td>
<td>(57 - 124)</td>
</tr>
<tr>
<td>IP NHS</td>
<td>4.0</td>
<td>(2.0 - 6.0)</td>
<td>49</td>
<td>(24 - 75)</td>
</tr>
<tr>
<td>FURTHER ASSESSMENT</td>
<td>9.2</td>
<td>(6.2 - 12.2)</td>
<td>114</td>
<td>(74 - 151)</td>
</tr>
</tbody>
</table>
Table 6.10: treatment needs amongst all sentenced prisoners.

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>NUMBER</th>
<th>PERCENT</th>
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<tbody>
<tr>
<td>OP PRISON SUPPORT</td>
<td>3978</td>
<td>10.5%</td>
</tr>
<tr>
<td>THERAPEUTIC COMMUNITY</td>
<td>2107</td>
<td>5.6%</td>
</tr>
<tr>
<td>IP NHS</td>
<td>1140</td>
<td>3.0%</td>
</tr>
<tr>
<td>FURTHER ASSESSMENT</td>
<td>1977</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

Table 6.11: all subjects (adult males, male youths and females) with diagnosis of psychosis - current treatment compared with ideal treatment (n = 37).

<table>
<thead>
<tr>
<th>IDEAL TREATMENT</th>
<th>NONE</th>
<th>OP</th>
<th>PRIS HO</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OP</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>PRIS HO</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>IP NHS</td>
<td>7</td>
<td>13</td>
<td>13</td>
<td>33</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9</td>
<td>15</td>
<td>13</td>
<td>37</td>
</tr>
</tbody>
</table>
Table 6.12: all subjects (adult males, male youths and females) with a primary diagnosis of neurosis - current treatment compared with ideal treatment (n = 125).

<table>
<thead>
<tr>
<th>IDEAL TREAT</th>
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<th>OP</th>
<th>PSYCH TRT</th>
<th>PRIS HO</th>
<th>IP NHS</th>
<th>FUR ASS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
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<td>OP</td>
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<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>PSYCH THER</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>PRIS HO</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>THER COMM</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>IP NHS</td>
<td>3</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>FUR ASS</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>96</td>
<td>19</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>125</td>
</tr>
</tbody>
</table>

Table 6.13: all subjects (adult males, male youths and females) with a primary diagnosis of substance dependency/abuse, personality disorders and sexual deviations - current treatment compared with ideal treatment (n = 620).

<table>
<thead>
<tr>
<th>IDEAL TREAT</th>
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<th>OP</th>
<th>PSYCH TRT</th>
<th>PRIS HO</th>
<th>THER COMM</th>
<th>IP NHS</th>
<th>FUR ASS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>266</td>
<td>6</td>
<td>3</td>
<td>4</td>
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<td>0</td>
<td>0</td>
<td>279</td>
</tr>
<tr>
<td>OP</td>
<td>47</td>
<td>13</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>69</td>
</tr>
<tr>
<td>PSYCH THER</td>
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<td>1</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>51</td>
</tr>
<tr>
<td>PRIS HO</td>
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<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>THER COMM</td>
<td>91</td>
<td>5</td>
<td>3</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>109</td>
</tr>
<tr>
<td>IP NHS</td>
<td>7</td>
<td>5</td>
<td>6</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>FUR ASS</td>
<td>76</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>0</td>
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<td>88</td>
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<tr>
<td>TOTAL</td>
<td>535</td>
<td>38</td>
<td>26</td>
<td>19</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>620</td>
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</tbody>
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CHAPTER 8
PSYCHIATRIC CARE IN PRISONS

Introduction

This account of existing facilities for the management of psychiatric disorder is based on the twenty-eight prisons visited during the survey and on information gained from interviews with medical, discipline and probation staff and inmates. It also incorporates our own impressions, resulting from spending many hours in prisons, observing the prison regime and talking informally with staff and inmates.

Selection of the sample prisons is described in Chapter 2; they vary across the full spectrum of levels of security, type of inmate and length of sentence. We visited overcrowded Victorian local prisons where the average day for an inmate is 23 hours locked in a cell with two or three other men; we also saw the most modern prisons with single cell accommodation, integral sanitation and varied training facilities. This variability makes a unitary description of facilities impossible. There is also enormous variation in the frequency and type of mental disorder encountered. Some prisons have a concentration of psychotic inmates, others have none. To take account of this variation, responses to different types of mental disorder will be described separately.

Our survey was conducted by doctors at the request of the Prison Medical Service and our emphasis is medical. However, many responses to mental disorder in prison are not primarily medical in nature. Mental disorder results in deviant behaviour or the threat of deviant behaviour; it can be dealt with by medical or disciplinary measures or a combination of the two. The prison medical officer sanctions many disciplinary measures, though he does not control them. It is impossible to describe medical responses in isolation so our account also refers to the general prison regime, in as much as it affects inmates with psychological problems.

The picture is further complicated by variation between male and female prisons and adult and young offenders. The following account describes facilities for male adults, noting ways in which other groups differ when these are relevant.

Facilities for the management of particular mental disorders

In general, this description is organised by psychiatric diagnosis. Self-harm was thought to warrant discussion in its own right as it cuts across many diagnostic groups. Management of some problem behaviours is discussed under a particular diagnosis whilst recognising that they may also occur in other conditions e.g. much of the discussion on managing neurotic symptoms could have been placed under personality disorder.
1. Psychosis

"Psychosis" refers to the group of disorders included in the following categories of ICD9:
295 Schizophrenic psychoses
296 Affective psychoses
297 Paranoid states.

a. The context: changes in the management of mental illness in the community.

The last forty years have seen the care of the mentally ill change dramatically in England and Wales, with the advent of effective pharmacological treatments for psychosis. The number of inpatient beds has fallen dramatically with an emphasis on the management of mental illness in the community. The Mental Health Act of 1959 and its successor the MHA 1983 are an essential part of these changes, enshrining in law the principle that admission to hospital should be on a voluntary basis whenever possible. The Acts preclude the compulsory treatment of people in prisons.

There is concern that the loss of inpatient provision has not been accompanied by a corresponding increase in other services for the mentally ill and that disproportionate numbers of the mentally ill are to be found among the homeless and those in prison.

b. The management of psychotic inmates within prison.

As our study shows, psychosis is unusual among sentenced prisoners. Its management in a system which was not designed for the purpose presents problems out of all proportion to the number of inmates concerned. Management of psychosis will therefore be discussed at some length. Many of the issues raised apply to the management of other types of mental disorder within the prison system.

i. The allocation and distribution of psychotic inmates

Actual or suspected mental illness is taken into account when a convicted prisoner is allocated to the prison where he will serve his sentence. Psychotic inmates are allocated to an establishment with full time medical cover. This will be a local or training prison, depending on whether the sentence is long or short. Consequently, some establishments will never be allocated a prisoner with a history of psychosis; should a case slip through the net, or psychotic illness develop during the sentence, the primary response is transfer to a prison in the region with full-time medical cover, for assessment and re-allocation. This is usually a local prison.

Open prisons and closed prisons without full-time medical cover rarely hold inmates suffering from psychosis. Doctors working at these prisons reported that this system worked well; psychotic inmates were encountered perhaps once or twice a year and were transferred to a local prison after a brief assessment. Transfer was not difficult and could be carried out within hours if necessary; the local prison rarely attempted to return the inmate. The question of liaison with outside hospitals over transfer does not arise in these establishments.

The account given by medical staff accords with our survey finding that psychosis is not encountered in this type of prison. Discipline staff frequently
lamented the increasing number of difficult or disturbed inmates now being allocated to them but the examples they gave did not suggest that psychosis was an important factor.

As psychosis is unusual in sentenced prisoners, it makes sense to confine psychotic prisoners to certain prisons or types of prison. Local prisons occupy a central role in this process as they also hold psychotic prisoners for assessment before allocation.

ii. The role of the local prison

Medical cover in local prisons is provided by a full-time senior medical officer and a number of other medical officers, working in conjunction with visiting psychiatrists. The medical officers varied greatly in their degree of psychiatric knowledge but all agreed that psychiatry made up the bulk of their work. At one prison, a medical officer was undergoing in-service training for the Membership examination of the Royal College of Psychiatrists; this necessitated a period of employment at a local psychiatric hospital and is unusual within the Prison Medical Service. It is difficult to see why this opportunity should not be available to all medical officers in local prisons. Apart from the obvious training benefit, it must improve liaison between the prison and local psychiatric services.

Adequacy of medical staffing levels at local prisons is difficult to comment on. The job is very busy but all doctors agreed that most of their time is spent dealing with remand prisoners. Similarly, most negotiations with outside hospitals concerned remands and reports for the court. The demands of the courts ensure that attention is given to remand prisoners whilst the sentenced prisoner's case appears less urgent.

Levels of cooperation between prison and outside hospitals were very variable. At best, local psychiatrists were regularly to be seen in the prison hospital and a prison medical officer attended meetings at the outside hospital. Discussion and referral of patients was often at an informal level and transfer for assessment or treatment was generally easy to arrange. Conversely, relations at another local prison were very strained. Doctors from outside were rarely seen in the prison, opinions being sought and given in a formal way and prison medical staff describing the outside hospital as reluctant to accept any transfers.

Specific difficulties in transferring patients were identified as a lack of suitable beds in some areas and a delay in arranging assessment. Prison doctors felt that they coped well with many ill patients but would occasionally require urgent transfer; this was often impossible to arrange. Causes of delay were seen as slow responses to the request for assessment, particularly when this involved a visit by nursing and other members of a multi-disciplinary team, and a long wait for a bed once transfer was agreed.

The major function of the local prison in relation to psychosis is one of assessment for allocation or transfer. This function is facilitated by close links with local psychiatric services, particularly forensic psychiatry services. In many other respects, the local prison is a difficult place in which to carry out assessments; the environment is often unsuitable and staff are very busy with a rapid turnover of remand prisoners.

These circumstances encourage the neglect of psychotic prisoners who do not present immediate management problems. When we identified psychotic inmates on normal location in local prisons, they had been identified at reception but no attempt
made to transfer them out of prison. A decision appeared to have been taken that they 
were of lower priority than more disturbed inmates and could be adequately 
"managed" on normal location. This did not appear to be successful.

Case history: an elderly man suffering from chronic schizophrenia displayed 
symptoms of severe thought disorder, delusions and hallucinations. He had been 
placed on normal location and was only returned to the hospital after repeated letters 
from the landing officer complaining that his behaviour kept his cell-mates awake at 
night and led to persecution by other inmates. At the time of the survey, he was again 
on normal location with his symptoms unchanged.

Case history: a young man suffering from schizophrenia was well-controlled on 
medication within the prison "hospital"; he was then placed on normal location and 
began to refuse medication. No action was taken; at the time of the survey, he 
remained on normal location but had relapsed, become deluded and aggressive and 
was about to be transferred back to the prison "hospital".

The assumption that "quiet" psychotic patients should go to normal location 
in local or other prisons seems harmful and potentially dangerous. It should not be 
accepted as routine procedure.

iii. Prison "hospitals"

Like other parts of Victorian establishments, the prison "hospital" is often dark, 
dirty, overcrowded and lacking in sanitary facilities. "Hospital" is in many ways a 
misnomer for a collection of cells and dormitories pressed into a service for which 
they are unsuitable. "Sick bay" would be a more appropriate term.

One local prison was forced by overcrowding to locate seriously disturbed 
patients in ordinary cells; another closed its hospital on grounds of health and safety 
during our visit. An environment of this type is inadequate for the provision of any 
but the most rudimentary psychiatric care.

This unsatisfactory environment contains an undesirable mix of prisoners with 
physical and psychiatric problems. Disabled, elderly, post-operative and even 
terminally ill inmates are contained within the same facilities as acutely disturbed 
schizophrenic patients, to the detriment of everyone involved.

At one local prison, psychiatric patients were segregated in an "overflow" area 
of ordinary cells, separate from the hospital and without facilities, leaving the hospital 
for those with physical illnesses. Most physically ill prisoners pose no immediate 
management problems and are given considerable freedom; this cannot be done with 
psychotic prisoners.

The term "hospital" as applied to prison facilities for the mentally disordered 
is also misleading as the Mental Health Act 1983 does not regard any facility within 
prison as a hospital. This prevents compulsory treatment within prison. The psychotic 
patient in prison is also deprived of the safeguards provided by the Mental Health Act 
Commission. In some prison hospitals, it is possible to see an acutely psychotic patient 
locked in a cell for the whole day. He may be clad only in a canvas shift with no 
possessions or furniture other than a mattress, possibly soaked in urine or soiled with 
faeces. Compulsory treatment can only be given in an emergency. Patients kept in 
such conditions in the health service would be the cause of public outcry and an 
enquiry. The situation is no more defensible when it occurs in prison.
One or two prisons had recently completed, modern hospitals. The bright and clean working environment and its effect in improving staff morale served to highlight the squalor found at many other establishments. Staff at one modern hospital did complain that they had not been closely involved in its planning and could not understand why some of the cells had been built without integral sanitation. Another complaint by prison doctors was that planners had incorporated two padded cells into this modern prison hospital; these were only used as rather costly storerooms but never for their intended purpose. The doctors stated that they would have advised against providing a redundant facility of this type, had they been consulted.

iv. training prisons and the psychotic inmate

Closed training prisons with full-time medical cover also deal with psychotic inmates, particularly those serving longer sentences. Overcrowding is less and activity less frenetic than in local prisons, allowing a more thorough assessment of patients. A disadvantage is that links with outside hospitals are less strong. There will be at least one visiting psychiatrist but he is generally not a forensic psychiatrist and selection seems to be haphazard. Some training prisons have a rural location and one prison medical officer complained that his visiting psychiatrist was obviously only used to pleasant, middle class patients in his everyday practice; he would never accept transfers from prison. In other cases, the visiting psychiatrist was a retired NHS consultant who no longer had access to beds.

Given that the training prison may also be far from the patient’s catchment area, transfer to hospital is often problematic. Medical officers were often pessimistic about the chances of successful transfer and therefore did not make referrals. For more dangerous patients, it was felt that the special hospitals provided a better assessment service and were less reluctant to take patients.

v. prisons acting as specialised assessment centres for psychotic inmates

Most psychotic prisoners are contained in local prisons or training prisons with full-time medical cover. However, a small number of the most severely disturbed find themselves in training prisons with special expertise in the assessment and management of psychosis. These prisons act as regional or national resources and collect some of the most problematic patients in the system. Their typical patient is psychotic, dangerous to others and himself and not fully cooperative with treatment. Many have a history of treatment in special hospitals; they are some of the most difficult psychotic patients in the country.

They are managed within antiquated and unsuitable Victorian buildings and many of the hospital officers have not had formal nursing training. Despite this, diagnosis and treatment is of a very high standard. Full time medical staff have training in and enthusiasm for psychiatry. They maintain close links with psychiatrists outside prison and frequently seek their opinion, often encouraging the outside psychiatrist to maintain an interest in a patient over a number of years, working towards an eventual hospital placement. Nursing care of difficult and often violent patients is also of a high standard.

Whilst we were impressed by the standards achieved, staff identified a number of problems. The physical environment has already been mentioned, as has the lack of training for staff. Many hospital and discipline officers complained that financial
restraints meant that they could only attend some training courses at local hospitals in their own time.

Relations with individuals in working in the NHS were generally good but the service provided often left much to be desired (see vii below).

Many of the referrals from this type of prison go to the special hospitals. Relations are good, one of the benefits of having a specialist prison whose doctors are in frequent contact with doctors in the special hospitals. The service provided for cases referred for transfer from prison under the Mental Health Act was reported to be generally good. The main difficulty is that Broadmoor is now full. Many psychotic prisoners in a prison such as Parkhurst are from the South of England and referring them to the other special hospitals presents problems in arranging assessments and then in maintaining contact with the family if transferred.

c. The role of the prison doctor in the management of psychosis

In relation to psychiatric disorder, doctors within prison are required to perform four major functions. The first is analogous to that of the general practitioner outside; detection of psychiatric disorder, the treatment of some patients and the referral of others for a specialist opinion. The second function of prison doctors is also, in many cases, to provide that specialist psychiatric opinion. This may be followed by psychiatric treatment or referral to the catchment area psychiatrist for possible transfer. A third function is to establish fitness for adjudication and punishment and to decide which inmates have medical needs that cannot be met within the prison. The fourth is the provision of reports to the courts and the parole board.

i. Detection of psychosis

In relation to psychosis, the "general practitioner" role of the prison doctor is performed effectively in most prisons. Medical officers predicted that undetected psychotic illness in the prison population would be uncommon and we found eight cases in the course of over 2,000 interviews, a prevalence of less than half of one percent. Most psychotic illness in sentenced prisoners is detected by existing arrangements.

ii. The provision of a specialist opinion

Further, comprehensive assessment of the patient requires a degree of expertise in forensic psychiatry. Some prison medical officers are trained in psychiatry and forensic psychiatry and carry out their own assessments. Many local and some training prisons have links with a consultant forensic psychiatrist, usually attached to a teaching hospital and supported by a multi-disciplinary team.

Difficulties arise when the medical officer carrying out an assessment does not have adequate training in forensic psychiatry.

Case history: a man serving a sentence for manslaughter had killed his girlfriend after developing a paranoid psychosis accompanied by morbid jealousy and the delusional belief that she was having a lesbian affair with a mutual friend. A psychiatric report to the parole board, one paragraph in length, stated that he had killed his girlfriend in anger after finding out she had been unfaithful, showed no evidence of psychiatric disorder and was not in need of supervision or further assessment.
Standards of expertise and of interest in forensic psychiatry varied widely. The most serious problems were found in prisons which rely on visiting psychiatrists for their psychiatric service. Prisons with a part-time prison medical officer (usually a local GP attending mainly for sick parades) may leave all psychiatric decisions within the prison to the visiting psychiatrist.

This is a reasonable model for a psychiatric service only if the visiting psychiatrist is suitable for this demanding job. In some prisons, the visiting psychiatrist is a lone consultant with no forensic experience and no NHS appointment. His powerful position, isolated from current developments and peer review, can result in idiosyncratic and occasionally incompetent practices.

One visiting doctor was preoccupied with determining whether inmates had committed the offence for which they had been sentenced, acting as a second judge and jury; his reports to the parole board or the courts were usually intertemperate, often inaccurate and concerned with justice and punishment rather than psychiatry.

Case history: an inmate serving a four year sentence for assault was mentally handicapped with a history of psychotic episodes and several hospital admissions. The inmate required continuous confinement in a unit within the prison and a special hospital consultant had agreed to transfer. This was opposed by the visiting psychiatrist on the grounds that the patient would escape just punishment by being transferred.

The unit at the prison mentioned in the case history held several psychiatric patients. No attempt had been made to transfer them to hospital and the visiting psychiatrist had decided that they should be managed on a disciplinary unit, rather than in the prison "hospital", despite the fact that they were taking regular psychotropic medication and receiving from discipline officers care which closely resembled psychiatric nursing.

This prison provides the worst example of a widespread lack of consistency in the standard of psychiatric care provided by visiting psychiatrists. Others doctors had a very narrow view of psychiatry, perhaps providing only one form of treatment. This variation in standards is compounded by the fact that there is no clear guidance as to the service the visiting psychiatrist is expected to provide and is no attempt to monitor the service. Isolation from colleagues seemed to affect some prison medical officers as well. One or two were excessively preoccupied by the problem of malingering. Of course, the prison environment encourages simulation of illness. Nevertheless, we remain unconvinced that schizophrenia can be faked easily. If this is suspected and the abnormal behaviour persists, it would be advisable to seek a second opinion from an outside psychiatrist. In a small number of cases this was not done and prevented correct treatment. Similarly, one medical officer diagnosed drug-induced psychosis in a number of prolonged illnesses that many other psychiatrists would have called schizophrenia and treated as such.

Variation in the type and standard of medical cover is particularly harmful as it is unrecognised, so no allowance can be made for it in the allocation of prisoners. We encountered doctors with a special interest in psychotherapy or the treatment of sex offenders, with little involvement in mainstream general psychiatry; provision for psychotic inmates was very limited. As the nature of the service was only apparent
locally, psychotic patients continued to be allocated to this prison, whilst those who could have benefited from his services went elsewhere.

The unique feature of ill prisoners is their lack of freedom to change doctors or seek a second opinion so standardisation of the service is more important than it would be outside prison. Present variation in standards results from a combination of inadequate training in some individuals and deficiencies in supervision and management of the Service.

**iii. Fitness for punishment and the decision to transfer inmates to hospital**

The ethical issues arising from this function are discussed elsewhere by Smith and the present discussion will concern practical issues. Adequate standards of expertise in psychiatry have been discussed; they are a necessary prerequisite for any decision on "fitness". In addition, the criteria for "fitness for adjudication or punishment" are not self-evident. There is nothing in a doctor's training to prepare him for this type of decision and there was wide variation in individual practice.

The Prison Medical Service does not provide adequate guidance in this area. The doctors we interviewed were in broad agreement about the recognition of psychosis but varied enormously in the point at which they would choose to refer the psychotic inmate for transfer to hospital. Our results confirm that some prison doctors are prepared to tolerate much higher levels of disturbance in psychotic patients before referring them for transfer.

Prison doctors themselves raised a further issue, pointing out that inmates with a psychiatric problem are disadvantaged relative to those with a physical problem. If the physical health of a prisoner is such that he needs treatment in an outside hospital, the prison doctor can arrange for him to be transferred immediately, with appropriate security. This is not possible at present for patients with an urgent psychiatric problem; the delay involved in use of the Mental Health Act has already been discussed.

**iv. preparation of reports**

Preparation of adequate reports is dependent on psychiatric skills, so the comments in the preceding sections apply here also. Reports to the court deserve mention in their own right because of their importance in deciding the future of mentally ill inmates.

We saw many reports on the subjects in our study and enormous variation in standards was apparent. Many reports are excellent but prison medical officers prepare reports on all types of mental disorder without necessarily having any specialist training. Doctors with little health service experience are at a particular disadvantage; a good report depends not only on diagnostic skills but on familiarity with current forensic psychiatric practice and the treatment options available.

Prison doctors complained about the number of reports they are required to write, particularly for the parole board. Many reports of this type concern inmates with no psychiatric history or current problems. Apart from wasting the doctor's time, there is an issue of principle; why should a psychiatrist have any say in parole for an inmate with no psychiatric diagnosis?

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d. The service provided to prisons by the Health Service

Relationships with doctors in the health service show a great deal of local variation. It is possible to describe a number of areas in which prison doctors report that the health service is failing to meet their needs.

i. The lack of facilities for long-term care in conditions of medium security.

Patients who require long-term care but not the maximum security of the special hospitals are difficult to transfer as psychiatrists are reluctant to block the small number of secure beds available. There is a need for a long-stay version of the regional secure units. Patients requiring this type of care may cope reasonably well in prison but are likely to return to prison in the absence of long-term psychiatric support in the outside world. Linkage with local forensic psychiatry services is therefore particularly important.

ii. The lack of facilities for rapid transfer of psychiatric patients from prison to hospital.

"Rapid" transfer to a regional secure unit may take weeks or months. Priority over sentenced men is often given to remand cases coming from the courts, rather than basing priority on clinical grounds. Even for remand cases, a delay of several weeks before transfer is not unusual. The system works but it works very slowly.

Doctors in some prisons manage highly disturbed patients who represent a considerable danger to themselves and others. When they are unable to manage, the problem is often an emergency e.g. catatonia, extreme violence and refusal of medication. There is a need for the health service to provide an effective emergency service, perhaps reserving a small number of secure beds for such admissions.

iii. Rejection of "difficult" patients by the health service.

Patients not at the higher levels of dangerousness may be expelled from secure units for minor infringements such as breaking windows or smoking cannabis and thus end up back in prison. In some cases, this is manipulation by patients who wish to return to prison but in others it is the deliberate policy of the secure unit. Some consultants show a very low tolerance for difficult (not dangerous) behaviour and the only place left for such patients is the prison system.

iv. The premature return of patients from secure units to prison.

After a short period of treatment under the Mental Health Act, secure units will often return patients to prison before they are fully stable, when they are still on very high doses of medication. Such high levels of medication call into question their true fitness for prison; refusal of medication and relapse is virtually certain, as compulsory medication is not possible within prison. Prison medical staff do not want to have the power to give compulsory medication but would like to see an increased recognition by NHS consultants that the need for compulsory medication is synonymous with the need to remain in or be transferred to hospital.
v. Brief or incomplete assessments by visiting NHS consultants.
Assessments by visiting consultants rarely exceed one hour in duration and are often totally inadequate for difficult and complicated patients. There is a need for the facility of transfer for a short period (e.g. 21 days) for assessment and observation; it is anomalous that the MHA 1983 allows for assessment before conviction but not afterwards. Prison hospitals do not have the facilities or the trained nurses to allow full assessment. This is seen as a particular difficulty in prisoners with transient psychoses.

vi. Difficulty in identifying a patient's catchment area.
Identification of the catchment area or responsible consultant for a particular prisoner can be very difficult. This may sound trivial but can take up three or four months, particularly when the area concerned is distant from the prison and has no links with it and when there is an attempt at buck-passing. RSU's may only take patients after obtaining assurances from the catchment area hospital that they can be moved on later, introducing a further source of delay.

vii. Budgetary constraints within the NHS.
With increasing emphasis on costs at district level, administrators are very critical of consultants who make mistakes in accepting patients from outside a hospital's catchment area. Psychiatrists are likely to become even more reluctant to accept any case where there is the slightest doubt. Doctors in prison felt that they were being drawn increasingly into arguments about funding within the NHS e.g. a hospital may respond to a request for transfer by saying that it would take the patient if money could be found for nursing services. It is feared that current plans for the NHS will exacerbate this problem. There are financial disincentives for hospitals to accept from prison patients with chronic psychotic disorders that may represent a long-term drain on resources.

Funding for the care of patients of this type is likely to become an even bigger problem when the NHS reforms are implemented. Some doctors expressed a fear that hospitals could save money by delaying the transfer of patients from prison. It may be necessary for the Home Office to make greater use of its powers to direct the acceptance of a patient.

viii. Liaison with NHS hospitals.
Liaison in preparation for release is a major problem when the inmate is a chronic psychiatric patient. There are no formal arrangements in existence. Prison doctors usually write to the local hospital but the most that can be hoped for is an outpatient appointment, with no follow-up when the patient fails to attend. The Royal College of Psychiatrists has agreed guidelines for the care of patients discharged from hospital; similar guidelines do not exist for the patient leaving prison.

Some doctors would like to see parole used to provide a period of supervision. At present, patients of this type are unlikely to get parole and its use would require an infrastructure to be set up, including increased probation service involvement and suitable hostels. Other doctors wondered if patients with chronic schizophrenia should serve their sentence somewhere other than prison.
e. Psychosis and Youth Custody Centres

The principle of management in Youth Custody Centres is the same i.e. concentration of psychotic inmates in certain prisons. According to doctors in the system, psychosis is rarely encountered in sentenced youth custody trainees and most of their work is concerned with remands.

Of our sample prisons, Glen Parva and Feltham are centres for mentally disordered inmates. Neither reported particular problems in transfer of psychotic inmates to the NHS except in cases where they fell between the special hospital and RSU criteria, i.e. were not considered to be in need of maximum security but required in-patient treatment for two years or longer.

f. Psychosis and female prisoners

Generally, facilities and standards for psychotic female prisoners are good and transfer not problematic. In absolute terms, fewer psychotic women are serving a prison sentence than men. Our study does not allow us to determine the reasons for this.

Unlike the male prisons, there is no significant overcrowding problem for the female "hospital" facilities. No women suffering from psychosis were found on normal prison location although the practices of one visiting psychiatrist resulted in some psychotic women being held on a disciplinary "special care unit".

Female prison hospital facilities benefit from the use of trained nurses as hospital officers. Good nursing is critically important to the care of psychotic inmates and the female prison "hospitals" could provide a model for the rest of the system.
2. Mental Handicap, Mental Retardation or Learning Difficulties.

These terms are used synonymously in this report to refer to disorders that fall within the ICD9 categories:
317 Mild mental retardation.
318 Other specified mental retardation.

a. The context: recent developments in the management of learning difficulties.

As in the case of psychosis, the last forty years has seen a shift away from large asylums to community care. In addition, there has been a move away from medical or psychiatric care of the mentally retarded to an emphasis on education, training and the provision of suitable accommodation. Many would argue that learning difficulties are the concern of the psychiatrist only when accompanied by psychiatric or behavioural disorders - a point of view reflected in the Mental Health Act 1983, which permits detention only when handicap is "associated with abnormally aggressive or seriously irresponsible conduct".

An association between delinquency, low IQ and poor educational attainment has long been recognised and it is not surprising to find low levels of literacy in the prison population. Most definitions of mental handicap include a reference to impairment of social functioning rather than relying entirely on IQ measures. IQ scores are not good predictors of performance in many spheres of life.

There is no evidence that prisons contain large numbers of mentally handicapped inmates. Claims to the contrary have been the result of using over-inclusive criteria to define the condition.

Although we did not use IQ tests, only a small minority of prisoners appeared on clinical criteria to be mentally handicapped but they often had special needs and would benefit from transfer to hospital.

b. Management of the mentally retarded in prisons.

Like most psychotic prisoners, the truly mentally retarded inmate also finds it very difficult to survive on normal location without becoming a target for bullying or exploitation. Prison "hospitals", segregation and vulnerable prisoner units are an important part of the management of prisoners with learning difficulties. In such a setting, many function without major problems, often protected by members of staff who adopt a paternalistic attitude towards them.

This situation is not without its difficulties. Discipline staff often stated that such people did not belong in prison. They were frustrated by trying to deal with people who were slow to learn the ropes and frequently transgressed minor prison rules. Some officers overlooked this behaviour, others applied rules rigorously, resulting in frequent disciplinary hearings for the inmate.

Many people are frightened and threatened by the mentally handicapped and officers have no special training in this area. Some coped well but others responded

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by patronising or sometimes overtly insulting the retarded inmate. We were disturbed
to find at one prison a segregation unit containing a small but significant minority of
mentally retarded inmates who had been there since entering prison and were
expected to serve out their sentence there. The conditions under which they were
living, with no trained staff and only menial work to occupy them, resembled the
impoverished environment of the back wards of the old asylums.

A major problem in confining the mentally retarded in segregation units (for
good order and discipline or own protection) is that many services, particularly
education, cannot be provided to prisoners in this situation. Many of the inmates most
in need of education are therefore denied access to it.

Mental handicap has always been a "Cinderella" specialty in psychiatry and
this attitude is shared with colleagues outside by prison doctors. Some doctors showed
a lack of knowledge or understanding of mental retardation and most had no interest
in it. In the example of the segregation unit described above, the doctor responsible
recognised that the inmates were mentally handicapped but took little further part in
their care, seeing their behaviour as a disciplinary problem. He showed no awareness
of the possibility of mental illness co-existing with mental handicap and had actively
obstructed consideration of transfer to hospital when he had been responsible for the
cases at the remand stage.

Our impression was that prison doctors take little part in the care of the
mentally handicapped in prison. In a sense, this is in line with the decreased
involvement of doctors with the mentally handicapped outside prison. The difference
is that many other agencies have responsibility for the mentally handicapped outside;
the alternative to medical supervision in prison is some form of disciplinary
management. In practice, the burden of care falls on a few well-meaning but untrained
prison officers working in vulnerable prisoner or segregation units. As a consequence,
mentally handicapped prisoners, with or without co-existing mental disorder, are one
of the most disadvantaged groups in the prison system.

Education deserves a mention here, although we did not study it in a
systematic way. Difficulties of access have already been mentioned; access to facilities
was best in those prisons with large vulnerable prisoner units as an alternative to small
scale Rule 43 provision. Even with good access, it was apparent that education was
gearred towards the majority of prisoners rather than the minority with learning
difficulties. Teaching this group is a specialised, time-consuming and demanding task.
There is little enough educational provision for the ordinary prisoner and the needs of
those with learning difficulties add weight to the case for the development of
educational provision in prisons.
3. Neurosis

"Neurosis, as seen in prison, consists largely of somatised anxiety and comes out mainly in fear of disease and in exaggerated reaction to simple ailments. It is one of the things which makes prison medical practice so difficult." W. F. Roper, Medical Officer at HMP Wakefield, 1949

"Neurosis" refers to the group of disorders included in the following categories of ICD9:
300 Neurotic disorders
309 Adjustment reaction.

Neurotic symptoms are a feature of many other psychiatric disorders, particularly psychoses and personality disorder. Most of the following comments apply to the treatment of neurotic symptoms, whatever the underlying diagnosis.

a. The context: neurosis in general practice.

Neurosis encompasses a wide range of conditions. Outside prison, only a minority of people suffering from neuroses such as anxiety and depression ever come to the notice of psychiatrists. The proportion becoming inpatients is even smaller; most are treated as outpatients, though more severe forms of neurosis can be totally disabling and milder forms produce great distress. Nevertheless, most medical treatment is provided by general practitioners. Social workers may provide counselling and others receive support from family and friends.

Prison separates the inmate from these sources of support. Through various stresses, it is likely to increase the frequency of neurotic disorder whilst removing the social networks which help people to cope with distress. Doctors in prison may therefore find themselves confronted by minor neurotic disorders which, outside prison, would occur less frequently and not come to medical attention.

In many cases, neurosis presents in a somatised form i.e. as physical complaints, not overtly psychiatric in nature. This is the case in general practice and is likely to be even more so within a macho prison culture that may regard other expressions of distress as signs of weakness.

Repeated complaints of anxiety, depression, tension or "boredom" are a feature of some personality disorders, further increasing the number of neurotic symptoms presented to the doctor working in prison.

b. Managing neurotic disorders in prison.

All prisons have the facility required to deal with these problems i.e. assessment of the general practice type, with provision for obtaining a further psychiatric opinion and providing medication, counselling or psychotherapy when indicated. Variation is mainly in the availability of staff trained in psychotherapy and counselling services. Services within prison can be divided into those provided by doctors and those provided by other staff.
i. The role of the doctor

In their general practice role, doctors assess and refer inmates as necessary. They also provide some psychotherapy and are responsible for prescribing medication. This function resembles that of the general practitioner. Standards are variable, as they are in general practice outside prison.

There is no evidence of widespread over-prescribing for neurotic symptoms; if anything, the reverse is true. Prison medical officers appear generally more reluctant to prescribe medication for minor neurotic disorder than are doctors outside prison. Some doctors stated that this is their deliberate policy, in order to minimise drug abuse. Others appeared to be following the general trend within psychiatry towards reducing the use of minor tranquillisers in treating neurosis.

Reluctance to prescribe was a source of complaint by some inmates who tended to over-emphasise the role of medication in dealing with emotional distress or insomniation. Many had been taking tranquillisers (prescribed or in the form of alcohol) before entering prison and it is likely that cessation of these exacerbated neurotic symptoms.

Two aspects of this approach are a cause for concern. Firstly, a minority of inmates with more serious neurotic illness may not be treated aggressively enough. We found that reluctance to prescribe extended to some patients with severe neurotic depression, a potentially life-threatening condition. Even when given, doses of antidepressant medication were sometimes inadequate and failure to respond was rarely regarded as a reason to refer for possible hospital transfer.

Secondly, a reduction in the use of medication requires an increase in the use of other methods of treating neurosis. In many cases, alternative treatments were not provided. Doctors showed enormous variation in their attitudes towards "psychological" therapies. Whilst some doctors provided effective counselling or supportive psychotherapy, others expressed little interest in these skills and were content to leave this function to the probation officer or chaplain.

The other aspects of medical practice deserving comment here are those of privacy, confidentiality and the physical setting in which medical care is provided. At sick parade, the inmate may stand in front of the medical officers desk and state his complaint. A hospital officer will be present and may also conduct a large part of the interview, asking questions and commenting on the replies. Security considerations do not justify all aspects of this practice. It was a common source of complaint by inmates and was seen in its worst form in some youth custody centres where security constraints are minimal and the object of the practice seemed to be intimidation if not humiliation of the patient. Such a setting is not conducive to the revealing of emotional problems.

The interview with the medical officer is often preceded by the need to state one's complaint to a hospital or discipline officer, in full hearing of other inmates. Some prisoners said that they had not consulted the doctor because they were unwilling to describe their problem in front of other prisoners. Screening of complaints by para-medical staff is an efficient and useful process, welcomed by many inmates as a rapid method of getting advice; it does require the maintenance of adequate standards of confidentiality.

ii. The role of non-medical staff
Counselling and support are provided by a wide variety of personnel, including discipline and hospital officers, probation officers, psychologists, teachers and chaplains. There is wide variation between establishments but some general comments are possible.

Discipline and hospital officers are ideally placed to perform this function and their role was appreciated by many inmates. Furthermore, it is a major source of job satisfaction for officers, although many complained that they do not receive recognition and support for this work. There was criticism of new shift systems and working practices which moved officers around different units, disrupting relationships with inmates.

Support and supervision for officers dealing with a difficult client group is very variable. Senior officers provide this at some prisons but not at others. We were impressed by the "personal officer" scheme at youth custody centres but noted that supervision or advice for the officer was often available only in an haphazard way. At one youth custody centre, it was provided by a probation officer with a strong interest in the work. At other centres, the relationship with probation staff was less close and alternative support did not seem to be available.

Many officers sought us out for advice on particular problems with inmates. They are confronted by severe neurotic or behavioural difficulties in people with grossly abnormal backgrounds. The nature and severity of these inmate's problems would lead to the rejection of the inmate as a patient by many helping professionals outside prison. It is unreasonable to expect officers to deal with problems of this type without adequate training and formal supervision.
4. Self-harm and attempted suicide

Deliberate self-harm (DSH) is discussed here, following neurotic disorder, as it is one form of expressing emotional distress. Neurotic illness is a common underlying factor but DSH may also arise from stress and a variety of other psychiatric diagnoses including psychosis, personality disorder and mental retardation.

a. The context.

Suicide is distinguished from parasuicide or deliberate self-harm, where it is accepted that the goal is not to bring about the person's death. Despite the distinction, parasuicides have a greatly increased risk of completed suicide compared to the rest of the population and many completed suicides have a history of previous deliberate self-harm.

Suicide within prison is a source of great concern and we are aware that its increasing prevalence has produced a comprehensive enquiry due to report in the near future. In addition, there is a growing literature on the subject\(^3\). We can make only a limited contribution. Firstly, our inquiry was limited to sentenced prisoners, whereas most self-injury and suicide occurs in remand prisons. Secondly, our survey collected no information about completed suicides. Finally, our main concern was the diagnosis of mental disorder rather than consideration of one particular pattern of behaviour that is frequently a manifestation of mental disorder.


The Prison Department's Circular Instruction 20/89 sets out a four-pronged strategy for dealing with self-harm, emphasising i) identification of risk, ii) provision of help and support, iii) reduction of opportunity and iv) staff awareness and training. Common practice following self-harm, in the prisons we visited, appeared to be a brief psychiatric assessment and transfer to a strip cell with regular observation by staff. Of the four components, priority was given to reducing or even eliminating the physical opportunity for self-harm and the practical consequence of this was that the inmate was placed in unfurnished accommodation. The concern must be that isolation, whilst reducing opportunity may increase motivation to end one's life and that isolation is incompatible with other aspects of the strategy, particularly the provision of help and support.

Our comments on facilities for the management of self-harm were influenced mainly by the accounts of inmates who reported harming themselves in the past. It is helpful to consider inmates who harm themselves as belonging to one of two overlapping groups. The first and larger group are inmates under stress who see self-harm as a way of relieving their situation (either by ending their life or by attracting help). The second, small group are repeated self-harmers, usually by cutting, and often suffer from psychiatric illness or severe personality disorder. They can present a severe management problem in any situation and their management falls within the

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\(^3\) Dooley E. Suicide in England & Wales 1972-87. B J Psych 1990 156:40-45
scope of our comments on the management of psychosis. The former group will be discussed here.

A prominent feature of these cases is the extent to which their self-injury is often explicitly goal-directed. Inmates would report that they were finding some aspect of life intolerable and had been unable to obtain any help. They would often discuss possible alternatives - deliberate self-harm or smashing up their cell. These were seen as equivalent responses, guaranteed to provoke a reaction and draw attention to their plight.

Current responses to self-injury meet some of these needs, by recognising the inmate’s distress. He is asked what the problem is and given the chance to discuss it; a psychiatric disorder may be recognised and treatment instituted. The measures taken are less appropriate to the aim of preventing further deliberate self-harm.

The strangest part of the prison regime is its use of isolation for suicidal inmates. This has no place in the management of suicidal behaviour in hospitals and is contraindicated in the majority of cases. The "suicide watch" in prison, essentially a regular glance through the cell door to ensure that the solitary inmate is not in the act of harming himself, is a grotesque parody of the close observation to be found in psychiatric hospitals. A further paradox of the system is that the less seriously depressed inmate is released more quickly back to contact with other inmates; the more severe case remains longer in isolation.

Some doctors justified this system on the grounds that it was the only way to prevent self-harm in the prison environment and the facilities for other forms of close observation did not exist. In fact, the method is demonstrably unsuccessful in preventing suicide. Prison "hospitals" could learn from health service hospitals about a range of nursing techniques for reducing the risk of suicide. This aim would be facilitated in the short term by increasing the number of prison "hospital" staff with a nursing qualification and experience of working in the health service.

Many suicidal inmates suffer from psychiatric disorder and past research has shown that psychiatric disorder is associated with many completed prison suicides. There can be no stronger case for transfer to hospital than the presence of life-threatening psychiatric disorder, even if the disorder is regarded as "neurotic" and is not accompanied by delusions or hallucinations. At present, most doctors in prison refer for transfer only when self-injury is accompanied by florid psychosis. There is no justification for this attitude, which reflects a narrow interpretation of the definition of mental disorder in the MHA 1983.

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4 Dooley, E. 1990 op cit.
5. Personality disorder

"Personality disorder" refers to those disorders included in ICD9 category: 301 Personality disorders.

a. The context: personality disorder and psychiatry

Personality disorder is the most controversial diagnosis within psychiatry. There is evidence that many psychiatrists use the term in a derogatory way and this has led to calls that it should be abandoned - without addressing the question of what to do with the patients who receive the diagnosis. Whatever the name, other studies have documented the origins of this disorder in early childhood and its stubborn persistence into adult life.

Patients with a personality disorder may fit the criteria for "psychopathic disorder" in the Mental Health Act 1983 but compulsory treatment can only be applied if that treatment is "likely to alleviate or prevent a deterioration of that condition".

The health service has never provided extensive in-patient treatment facilities for patients with anti-social personality disorder. Specialist services are restricted to therapeutic communities such as the Henderson and parts of the special hospital system. Forensic psychiatric services provide treatment for many patients with this diagnosis, generally on an outpatient basis.

The Butler Committee recommended that prisoners with "psychopathic disorder" should be treated in special units within prisons.

b. Treatment for the personality disordered inmate in prison.

i. Specialist treatment facilities in prisons

HMP Grendon and the Wormwood Scrubs annexe provide treatment in a therapeutic community setting. We visited both establishments but did not study Grendon in detail as it has been extensively described elsewhere. Glen Parva provides treatment in a therapeutic community setting for a small number of young offenders.

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8 DHSS. Report of the Committee on Mentally Abnormal Offenders

Our comments should be read in conjunction with the more detailed descriptions of HMP Grendon and would apply to the role of these units in treating sexual deviation as well as personality disorder.

We noted a lack of morale at Wormwood Scrubs, partly due to uncertainty over re-building of the hospital and doubts over the long-term future of the unit. Staffing was also identified as a problem; it was difficult to obtain enough interested and motivated officers, largely because of the demands of the rest of the prison. Some staff claimed that Fresh Start had exacerbated this problem.

A second problem at Wormwood Scrubs was difficulty in obtaining enough suitable referrals, even though Grendon was forced to operate a waiting list for men requiring similar treatment. This lack of referrals, despite other indications of a high demand for a service of this type, was attributed by some staff to a lack of awareness by inmates and medical staff at other prisons of the treatment provided. One doctor at Wormwood Scrubs described the Annexe as "one of the best kept secrets in the prison service". Glen Parva suffered from a similar problem and there appeared to be little awareness of its function within the rest of the youth custody system, despite the practice of Principal Medical Officers in circulating Managing Medical Officers on this subject. Grendon received plenty of referrals but complained that many were unsuitable.

We encountered a number of inmates who had been to Grendon or were requesting transfer there. Medical officers had widely differing attitudes to Grendon. Some would refer anyone who asked and would suggest treatment to cases they considered suitable. Others appeared very resistant to the idea; some inmates reported a prolonged struggle before they were able to have their request considered. One or two medical officers made inappropriate referrals (usually of inmates with obvious low intelligence) or regarded Grendon as a way of moving on difficult men. Some medical and discipline officers were very cynical about its regime, suggesting it provided a soft option for intelligent or cunning inmates who were not really difficult, "not like the cases we have to cope with here".

The Genders and Player report notes that the clientele of Grendon has changed, moving towards "the heavy end of the market" (ibid. p.10). This may be because of changes in the whole prison population but does identify a gap in provision, for those serving shorter sentences for less serious offences. Whether the diagnosis is personality disorder or substance abuse, our findings do suggest considerable demand for therapeutic community facilities at this level.

As we did not sample Grendon inmates, our findings represent additional demand for treatment places of this type.

**ii. Other treatment for the personality disordered inmate.**

This can be divided into medical and disciplinary responses, with some overlap.

On the medical side, the situation is analogous to that in the health service, with personality disordered inmates generally being fitted in to a system designed to deal with mental illness. Medical officers complained about personality disordered inmates who would present with neurotic symptoms or repeated acts of deliberate self-harm. Medication may be demanded by the inmate or offered by the doctor but there was a general feeling that this was ineffective and problems would recur. As in the NHS, doctors often saw such patients as difficult and unrewarding to treat. A few
complained about the difficulty in getting patients into Grendon, saying that the admission criteria were too strict.

On the discipline side, a considerable proportion of the time and energy spent on disciplinary matters is taken up by a minority of difficult, personality disordered inmates. Officers at all levels would comment that 90% of their inmates presented few disciplinary problems and most security measures were in place to deal with the other 10%. Personality disordered men are over-represented in the segregation units at most prisons and staff have developed a considerable expertise in dealing with disordered inmates.

Medical input here is minimal and generally limited to questions of assessment. Primary management of difficult behaviour in the non-psychotic inmate was disciplinary. Only in cases of extreme intractable behaviour would further medical help be sought. Even then, hospital transfer was not a likely option. Doctors saw disciplinary measures as most appropriate for prisoners they did not regard as ill. In a minority of cases they would consider Grendon or the special control units but hospital transfer was not regarded as a suitable option. In most cases, the reason given was that inmates of this type were not ill or not treatable. Doctors who did regard treatment as appropriate stated that referral for transfer would not be worthwhile as hospitals would not accept the patient.

These attitudes reflect existing practice. In 1988/89, only 8% of transfers from prison to hospital under Section 47 and 48 of the MHA 1983 were in the category of psychopathic disorder10 (this represents 14 individuals).

It is a frequent criticism of medical practice within prisons that difficult behaviour is medicalised and treated inappropriately with medication (the "liquid cosh" of newspaper parlance). We found no examples of this practice and doctors attitudes were generally in the opposite direction; they wished to minimise their involvement with inmates of this type and were reluctant to regard such behaviour as a medical problem. Conversely, the disciplinary side of prisons and its system of withdrawing privileges was geared to containment of difficult and violent men of this type. A small number of men would spend long periods in segregation units, frequently being moved around the system.

The costs of this containment approach to personality disordered inmates appear to be as follows. A minority of inmates spend long periods in segregation units, an impoverished environment not designed for long-term containment. Staff at all levels reported disillusion and frustration in dealing with this difficult minority11. Discipline officers often stated that this small proportion of difficult men was behind most of the trouble in their prison (other inmates confirmed this impression, frequently referring to the unpleasantness of living in close proximity with personality disordered men).

A specialised and relatively expensive response to highly disruptive long-term prisoners has been the development of small units which take most of their referrals from dispersal prisons. These units are based on the principle of high staff:inmate

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10 Report on the Work of the Prison Service 1988/89; Cmn 835

11 The general question of support and supervision for staff dealing with disordered inmates is discussed under the heading neurotic disorder.
ratios and a personal officer scheme. A small amount of medical time is allocated to the one at HMP Parkhurst but the units are largely outside the medical system even though they take prisoners labelled as severely personality disordered in many cases. We did not survey these units.

C Wing at HMP Parkhurst has also been surveyed by members of this department. The high proportion of men with a psychiatric disorder and a history of special hospital treatment was noted.

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CHAPTER 9
UNMET NEEDS: RECOMMENDATIONS FOR CHANGE

Introduction

This chapter discusses the implications of our findings and recommends changes designed to improve the management of mentally disordered people in prison. Many of these recommendations follow from the description of existing services in the preceding chapter.

As in that chapter, the discussion is organised according to diagnostic groups, with the qualification that many recommendations will apply to prisoners with other diagnoses. Within each diagnosis, recommendations may concern changes within prison or in the service that prisons require from the health service.

Assumptions underlying the recommendations

Estimates of service needs often require assumptions about the type of treatment that is appropriate to particular patients and conditions. These assumptions are not shared by all doctors or health administrators. A high degree of consensus exists in the case of schizophrenia and other psychotic illnesses, whereas personality disorder and sexual deviation generate heated debate.

These issues will not be explored in detail. This study uses as its reference point standards of care exiting in the health service. Other assumptions used in estimating service needs are stated under particular diagnoses, particularly when these assumptions are likely to be controversial.

Limitations of the present study

This study is the most comprehensive yet undertaken into the sentenced prison population of England and Wales. There is still room for error and uncertainty in our findings and estimates. Confidence limits have been given as a measure of the uncertainty in our findings but other limitations remain. Again, these will be discussed under specific diagnoses. One overall qualification can be reiterated here: this study does not deal with the remand population and the needs of remand prisoners must be considered as additional to the service needs described in our study. There is evidence to suggest that most indices of psychopathology are higher in the remand population and it is possible that its demands on medical resources will be greater.

Where appropriate, reference will be made to possible questions for future research.

Overall recommendations

Before stating our specific recommendations under diagnostic headings, four general recommendations can be made, which apply across all diagnoses.

i. Adequate funding for health services within prisons.

Frequent reference has been made to the inadequate facilities within which medical officers are required to carry out their work. The development of treatment services for sex offenders and drug users cannot take place without adequate resources.
ii. Adequate training for all prison staff.

Doctors working within prison require expertise in forensic psychiatry. In addition, a large part of their work involves problems of alcoholism or drug addiction; both are neglected areas within medicine and psychiatry and it cannot be assumed that an ordinary medical training provides sufficient experience in these areas.

Standards of health care in prisons should be the same as those provided in the NHS. This requires that specialist psychiatric tasks of assessment and treatment are carried out by fully trained specialists i.e. by doctors eligible to apply for relevant consultant posts in the NHS.

Prison officers also require adequate training, for their roles as personal officers, counsellors or the providers of nursing care.

iii. A prison health service must develop clear policies on the management of psychiatric problems.

A constant theme of our description of prison medical services is the extreme variation in standards between prisons and individual doctors. Improved training would do much to improve this but there is also a need for guidelines in some areas e.g. the degree of mental disorder that is tolerable within prison before taking a decision to refer the case for hospital transfer.

Prison medical officers can influence, if not control, entry to and exit from the prison system on medical grounds. At present, exercise of this function is left entirely to the discretion of the individual doctor and there is wide variation in the criteria used. It is reasonable for prison health service management to formulate a policy in this area. This will become essential if prison medical services are ever to be provided by outside contractors, when variation in standards may increase.

A second area in which guidelines are required is the provision of particular services e.g. for drug or alcohol problems. At present, the level of these services is determined locally and the result is tremendous variation. Prison health service management must specify the type of service it expects to be provided; again, this will be essential if services are to be contracted out.

Development of clear guidelines would facilitate monitoring of the performance of prison health services, which is impossible at the moment.

iv. There is a need for clarification of the roles of the prison service and the health service in managing mental disorder.

We have already referred to the failure of the prison medical service to develop an explicit policy on the degree to which it will accept responsibility for managing psychiatric disorder. Health service policy is to make all staff aware of the cost of treating patients. Several London hospitals have closed (medical and surgical) wards in order to reduce the number of patients treated and thereby remain within budget. At least one health region has considered removing patients from its waiting list for "non-essential" operations and is acknowledging that it is unable to supply some surgical procedures. There is active debate among health administrators and economists as to how health care should be rationed.

The mentally disordered offender may fall uncomfortably between the health and prison systems. As the health system restricts the service it provides, the prison service could easily be left to make up the shortfall. This was the case in at least one well documented example, between 1960 and 1983, when restrictions on health service
treatment (the Broadmoor waiting list) resulted in an increase in the time which mentally disordered inmates spent in prison awaiting transfer\(^1\). The paper cited does not contain an economic analysis but it seems obvious that the effect of an increased delay in transfer is to shift costs from the health service to the prison service during the increased waiting time. For example, the mean time from medical recommendation to admission in 1960 was 1.3 months, whereas by 1983 it was 7.6 months, an increase of 6.3 months. The effect of this delay is to shift boarding and some treatment costs from the health service to the prison service, for the period in question. Present arrangements contain no economic incentive for the health service to expedite transfer.

Prison medical officers reported increasing difficulty in persuading consultants to accept patients for transfer, especially when there was any controversy about catchment area. Consultants were under pressure not to make any mistakes (ie not to accept patients who did not belong to their catchment area) from administrators and managers. They were being made aware that mistakes carried financial penalties. There is no financial pressure in the opposite direction ie. to encourage rapid acceptance of patients. Wrangling over catchment area may delay transfer by up to a year. Evidence from prison medical officers who had dealt with private secure units suggested that transfer could be effected more rapidly. It is difficult to believe that this is not partly a result of the differing economic incentives that exist in the NHS and private systems. There is an urgent need to resolve the problem of funding for the care of mentally disordered offenders.

As medical care is to be organised increasingly according to the principle of money following the patient, consideration should be given to the possibility of the prison service charging health districts/regions for psychiatric care which they deliver to the district/region's patients. The high level of these charges would reflect the difficulty of providing psychiatric care in prison and provide an incentive for the district/region to provide it elsewhere.

Recommendations according to diagnostic group.

1. Psychosis

Introduction

Prison is an unsuitable place in which to manage people with a serious mental illness and the following recommendations are based on this assumption.

The main thrust of mental health legislation in England and Wales since the report of the Percy Commission\(^2\) in 1957 has been that the treatment of the mentally ill should increasingly be governed by the principles applying to physical illness. The

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majority of people suffering from mental illness will receive treatment on a voluntary basis with exceptions to this principle being carefully defined and regulated\(^3\).

It is generally accepted that the medical treatment of prisoners with physical illnesses should be equivalent to that provided by the health service and that transfer to hospital will take place when necessary to ensure adequate investigation and treatment of physical complaints. The same principles apply to the treatment of mental illness in prison - independently of any issues concerning the relationship between mental disorder, crime and criminal responsibility.

Prisons are not equipped to provide anything more than "first-aid" care for individuals suffering from severe mental illness. At one end of the spectrum, they are prevented from prescribing to seriously disturbed patients who refuse medication. At the other, they do not have the resources to provide a full multidisciplinary assessment and treatment package for patients with a chronic mental illness such as schizophrenia. As "total institutions" prisons resemble the old asylums. These are accepted to have been detrimental to many patients with chronic mental illnesses. Modern management, with medical, nursing and occupational therapy input, can maximise functioning in chronic mental illness and help to prevent deterioration. This service cannot be provided in prison.

This position is further reinforced by "public health" considerations. Life in prison is unpleasant in many ways; it can be made intolerable for inmates forced to share a cell with a person suffering from schizophrenia. Minor behaviour problems (eg restlessness at night, talking to oneself) can easily become major sources of irritation in the prison environment. Quite apart from the abuse to which the chronically mentally ill are vulnerable, this is an unnecessary source of friction in a volatile population.

Concern for public health also demands that mentally ill people convicted of crimes serious enough to warrant imprisonment are fully assessed with respect to possible future dangerousness. Neither the trial nor parole procedures fulfil this need in many cases. Psychiatric evidence may not be considered at trial, parole assessments may be perfunctory.

These considerations may apply to quite mundane cases.

**Case history:** a man suffering from chronic schizophrenia was serving a six month sentence following repeated offences of drunken driving; he had not been assessed and was due for release in the near future, with no consideration of the likelihood of repetition of this potentially lethal behaviour. At the time of the study he was deluded and had did not acknowledge the seriousness of his offences.

The aim of managing the psychotic offender elsewhere than prison is not only desirable but also achievable. The number of psychotic men serving a prison sentence is around 700 (95% confidence interval 460 to 930; see Ch. 5, Table 5.3). The implications of this number for bed provision in the health service will be explored below. It is sufficient to note here that this is a tiny proportion of the prison population.

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\(^3\) Buglass R. A Guide to the Mental Health Act 1983. Ch. 1, Background to the new Mental Health Act. 1983 London: Churchill Livingstone
The next section suggests changes in the organisation of medical care within prisons aimed at reducing the number of mentally ill people in prison. This is followed by a discussion of complementary changes required in the health service. Finally, we consider the implications for the health service in terms of the number of beds required to accommodate patients who are currently in prison.

Maximising identification and transfer of mentally ill prisoners.

a. Changes within prison

The explicit principle of a prison health service should be that inmates suffering from psychosis will not be contained in prison.

Our results show that identification of cases by existing medical services is not a major problem. Many psychotic inmates were currently placed in prison "hospitals" or had spent time there during their sentence. The few unrecognised psychotic people we found had often become ill recently and were in the process of being brought to the notice of prison staff. Identification is not followed by efforts to transfer in all cases. The present reactive policy should be replaced by an active attempt to prevent the entry of psychotic inmates to the sentenced population and secure the transfer of those already there.

The following changes would help to achieve this:

i. Prison medical officers should exert greater influence over access to the prison system.

One duty of prison doctors is to certify fitness for imprisonment or transfer. They should explore all possible ways of using their influence to ensure that prisoners unfit for prison by reason of mental disorder are transferred for treatment as quickly as those who are unfit due to the need for urgent physical treatment.

Prisons do not have the power to refuse inmates sent to them by the courts but doctors should make it clear to governors, courts, health authorities and hospital managers that an inmate is not fit for imprisonment and that his continued presence there is against medical advice.

ii. Services for psychotic inmates should be centred on a small number of prisons.

There exists already a degree of organisation around specialised centres, whether these are locals or training prisons such as HMP Parkhurst. It is reasonable to build on the existing structure but improvements are necessary in the following areas:

The physical environment. With one or two modern exceptions, prison "hospitals" lack the facilities associated with hospitals elsewhere (even allowing for the dilapidated state of many NHS buildings) and are unsuitable for the care of psychotic patients.

Staff training. Improvements in the physical environment would make it easier to recruit qualified staff. Many more hospital officers should have a recognised nursing
Qualification. For medical staff, there is a need for a specific training course in prison medicine. Psychiatric duties should be carried out by fully trained psychiatrists.

Separation of the needs of sentenced and remand prisoners. In local prisons, discipline and medical services have as their priority the remand population, to the detriment of the sentenced psychotic inmate. The ideal solution would be to remand psychotic inmates to NHS hospitals for assessment and to hold sentenced and remanded inmates in separate establishments. At the very least, there should be a medical officer with specific responsibility for sentenced men and separate accommodation within prison "hospital" facilities.

iii. Psychotic inmates should never be placed on normal location or in disciplinary units.

Abandoning attempts to "see if the psychotic inmate can cope on normal location" would ensure that these patients get the care they need and facilitate specialist assessment and transfer to an outside hospital.

Management of psychotic or mentally handicapped inmates on disciplinary units is uncommon but indefensible as routine practice (see Ch. 8). The decision by a prison doctor to sanction such a practice in exceptional circumstances should require mandatory consultation at the highest level of prison health service management.

iv. A closer relationship between prisons and the NHS is essential.

The proposed new arrangements whereby medical services are bought in on contract from the NHS will help in this respect by increasing the number of doctors working in both services. However, changes in NHS financing (see below) may jeopardise the relationship by leading to arguments about funding.

v. Prison health services should monitor their performance.

If psychotic inmates are held in certain prisons rather than dispersed throughout the system, it becomes relatively simple to monitor progress in attempting to secure transfer to the health service. By implication, the performance of the NHS is also monitored, by identifying the NHS regions responsible for psychotic inmates who remain in prison. Information of this type is not readily accessible at present.

If transfer of a psychotic inmate is not possible, monitoring should include a formal review of the individual case at regular intervals, to re-assess the possibility of transfer.

b. Changes within the health service

It is pointless for the Prison Medical Service to identify and refer patients requiring transfer if the health service is unwilling or unable to accept them. Many of the cases we identified were well known to their local psychiatric services and they reveal a number of gaps in health service provision.
i. There is a need for units providing long term care in conditions of medium security.

Psychiatric reports in some cases depicted the progressive failure of district services to cope with a patient, only for the patient to be turned down by the special hospitals as not requiring such a high level of security.

Case history: a 27 year old woman with borderline mental handicap and intermittent psychotic illness was unable to live independently in the community. Hostel placements broke down because of damage to property or assaults on staff. Previous hospital admissions resulted in assaults on staff and patients. Violence was not considered serious enough to warrant special hospital placement but all psychiatric reports agreed that she required long-term psychiatric care at medium secure level.

Although the explicit distinction between special hospitals and medium secure units is in the level of security they provide, they also differ in the length of time for which they provide care. Medium secure units do not cater for patients who are likely to require their services for more than two years. Patients requiring care for a longer period may be rejected by special hospitals on the reasonable grounds that they do not require maximum security (and its consequent expense).

The underlying reason for this problem is the lack of sufficient places in medium security, forcing units to restrict the entry of long-term patients in order to prevent blocking of beds. Current provision of medium security beds falls well below the 2,000 recommended by Butler⁴ and the 1,000 accepted as an initial target by the Department of Health⁵.

ii. There is a need to provide for prisons an emergency admission and assessment service.

"Rapid" transfer is practically impossible at present, although current legislation allows it. Ready access to secure unit beds would allow rapid stabilisation of the acutely psychotic patient in a safe environment subject to the controls of the MHA 1983.

Barriers to this at present are the fact that RSU's will often not take people without a lengthy assessment or have a waiting list for admissions; they are unresponsive to this demand from the prison system. Funding would be a problem but perhaps prisons should be inviting tenders from units willing to provide this short-term, treatment and assessment function.

Ultimately, the existence and efficient operation of such a service depends on the availability of sufficient places in medium secure units (see i. above).

iii. There is a need for improved district services for difficult and chronic patients.

Rather than requiring security, some patients presented "nuisance" problems in addition to their mental illness; non-compliance, drinking or drug-taking, verbal abuse. Others simply remained psychotic after prolonged treatment and appeared to have exhausted local resources. Some districts provide a service for such patients; a reasonable model is a hostel with high staffing levels and psychiatric supervision.

⁴ Interim report of the committee on mentally abnormal offenders. 1974 HMSO Cmd 5698
⁵ DHSS Health Service Circular (Interim Series) HSC(IS)61
There is no expectation that the residents will move on and such facilities are expensive.

iv. Adequate standards of psychiatric care for offender-patients must be established and monitored.

Some patients presented no particular difficulty but appeared to be the victims of a failure to provide an adequate psychiatric service.

Case history: a 25 year old man with a history of several admissions for schizophrenia was adequately controlled on depot medication but often failed to attend for injections. Prior to his current offence (petty theft) he was being supervised by a probation officer and attending a psychiatric clinic as a condition of the same order. The probation officer repeatedly informed the responsible doctor by letter and telephone that the patient had relapsed, was floridly psychotic and without insight into his condition. The only response was to send the patient a further outpatient appointment, despite previous failure to attend. Following his arrest, emergency, compulsory treatment on remand led to rapid recovery and an unhelpful psychiatric report led to a prison sentence. Placed on normal location, the patient was lost to medical supervision, refused medication and relapsed. At interview, he had covered himself from head to toe in boot polish, was deluded and hallucinated and so thought disordered as to be incapable of the simplest conversation.

The attitudes and practice of a minority of psychiatrists contribute significantly to the problem of mental illness in prison. There is a need for better training of general psychiatrists in the management of offender-patients. The Royal College of Psychiatrists has formulated guidelines on good practice but their implementation will require careful monitoring.

v. There is a need to provide adequate funding for the care of difficult and chronic patients within the health service.

To a large extent, this cuts across all other recommendations. There are major disincentives for district services to accept difficult patients who may well occupy beds for many years and represent a substantial drain on budgets. The NHS reforms do not address the fundamental question of who is to pay for the care of such patients. The problem is not confined to psychiatry and concern has been expressed about the care of other "expensive" patient groups, including those with HIV infection; the authors suggest regional or supra-regional funding as a possible solution. In the case of psychiatric patients in prison, a source of adequate funding for their care within the health service is an urgent priority if the situation is not to deteriorate even further.

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6 Royal College of Psychiatrists. Working party report on good practice in discharge and aftercare procedures for patients discharged from inpatient psychiatric treatment. London: Royal College of Psychiatrists 1989


c. How many health service beds are required?

It would be wrong to regard the problem of mentally disordered people in prison as being primarily one of bed numbers within the health service. Most of our recommendations concern the way in which health care is provided to this group of patients. Nevertheless, bed numbers cannot be ignored - particularly in the case of medium secure units or special hospitals. At these higher levels of security, the recommended increase in beds is a significant proportion of existing provision.

The following four questions are addressed:

i. What is the best estimate of need for health service beds, based on our findings?

ii. What are the statistical sources of error in the estimate?

iii. What are the other sources of uncertainty in the estimate?

iv. What are the bed requirements at each level of security?

i. An estimate of need for health service beds

The best estimate of the number of beds required by people serving a prison sentence is around 1,140 (see Table 6.10). This figure includes 695 adult men (95% confidence interval 460 to 930) and an estimated 14 male young offenders and 15 women suffering from psychosis (a meaningful confidence interval cannot be calculated for these smaller figures; see tables 5.3, 5.4 and 5.5).

The total figure of 1,140 also includes the estimated number of inmates with other diagnoses who require transfer. (Issues related to hospital transfer are discussed here. Specific recommendations relating to inmates with diagnoses other than psychosis are discussed in later sections of this chapter).

ii. Statistical error in the estimate of bed numbers

The figure of 1,140 is an estimated point prevalence\(^9\) i.e. an estimate of how many cases requiring hospital transfer exist in the population at one point in time. It is possible to estimate a confidence interval for the adult men and women included in this figure; 95% confidence limits would be 756 to 1371.

This means that there is a 95% certainty that the true number of adult men and women in the sentenced prison population who require transfer to hospital lies in the range 756 to 1371. There is only a 5% or one in twenty chance that the true number lies outside this range. (An unknown number of male young offenders must also be added to this figure; as mentioned above, the proportion requiring transfer was so small that a meaningful confidence interval could not be calculated).

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\(^9\)The other principal measure of the frequency of a disease in a population is the incidence i.e. the rate at which new cases develop. For long-term, chronic conditions, the incidence may be low and the prevalence high; few new cases develop but each remains in the population for a long period.
Confidence limits estimate statistical error; they quantify the uncertainty involved in estimating characteristics of the entire population (all sentenced prisoners) from measurements conducted on a small sample (the prisoners we interviewed).

In this case, the confidence limits are relatively wide. The upper limit is almost twice the lower. The fact that young offenders could not be included increases the uncertainty still further, although the small numbers involved mean that this is unlikely to make a great difference. Nevertheless, there is considerable uncertainty in our estimate of bed numbers.

Statistical error is not the only source of uncertainty. Confidence limits cannot allow for other sources of error, which include errors of sampling or defects in the model on which the study has been constructed. Some of these sources of error will be illustrated by describing the assumptions upon which our estimate of bed need is based.

iii. Other sources of uncertainty in the estimate of bed numbers

Our model for estimating the number of beds required assumes that the pool of mentally ill people in the sentenced prison system is at a steady state. The rate of entry to this pool (mentally ill people being sentenced and previously sentenced prisoners developing mental illness) equals the rate of loss from the pool (by recovery from illness, discharge/transfer from prison or death). If our study were repeated at two-year intervals, we would expect the numbers of people requiring transfer to be similar, even though many of the individuals would be different.

Use of point prevalence as an estimate of bed numbers assumes that the pool of mentally ill people serving a prison sentence can be moved to hospital. Individuals would continue to enter and leave the pool in the same way - it would merely be in a different location.

This model presupposes the following conditions:

- the existence of an efficient mechanism, as outlined above, for the detection and transfer of mentally ill people in prison to hospital.

- no delay in moving patients from hospital as soon as they become well i.e. cease to be hospital cases. We assume one case equals one bed needed; the estimate does not allow for beds blocked by patients who cannot be moved on for non-medical reasons (a common state of affairs in the special hospitals). This would increase the bed requirement by an unknown amount.

- patients do not remain in hospital for longer than they would remain in prison. A man with chronic schizophrenia serving a short sentence is lost from the pool of mentally ill people in prison at the end of his sentence. If transferred, discharge would depend on his mental state and he may occupy a bed for much longer than the time he would have spent in prison. Again, this would increase the bed requirement by an unknown amount.

- that treatment in hospital has no effect on the length of time for which a patient remains a case. Even the most cynical observer of psychiatry could not support this proposition without some reservations. There is ample evidence that both hospital
admission and medication shorten the length of psychotic episodes. Effective treatment would mean an early exit from the pool of the mentally ill and would tend to decrease the bed requirement.

- that the number of mentally ill sentenced prisoners does not increase. Point prevalence identifies need at a fixed point in time and cannot take account of future changes in the size or nature of the sentenced prison population. Long-term, chronic patients have a disproportionately large impact on bed requirements, so that even a small increase in their numbers in prison would increase significantly the need for beds.

It is beyond the scope of our study to estimate the extent to which these factors will render our estimate inaccurate. Most of these sources of error would increase the true bed requirement relative to our estimate.

iii. bed requirements at different levels of security

Our estimate is that bed needs are distributed fairly evenly across special hospitals, medium security and district psychiatric services. It is tempting to conclude that the shortfall in provision at each level is around 400 beds but there are many reasons for not translating this estimate into firm numbers.

The relatively wide confidence limits of this estimate are discussed above. The extremes of the range 756 to 1371 suggest a requirement at each security level of between 252 and 457 beds.

In addition to this uncertainty, there are two other sources of inaccuracy. Firstly, when subdivided according to levels of security, the numbers in our sample become too small to allow any far-reaching conclusions. The study was designed to estimate the extent of psychiatric illness in the sentenced population by sampling as widely as possible. It was not designed to provide a comprehensive and detailed description of a particular section of the population, those prisoners felt to require transfer. Whilst we can estimate with confidence that the population contains around 1,100 inmates of this type, our sample contains 48. Dividing by three leaves 16 inmates at each security level; the problems of extrapolating from such small numbers are obvious and further subdivision (by offence type, diagnosis, sentence length, etc.) is pointless.

Secondly, our judgements about security requirements were based on clinical criteria and the assumption of an ideal world. In the real world of psychiatry, services at lower levels of security often refuse to accept patients for a variety of reasons not directly linked to their clinical condition. It may be argued that the patient is difficult or staffing levels inadequate. Some district services refuse to accept patients who have been in prison, irrespective of their offence. Whatever the reason, the result is increased demand for beds at higher levels of security.

With these reservations in mind, it is worth noting that the shortfall in bed provision appears greatest in proportional terms at medium security level, where

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current provision is around 600 beds. Full implementation of the Butler Committee’s recommendations in respect of medium secure units would ease this problem.

d. The need for future research

There is no point in further surveys of the prevalence of psychiatric disorder in the sentenced prison population. The remand and trial process is being studied with a view to determining how the mentally ill reach prison.

There is a need for a more detailed study of the treatment needs of the estimated 700 mentally ill and 400 other sentenced prisoners who require transfer to hospital. This would allow more accurate prediction of bed numbers, and at which levels of security they should be provided. It may also allow an estimate as to the length of time for which a bed would be required. An important piece of medical audit or service research would be to determine how these patients are distributed across the health regions of England and Wales.

A self-report questionnaire (as in the South East prison survey) combined with a survey of prison discipline and medical records centred on certain prisons (or specialist units within certain prisons) should allow identification of cases.

Service research should also be directed at procedures for the referral and transfer of prisoners to the NHS. In particular, there is a need to investigate and ways of speeding up the process.
2. Mental handicap

Introduction

The mentally handicapped within prison often have other psychiatric diagnoses and hospital transfer should be the primary goal in these cases (see discussion above). In contrast to mental illness, detection or correct identification of mental handicap does seem to be a major problem. It is of particular concern that mental handicap is incorrectly labelled and managed sometimes as bad or difficult behaviour. Improvement of diagnosis and assessment must be the first priority.

Inmates with borderline levels of intellectual impairment unaccompanied by psychiatric illness should be diverted from prison where possible. Within prison, they require specialist provision from several disciplines.

a. Changes within prison

In prison, many of the other services which contribute to the care of the mentally handicapped in the community are absent, so the role of the doctor acquires greater importance.

i. A medical service for mentally handicapped inmates.

Reasonable aims of a service for the mentally handicapped within prison are:

- correct identification of mentally handicapped inmates.

- detection and treatment of co-existing psychiatric disorder.

  The mentally handicapped people in our study often had other diagnoses which were missed; difficult behaviour was attributed to the handicap. A number of inmates suffering from both a psychotic illness and mild mental retardation were managed inappropriately in a purely disciplinary manner as their disorder was unrecognised.

- assessment for possible transfer to hospital.

  Most of the mentally handicapped inmates we encountered had other psychiatric disorders and treatment needs that were not being met in prison.

- coordination of a multidisciplinary approach to assessment and management.

  The medical officer is ideally placed to coordinate input from probation, psychology and education.

ii. There is a need for improved training for medical officers.

  Mental handicap is a specialist field within psychiatry and only a minority of doctors have the requisite expertise to provide an adequate assessment. In the absence of other services dealing with mental handicap, the prison doctor’s role is increased in importance. It is essential that basic prison medical officer training includes the skills necessary for an initial assessment.
iii. Visiting specialists in mental handicap should be involved in assessments.

Mentally handicapped prisoners were often poorly served by reports to court (reports by doctors from Rampton were an exception). Reports and management would be improved by involving visiting specialists with a special interest in mental handicap. This is done occasionally at present (mostly when special hospital transfer is contemplated). All Rule 43 or vulnerable prisoner units should have available the services of a specialist in mental handicap.

The specialist has the advantage of expertise in diagnosis but will also be familiar with treatment options with which other doctors may be unfamiliar. His role is central to a pre-release assessment, when he can liaise with a variety of agencies in the community.

iv. There is a need for psychologists with an interest in mental handicap.

The role of IQ testing in mental handicap has decreased in recent years but the importance of other psychological assessments has not. Testing of IQ appears to be rare in prisons but other psychological testing has not replaced it and this probably contributes to the failure to recognise the problem.

v. There is a need for improved remedial education services.

A good remedial education service would aid the assessment of mentally handicapped inmates and could also benefit those prisoners who are not mentally handicapped but have serious difficulties with literacy or numeracy.

b. Changes in the health service

Specific difficulties were not readily apparent. Referrals were uncommon; they tended to be to special hospitals and complaints about the service were few. As with mental illness, there is a lack of provision for long term care in conditions of medium security.
3. Neurotic illness

Introduction

The model for treating neurotic disorder within prison is likely to remain as described in the preceding chapter. Within this model, a number of improvements can be suggested.

a. Changes within prison.

i. There is a need to improve confidentiality and the setting in which care is delivered.

The point of reference should be the standards found in a good general practice.

ii. There is a need to broaden the training of doctors.

The low level of reliance on medication requires that doctors are skilled in recognising the minority of patients with a significant depressive illness that requires antidepressant therapy.

There is also a need for training in non-pharmacological therapies including individual and group psychotherapies and basic psychological techniques such as relaxation training.

iii. There is a need for adequate training, support and supervision for all non-medical staff providing psychological care.

This includes all officers taking part in personal officer schemes and all staff running groups for inmates e.g. for drug or alcohol abusers.

iv. Referral to the NHS is necessary for severe neurotic illness that does not respond to treatment in prison.

Many doctors dismiss the possibility of transfer for inmates with diagnoses other than psychosis. Severe neurotic illness that does not respond to treatment is a valid reason for referral for a second opinion and possible hospital transfer.

v. There is a need for improved liaison with the health service.

Many inmates given a diagnosis of neurosis have long-term neurotic problems. A number of alcohol and drug abusers also received a diagnosis of neurosis and substance abuse can be seen as an attempt at self-medication for anxiety in some of these cases. Prior to release, it is important to establish contact with local psychiatric services.

vi. Doctors can offer advice on general measures to lessen the impact of neurosis within prison.

Provision of telephones, for example, would reduce some of the stresses of imprisonment.
b. Changes within the health service.

*It is important that hospitals do not use the presence of psychotic symptoms as the only criterion for offering treatment to prisoners.*
4. Self harm and attempted suicide

Introduction

We would endorse any recommendations for improving the prison regime to reduce the incidence of self-harm e.g. provision of access to telephones, removal of bars from which inmates can hang themselves.

Our specific comments will be brief as the problem is mainly one of remand prisons and was not a central concern of our study.

a. Changes within prison

The explicit object of medical involvement in actual or potential self-harm is to make a diagnosis, assess suicidal motivation and institute and oversee appropriate treatment.

i. The need to abandon isolation as a device for suicide prevention.

Isolation and placement in a "strip" cell has no part to play in the routine management of suicidal behaviour, which would be better designed around a ward setting, with levels of observation as dictated by the patient's clinical condition.

ii. The need for skilled nursing care.

The suicidal patient is a challenge to psychiatric nurses working in a hospital environment. The suicidal patient in prison cannot be managed effectively without similar nursing care. More trained nurses are needed within prison "hospitals".

iii. The need to recognise the limitations of treatment within the prison environment.

Cases assessed as a persistent suicide risk in the prison setting should be referred for urgent hospital transfer. Psychiatric disorder in these circumstances is of a similar significance to life-threatening physical illness.

b. Changes within the health service.

It is of crucial importance that the health service offers emergency assessment and possible admission to suicidal patients referred from prison.
5. Personality Disorder

a. Changes within prison

i. There is a need for expansion of existing specialist services

Our findings point to considerable unmet need for treatment in a therapeutic community, as at HMP Grendon. The magnitude of this demand, given the length of the waiting list for admission to Grendon, is sufficient to justify the development of at least one other prison of this type. There is a specific gap in provision for the less serious recidivist not catered for at Grendon.

The Annexe at Wormwood Scrubs needs more publicity within the system. There is no therapeutic community provision for women. Consideration should be given to setting up a therapeutic community for personality disordered women, which could be a small unit within an existing prison.

The level of specialist provision in young offender centres appears adequate, with the qualification that other institutions were often unaware of the facilities. There is a need to publicise the facility and its admission criteria within the system - only then will the true level of demand become apparent.

ii. Doctors have an important role to play in all units handling personality disordered inmates

Whatever the approach of a particular unit, a large number of inmates will have a psychiatric diagnosis. Medical input, at least in an advisory or consulting role, is necessary to ensure the detection and correct treatment of all psychiatric conditions and to avoid the management of psychiatric disorder in a purely disciplinary way.

iii. Changes within the wider prison system.

Many personality disordered inmates will continue to be managed in the rest of the system by medical, discipline and probation staff. Improved training is essential for all staff, as is continuing, formal supervision and support.

An extension of the personal officer scheme would benefit many personality disordered inmates.

There is a need for inmates in ordinary prisons to be made aware of the treatment available on a voluntary basis at specialist centres such as Grendon.

Some personality disordered inmates require transfer to hospital. The low level of requests for hospital transfer reflects the lack of provision within the health service. It is pointless to recommend a higher level of referral without an increased willingness by the health service to accept patients of this type.

b. Changes within the health service

It is unreasonable to expect prisons to shoulder the entire burden of treating offenders with a personality disorder. There is a need for increased provision of therapeutic community treatment within the health service. Most of the current provision is within the special hospital system but there is a need for this facility at all levels of security.
If even a small proportion of prisoners requiring therapeutic community treatment were to be treated within the NHS, this would greatly increase the estimated bed requirements discussed above.

c. directions for future research

Studies of units for the personality disordered within prisons identify aspects of these special regimes that influence the behaviour of the most difficult inmates in the system. There is a need to establish the extent to which some of these principles could be more widely applied in prisons outside specialist centres.

The general regime for women at some prisons, particularly Holloway, gives inmates a considerable amount of freedom within the perimeter and encourages them to take responsibility for their own behaviour. It is suggested that this has helped to reduce self-harm, among other improvements. "Experiments" of this type need to be monitored and assessed.

Both within and outside prison, there is a need to establish and evaluate new treatment facilities for personality disordered patients. A Region or Special Health Authority could pioneer experimental therapeutic community treatments in order to determine the proper national provision for this type of service.