INVITED COMMENTARY ON
The mental health of prisoners

Psychiatrists have always been concerned about the mental health of prisoners. If they did not devote much energy to their treatment, it was only because they had more-pressing problems, including how to squeeze ten patients into nine beds. In any case, it was someone else's job to look after prisoners. Luke Birmingham's article (Birmingham, 2003, this issue) could not be more timely, as this situation has now changed. With the publication of *The Future Organisation of Prison Healthcare* (Prison Service & NHS Executive Working Group, 1999), and the creation of a joint Department of Health and Home Office task force, the Government has made it clear that the problem of mentally disordered offenders belongs to the National Health Service (NHS). There is a plan, there is a partnership and there are targets. Can those of us who have been worrying about prisoners with mental illness sit back and relax, as the solution unfolds?

As Birmingham hints, celebration might be premature. It is one thing to set targets and quite another to achieve them. While greeting the initiative enthusiastically, we should not forget that, despite the fanfare, it is the second-best option. Expert advice favoured a complete handing over of responsibility to the NHS and the reasoning is simple. Two stools may cost less than one sofa, but most families choose the latter if they want to watch television in comfort. When services share work, there is debate about who belongs where, and patients disappear down the gap while the argument rages. Far from being a peripheral issue, this problem defines psychiatry. It is the only branch of medicine in which the question of who treats a patient receives more attention than how the patient is treated.

With this concern in mind, it is alarming to find that some awkward questions are being avoided. Coid (1988*a,b*) found that psychiatric services may not even assess prisoners with mental illness who are brought to their notice. Robertson *et al* (1994) showed that only one-third of prisoners with known psychosis ended up in hospital and the situation was worse for other diagnoses. The Reed Report (Department of Health & Home Office, 1992) made sense of these findings, using the concept of perverse incentives: why should a hard-pressed psychiatric service admit a prisoner with mental illness, who is likely to be more difficult, more chronic and more expensive than average, when competing patients are at large in the community, where they can do more damage? It is naïve to suppose that psychiatric services will begin to take such patients just because they have been told to do so. While covert rationing continues, prisoners are likely to remain at the end of the queue.

Even given goodwill (a rare commodity when arguing about the transfer of prisoners with mental illness), the logistical problems are enormous. Health authorities have been carrying out needs assessments in their local prisons and many are now discovering that most patients come from other areas and are therefore the responsibility of other health authorities. Inreach services will lead to many community psychiatric nurses going into prisons, hoping to mirror their outreach function in the wider community. They are likely to become disillusioned if they find themselves spending hours on the telephone trying to arrange assessment or admission by a distant and disinterested service.

On the other hand, it can be argued that inreach is valuable, irrespective of its impact on delays in moving those with serious mental illness out of prison into hospital. Prisons need a wider range of psychiatric services for the vast number of mentally disordered offenders who do not need a hospital bed. Indeed, the true prize would be a reduction in the number of prisoners needing a transfer as a result of earlier and better treatment within prison.

These are fair points, and general adult psychiatry provides a perfect example, outside prisons, of operating a range of successful services despite not having enough beds for the acutely ill. Unfortunately, prisons are different. Prisoners with mental illnesses may be out of sight of the wider community, but they are all too visible to those working in closed institutions. A small number of disturbed individuals within prison health care centres soak up a disproportionate share of resources, both financial and emotional. Health care professionals will not be able to work efficiently in prisons if it is impossible to move those prisoners who need to go.

How is efficient transfer of the acutely ill to be achieved? It is rare to see this question stated explicitly, perhaps because it is so difficult to answer. Is it assumed that needs assessment, screening and the greater involvement of general psychiatry will deal with the problem automatically? There is no basis for that assumption. It is most likely that catchment area services, with finite resources, will

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continue to behave rationally, by doing all they can to avoid an influx of patients into acute wards that are already bursting at the seams. Radical solutions are needed. Could health authorities be charged for the care of patients with acute mental illness who are within prisons? The rate would have to be set at a level that made it uneconomical for them to remain there. Should we invite the private sector to find beds for them, sending the bill to the appropriate place? This approach was successful in ameliorating the problem of insufficient beds at the level of medium security, albeit at massive cost. As an alternative, should some prison health care centres be handed over to the NHS, to be run according to the same standards as operate in psychiatric hospitals? They would allow the proper treatment of prisoners with acute mental illness, including compulsory treatment under the Mental Health Act. The service would be more expensive, but it would offer better value. In any case, costs could be met by the patient's health authority, giving them an incentive to develop services of their own. These problems are considerable, but the loudest objections would come from the Prison Service, asked to give up part of its estate to be run according to a different set of principles. It is easy to imagine the howls of protest about security. But then again, who said partnership was easy? Unless we face some of these difficult questions, one fears that the current initiative will go the way of all the others that have been meant to solve the problem of those with mentally illness in prisons. Are we happy with déja vu all over again?

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