Inpatient care of mentally ill people in prison: results of a year's programme of semistructured inspections

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Abstract

Objective To investigate the facilities for inpatient care of mentally disordered people in prison.
Design Semistructured inspections conducted by doctor and nurse. Expected standards were based on healthcare quality standards published by the Prison Service or the NHS.
Setting 13 prisons with inpatient beds in England and Wales subject to the prison inspectorate's routine inspection programme during 1997-8.
Main outcomes measures Appraisals of quality of care against published standards.
Results The 13 prisons had 348 beds, 20% of all beds in prisons. Inpatient units had between 3 and 75 beds. No doctor in charge of inpatients had completed specialist psychiatric training. 24% of nursing staff had mental health training; 32% were non-nursing trained healthcare officers. Only one prison had occupational therapy input; two had input from a clinical psychologist. Most patients were unlocked for about 3.5 hours a day and none for more than nine hours a day. Four prisons provided statistics on the use of seclusion. The average length of an episode of seclusion was 50 hours.
Conclusion The quality of services for mentally ill prisoners fell far below the standards in the NHS. Patients' lives were unacceptably restricted and therapy limited. The present policy dividing inpatient care of mentally disordered prisoners between the prison service and the NHS needs reconsideration.

Introduction

A survey by the Office for National Statistics in 1998 showed a high prevalence of mental disorder among prisoners.[1] Compared with 0.4% of the general household population,[2] 7% of sentenced men, 10% of men on remand, and 14% of female prisoners had evidence of psychosis in the year preceding interview; most of these prisoners had schizophrenia or other delusional disorder. Sixty four per cent of women on remand reported symptoms of depression compared with 11% in the general population. These rates are considerably higher than those reported by the prison service, whose unstructured "snapshot surveys" found that 5% of prisoners in 1995 and 3.8% in 1996 had "some degree of mental disorder requiring intervention."[3] The rates are also higher than those found in previous research studies.[4–6]

The NHS is not responsible for most health care in prisons, although since 1991 the Prison Service in England and Wales has aimed to provide health care of the same standard as the NHS.[7] Health care in prisons is provided mainly by staff employed by the prison service, although some prisons contract services from the NHS or independent healthcare providers. Not all nursing staff are registered nurses; a proportion are non-nursing qualified healthcare officers who have received six months healthcare training as well as prison officer training. The prison governor, who has rarely had any healthcare training, is responsible for setting the budget for health care and for contracting and monitoring services. The main NHS responsibility until recently has been for secondary care of prisoners either through consultants visiting prisons or by transfer to NHS inpatient care.

Prison healthcare centres, although commonly called hospitals, are not like NHS hospitals but more like sickbays with primary care cover. Not all prisons have beds in their healthcare centres, although all have access to beds by transferring patients to another prison if necessary. Inpatients have diverse clinical problems, ranging from those awaiting transfer to high security NHS hospitals to others with minor physical illness. About 75% of patients admitted to healthcare centre beds have mental health problems.[3] The provisions of the Mental Health Act 1983 do not apply to inpatient care in prisons, and treatment without consent is possible only in emergencies under common law.

The standard of health care in prisons has caused concern for many years.[8] The health advisory committee to the prison service found that national policies for mental illness did not apply in prisons, that commissioning and management standards were lower than in the NHS, that patients in prison did not have access to a full range of services, and that there were few multidisciplinary teams.[9] The committee did not, however, inspect services in individual prisons. In 1997, we reported on health care in 19 prisons in England and Wales based on a year's programme of semistructured inspections.[10] We found wide variations in the quality of health care. A few prisons provided care broadly equivalent to that in the NHS but in many the health care was of low quality, some doctors were not

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adequately trained, and some care failed to meet proper ethical standards. The present study reports on inpatient mental health care in healthcare centres based on the inspection of 13 prisons in England and Wales between September 1997 and August 1998.

Her Majesty's Inspectorate of Prisons

Prisons have been subject to inspection since 1791, with a truly independent inspectorate being established in 1979. The purpose of the inspectorate is "To contribute to the reduction in crime by inspecting the treatment and conditions of those in prison service custody and in Immigration Service detention." Its reports are public documents available from the inspectorate or on the internet (www.homeoffice.gov.uk). The inspectorate aims to visit every prison once in five years, and its work comprises a programme of announced inspections lasting a week or longer, shorter unannounced inspections, and thematic reports on various issues.

Methods

The inspectorate has a set of expectations of the level and quality of service and care in prisons. The expectations for health care are based on the prison service standing order 13,[11] the nine healthcare standards approved by the Prisons' Board during 1994-6 for implementation by mid-1997,[12] and standards current in the NHS. The healthcare standards cover health assessment at first reception, mental health services, primary and outpatient care, inpatient care, reception, transfer and discharge, health promotion, clinical services for HIV and AIDS, clinical services for substance misusers, and the use of medicines.

The 13 prisons were visited as part of the inspectorate's routine programme and were not selected because of special concerns about health care. Healthcare inspections lasted two to four days and were conducted by a medical inspector, a nursing inspector, a professional standards inspector from the Royal Pharmaceutical Society (since 1997) and a dentist from the Dental Practice Board (since 1998). The results of inspection of pharmacy services have been given elsewhere.[13] Inspectors visit all healthcare areas, hold discussions with staff (both those employed by the prison and visiting specialists), review the annual reports on health care in the prison and local guidelines and protocols, and meet patients individually and, when appropriate, in a group. The views of inmates in the prison as a whole are sought about a range of aspects of prison life through confidential questionnaires and group discussions.

Results

The 13 prisons comprised eight local prisons (dealing with remand prisoners and those early in their sentences), three high security dispersal prisons, one category B training prison, and one young offenders' institution. Most prisons are multifunctional, and several of the local prisons also performed other functions including acting as training prisons and young offenders' institutions.

Size of prison inpatient units

No of beds*	No of inpatient units
<10	3
10-20	3
21-30	3
31-40	2
>40	2

*Range 3-75.

Management

Day to day management of prisons' healthcare services was generally the responsibility of a member of nursing or healthcare officer staff with the managing medical officer providing oversight and strategic direction. Nine of the thirteen services inspected were managed by non-nurse qualified healthcare officers and one (with 16 beds) was managed by a discipline prison officer with no healthcare training.

Size and structure of inpatient areas

The 13 healthcare centres had a total of 348 beds, 20% of the total of beds reported as available throughout the prison service.[14] The table shows the size of the inpatient units.

The physical structure of the inpatient areas varied greatly. Most had a mix of small wards and single rooms similar to cells. One newly built healthcare centre was comparable in design and facilities to a modern NHS psychiatric unit, but only a small part was used for health care. Other relatively new centres were poorly designed, with nursing stations often badly placed for observing patient areas. Older units had often been poorly adapted from old prison cells. Two did not meet the requirement for separate day rooms, and in one of these the day area had no natural lighting. The largest inpatient unit had been "temporarily" located for some years in a Victorian prison residential wing on three floors with no lift, no facilities for patients with disabilities, no separate day rooms, and limited office space. No healthcare centre provided carpets or rugs and curtains, as set out in healthcare standard 4. Cleaning was done by patients or other prisoners and varied greatly. Only one healthcare centre had adequately clean patients' lavatories. Staff lavatories, which were also cleaned by prisoners, were much cleaner.

All but one of the inpatient units had unfurnished rooms and some had "protected" (padded) rooms for patients who could not be managed in normal rooms or wards. Nursing observation of these rooms was often particularly difficult as they tended to be placed furthest from the nurses' office.

Staffing

Medical—The healthcare standards require that clinical responsibility for services for mentally disordered inpatients rests with a "doctor who is psychiatrically qualified." The inspectorate takes this to mean a doctor whose name is on the relevant specialist register. No doctor in charge of inpatients in the prisons inspected met this standard, although some had received some specialist psychiatric training. A survey found that 21 of the 190 doctors employed by the prison service were members of the Royal College of Psychiatrists or held a diploma in psychological medicine.[15]

Nursing—Healthcare standard 2 says that "staff will have received training in mental health care" and "a proportion [of staff] will be nurses with a mental health qualification." Most nursing staff in the prisons had no mental health training. Non-nurse trained healthcare officers accounted for 32% of staff, 44% were general nurses, and only 24% were mental health or dually trained nurses.

The standard also requires that the care regime is multidisciplinary, including healthcare staff, other prison staff (psychologists, probation officers, chaplains, and teachers), visiting specialists, and voluntary agencies. Only one prison held regular multidisciplinary team meetings, and care was usually described as "bidisciplinary," involving nurses and doctors. Only two prisons had established clinical psychology sessions and one also had two sessions from an occupational therapist. Three inpatient units had regular input from local community psychiatric nurses.

Night staffing

No standards have been set for night staffing, and patients' access to nursing staff during the night was poor. Most prisons had only one nurse or healthcare officer on duty at night, usually assisted by a support grade officer with no healthcare training. For security, nurses on night duty usually could not carry room keys. The keys and extra staff had to be brought from the main prison before a patient could be unlocked. It took at least 10 minutes before a nurse could gain access to a patient. Staff often spoke of their concern that this delay might be critical. The night nurse also had to attend the main wings if an inmate required health care. Such incidents left inpatients without trained staff for up to an hour.

Patients' day

The healthcare standards require that patients whose clinical state permits it spend 12 hours a day unlocked and out of their rooms. Patients should take part in at least six hours of planned activity daily. The inspectorate expects that this will be therapeutic activity including education and the development of interpersonal and daily living skills such as would be found in an NHS inpatient psychiatric unit. No prison met these standards. The actual time unlocked was hard to quantify since it varied day by day depending on staff availability. The healthcare centre which was nearest to meeting the standard had patients unlocked for about nine hours a day with group work or education sessions four afternoons a week. Most prisons had patients unlocked for around 3.5 hours a day. In all prisons patients were locked in their rooms or wards for 12 hours or more each night. The longest period of night time lock up we recorded was from 4 30 pm to 9 30 am and the shortest 7 00 pm to 7 00 am.

Therapeutic activity was limited, and the commonest planned activities were watching television, playing pool, and cleaning. All inpatient units had a selection of books from the main prison library. Some had board games, although these were often incomplete. Some units allowed only battery operated radio sets in case leads were used to commit suicide; others allowed leads to low voltage points. One provided no facilities for radio or television in the main ward area.

Use of seclusion

Only four inpatient units had returned the statistics required about their use of unfurnished and protected rooms in the month before our visit. These four units had secluded 36 patients on 43 occasions for a total of 2168 hours, an episode of seclusion lasting on average 50 hours, and on average a patient who needed seclusion had been restricted for 60 hours in the month examined. These times were longer than those reported nationally by the prison service for 1996-7, when an episode of seclusion averaged 20 hours and time in seclusion per patient averaged 24.7 hours.[13] We were told that high levels of seclusion were unavoidable because staffing levels made more humane management of acutely disturbed patients impossible. Seclusion often took place overnight or during weekends, when the staffing problems were greatest.

Only broad comparisons of the use of seclusion in prison health care and the NHS are possible because of the different legislative bases. However, unpublished data from the Mental Health Act Commission show that in 1996-7 there were around 4800 episodes of seclusion among the 24 191 patients detained under the provisions of the Mental Health Act 1983.[16] In the same year there were 5268 episodes of seclusion of the 14 784 mental health admissions to prison healthcare centres.[14] In the NHS nearly all seclusions were because of risks to other patients and staff. In prison nearly all seclusions were because of the risk of the patient self harming.

Referral and transfer to NHS

All prisons had arrangements for psychiatrists to visit and assess patients either for suitability for transfer to the NHS or to advise on treatment in prison, and these arrangements worked well. In contrast to our previous findings,[10] many prisoners meeting the criteria for transfer to the NHS experienced long waits in prison until a bed became available. One prison had 10 patients waiting assessment or transfer. The four accepted for transfer to the NHS had waited between 4 and 20 months with an average of just under 11 months. Although the numbers awaiting transfer from this prison were high, lengthy waits were usual in the prisons we visited and have been reported elsewhere.[17]

Discussion

A period in prison should present an opportunity to detect, diagnose, and treat mental illness in a population often hard to engage with NHS services. This could bring major benefits not only to patients but to the wider community by ensuring continuity of care and reducing the risk of reoffending on release.

Most staff whom we met were caring professionals who were trying under difficult circumstances to do their best to help their patients. Mentally ill patients in prison healthcare centres are often described as being similar to those in NHS medium secure units. There are no comparative studies to support this, but the Office for National Statistics study suggests that there are around 5000 people with psychosis detained in prison at any one time and prison inpatient units hold many mentally disordered patients clinically similar to those in NHS secure psychiatric units.[1] Yet the

What is already known on this topic

The level of psychiatric morbidity among prisoners is known to be much higher than in the general population.

About 75% of inpatients in prison healthcare centres have mental health problems

What this study adds

Semistructured inspection of 13 prisons with inpatient beds showed that facilities were often poor, staff numbers were low, and many staff were not sufficiently trained

Patients' spent too much time locked up and had insufficient therapeutic activity

Providing two inpatient services for mentally ill offenders, one in prison and one in the NHS, may not be the best way to provide proper patient care and help ensure public safety

management, staffing, and clinical facilities of prison inpatient units is much worse than in the NHS. Patients had restricted days with little constructive to do. Most nursing staff had no mental health training, and no doctor in charge of inpatients had completed specialist psychiatric training. Only one prison had a full multidisciplinary team.

Despite the requirement to implement the healthcare standards by mid-1997,[9] we found little evidence that the prison service had attempted to ensure that the standards were met. The Chief Inspector of Prisons has been critical of the lack of central direction of prison health care, describing a "ridiculous" situation in which the prison services' director of health care is "responsible for the policy of equivalence with the National Health Service but not, apparently, for ensuring that equivalence is delivered."[18] The government has recently renewed its commitment to improving the health care of prisoners.[19] A new policy unit based in the NHS Executive will replace the existing Health Care Directorate, which is based in Prison Service headquarters, and a task force will work with prisons and the NHS to lead and support change locally. This new initiative should deal with many of the issues we have raised, notably the need for greater expertise in assessing need and in commissioning health care.

Future strategy

An early objective for the policy unit and task force should be improving the care of mentally disordered prisoners, particularly those who require inpatient care. If the present policy of transferring to the NHS only patients detainable under the Mental Health Act and retaining others in prison even if they need 24 hour nursing care is continued, it will be necessary, at a minimum, to ensure that inpatient care in prisons is given by doctors and nurses with appropriate training, that the relevant healthcare standards are met, and that patients meeting the criteria for transfer to the NHS are transferred promptly. Achieving this would require a major programme of upgrading healthcare centres, and establishing two inpatient services, one in prisons and one in the NHS, would be staff intensive and risk duplication of services.

An alternative strategy would be to transfer all mentally ill prisoners who require specialist mental health care and full time nursing care to the NHS, whether or not they meet the criteria for detention under the act. Those not meeting the act's criteria would be transferred on temporary licence, as is the case with physically ill patients. We estimate that such a move would reduce by at least a third the number of beds required in prison healthcare centres, with a corresponding increase in secure psychiatric beds in the NHS. This approach is more likely to provide an adequate service to patients, ensure uniform standards, and avoid wasteful duplication.

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Correction

Coronary and cardiovascular risk estimation for primary prevention: validation of a new Sheffield table in the 1995 Scottish health survey population

"In this paper by Erica J Wallis et al (11 March, pp 671-6), five values of the total:HDL cholesterol ratio were wrong in the table on p 672 because of an error during the editorial process. The values for men aged 40, 38, 36, 34, and 32 years in the far left hand column (15%) should read 5.2, 5.8, 6.4, 7.2, 8.2 respectively (not 2.0, 2.0, 2.0, 2.0, 2.1). For the revised, correct table see bmj.com/cgi/content/full/320/7236/671