

## Between prison and the community

The 'revolving door psychiatric patient' of the nineties

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According to Torrey (1995), de-institutionalisation of the seriously mentally ill in America has been the largest failed social experiment of the 20th century. Many have failed to survive in the community because of inadequate after-care, and America's prisons and jails have slowly replaced mental hospitals as the primary provider of institutional care for the mentally ill. Estimates suggest that on any given day there are now twice as many seriously mentally ill individuals in prison as in state mental hospitals.

Evidence is now emerging that indicates that the closure of psychiatric hospitals coupled with under-resourced community care is causing a similar problem in Britain. Furthermore, it would seem that our prisons are acting as little more than temporary accommodation for the mentally ill, who are liable to remain undetected in prison and return to the community without treatment or psychiatric after-care.

Mental health services in Britain, especially those in inner-city areas, are in crisis (Marshall, 1997; Shepherd *et al*, 1997). If psychiatric services cannot respond to the needs of the seriously mentally ill in the community, individuals with troublesome or dangerous behaviour are likely to be dealt with by the criminal justice system. Teplin (1984) has shown that in similar circumstances, people with mental disorders are more likely to be arrested than their non-mentally disordered counterparts. The probability of remand into custody is also greater: those who commit violent acts are perceived as being more dangerous simply by virtue of having mental illness, and even when offending is of a less serious nature, the presence of mental illness increases the likelihood of remand (Taylor & Gunn, 1984).

Court diversion services often experience an uphill struggle when faced with a mentally ill person in custody. Overstretched general psychiatric services may be unable or unwilling to help, a forensic bed is not usually an option, and even if a

psychiatric disposal can be offered, the magistrate may refuse to accept this (Rowlands *et al*, 1996). Therefore, it is not surprising that research has shown that one in 20 men entering prison on remand is suffering from a psychosis (Birmingham *et al*, 1996).

Research by Gunn *et al* (1991) on male sentenced prisoners, together with that by Brooke *et al* (1996) on male remand prisoners, suggests that prisons in England and Wales contain more than 1000 men suffering from psychosis and nearly 2000 male prisoners who need treatment in psychiatric hospitals. The report on the prevalence of psychiatric morbidity among prisoners in England and Wales, published in October 1998 by the Office for National Statistics, paints an even bleaker picture. This large-scale study reports that 7% of male sentenced and 10% of male remand prisoners suffer from functional psychotic disorders. If these findings are generalised to the prison population as a whole, this indicates that there are in excess of 4500 men with psychotic disorders in prison at the present time. Of course, prisoners with serious mental illness represent only the tip of the iceberg of psychiatric morbidity. There are many more prisoners who suffer from less severe forms of mental disorder, who do not require transfer to a psychiatric hospital, but who would none the less benefit from psychiatric treatment given in the prison setting.

Prisons were never intended to accommodate such a large health care burden and they are ill-equipped to do so. Prison reception health screening often fails to identify psychiatric morbidity (Mitchison *et al*, 1994; Birmingham *et al*, 1996, 1997) and mental illness frequently remains undetected during remand (Birmingham *et al*, 1998). When psychiatric treatment needs are identified, the response of the system is inefficient. A number of prisoners who are potential candidates for hospital treatment are rejected by consultant psychiatrists because they are perceived as being too disturbed or dangerous, or are seen as

criminals who are unsuitable for treatment (Coid, 1988). Poor communication between prison, court and hospital systems hinders the assessment and management of mentally disordered offenders, and medical intervention can actually delay their release from custody (Robertson *et al*, 1994). When communication breaks down altogether, the result can be a sudden and unpredicted release of prisoners with acute psychosis who are then lost to follow-up in the community. However, many mentally ill prisoners receive no treatment or aftercare when they are released because their treatment needs are not recognised (Birmingham *et al*, 1998; Dell *et al*, 1993).

Once back in the community, mentally disordered offenders are unlikely to prove popular patients with general practitioners and psychiatrists. Those with a serious mental illness who do engage with health services may have additional problems such as comorbid substance misuse, and may comply poorly with treatment. Without assertive follow-up these patients are particularly prone to losing contact with services. Those who are in poor mental health, and who fall outside the umbrella of psychiatric services, are particularly prone to re-offend. Once this happens the cycle, starting with remand into custody, is likely to begin again.

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(First received 20 October 1998, accepted 4 December 1998)

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