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Challenges in the Provision of Mental Healthcare

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Introduction

Headline-grabbing articles on suicide and self-harm declare that prisons are currently plagued by a 'mental health crisis'. These reports call for an expansion of prison mental health care services, the recruitment of more staff and the creation of more psychiatric facilities. Such a crisis is not new, rather mental distress, self-harm and suicide have been present since prisons first appeared at the end of the 18th century. Even with comprehensive mental health services, prisons are ultimately damaging; a steady simmering of multiple harms and indifference.

In NZ prisons, over a 12 month period:

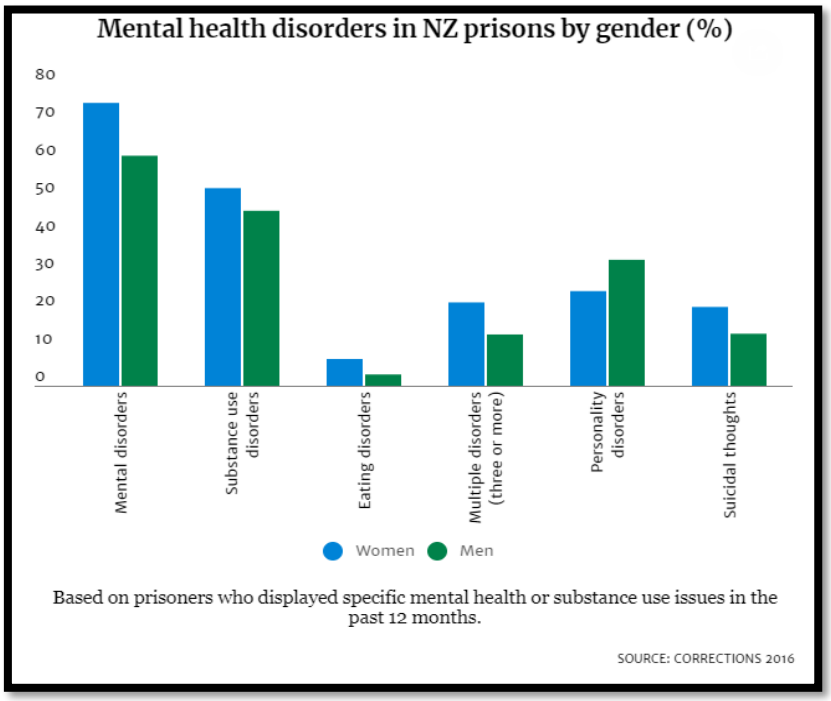
- 62% of prisoners have a mental disorder or substance use disorder
- 20% have both a mental and substance abuse disorder
- 24% have a mood disorder
- 24% have an anxiety disorder
- 6% have attempted suicide
- Only 46% had received any treatment

Lifetime Diagnosis:

- 91% have a mental health or substance use disorder
- Prisoners are 3 times more likely to have a mental health disorder, and the likelihood of suicide is 8.6 times higher – NZ Department of Corrections

Lessons from England and Wales

In the early 2000s, multi-disciplinary mental health teams were introduced into prisons in England and Wales, intended to provide the same range and quality of services to prisoners as is available to the general population (the principle of 'equivalence of care'). However, little thought was given to how such teams might operate in the closed prison environment where security and control take precedence over more therapeutic goals. This study of a mental health team at an English prison highlights the enduring conflict between **care and custody**. The study findings challenge the goal of providing equivalent care and the notion of 'healthy prisons', as the prison imposed numerous harms to mental health and the work of the mental health team was dominated by risk management-related activities.



Mental health in prisons in England and Wales

Over 90% of prisoners had one or more mental health problems. Certain groups including women, young prisoners, and older prisoners, are at higher risk of mental health problems than others, and prisoners identified as having mental health problems tend to have backgrounds of complex multiple disadvantage, trauma and social exclusion. Women are particularly likely to have histories of domestic violence, sexual assault, child abuse and bereavement.

The multi-disciplinary mental health in-reach teams (MHIRTs) have undoubtedly led to some improvements in mental healthcare in prisons, however, they have faced difficulties implementing 'equivalent' care in a secure setting. As in New Zealand, many prisoners with mental health problems continue to be unidentified and untreated. MHIRT staff can be hindered by the priorities of the prison to confine, control and punish.

The goal of equivalent care is unrealistic and inappropriate, given the capacity of the prison to dehumanise, deprive and degrade. Rather than offering mental health treatment in prison, we could adopt alternatives which instead foster the creation of compassionate and socially just communities.

Ombudsman concerns in the latest NZ OPCAT report included a lack of mental health training for Corrections staff, limited interaction or therapeutic activities for prisoners isolated in At-Risk Units, poor record keeping, and limited staff training, as well as high rates of seclusion and restraint.

The Custodial Context, Risk and Institutional Convenience

- The majority of prisoners in the study who had contact with mental health staff did so primarily for assessment, categorization and the prescription of drugs.
- Practices which were integral to the disciplinary regime of the prison and to the larger socio-legal apparatus, such as court reports and suicide prevention took priority, which meant that MHIRTs operated more as a crisis resolution team, with little time to engage in therapeutic services.
- The ability to speak and be listened to with kindness and care is fundamental to a good therapeutic relationship, however, the emphasis on security exacerbated the challenges of providing any treatment other than medication.
- The formal and informal networks of power in the prison created such high levels of stress and dissatisfaction that within the first six months of the project, three team members had left and one had taken extended sick leave.

Anti-therapeutic: Can prisons really be mentally 'healthy'?

Prison may act as a 'stabilising' factor in otherwise chaotic lives and can represent an opportunity to engage prisoners with services that they may not have access to in the community. However, imprisonment and the 'pains' or deprivations it entails, are also likely to have a negative impact on mental health, making prison an unsuitable place to carry out mental health treatment.

One of the key issues raised by prisoners was the lack of purposeful activity in the prison. The amount of time prisoners spent 'banged up' in their cells was the most frequently mentioned aspect, creating feelings of anger, frustration, anxiety, stress and boredom, and exacerbating the likelihood of substance misuse and/or the risk of self-harm. Whilst some may benefit from the healthcare they receive while incarcerated, prisoners are unlikely to be able to take steps towards mental well-being in prison when isolated from family and friends, with little or no constructive activity. This may be aggravated by the current substantial overcrowding, which is likely to fuel tension and restrict access to services and activities. We would be hard pressed to design anything worse than prisons for people who are emotionally distressed and vulnerable.

The question must therefore be raised as to whether 'healthy prisons' can ever be possible? The healthy prison movement may deflect attention away from systemic inequities contributing to the poor mental and physical health of criminalised individuals. This process individualises and depoliticises inequities such as poverty, racism, sexism and ableism, directing resources toward psychiatric rather than social care. It can also serve to obscure how imprisonment has become a means of addressing social problems, which also gives the illusion of solving them.

Conclusion

Rather than continue to invest in prisons and subject society's poorest and most oppressed populations to the violence of imprisonment, alternatives to prison must be considered, not just for individuals experiencing mental distress, but for everyone.

POLICY IMPLICATIONS:

* Mental health services can neither rehabilitate prisoners nor mitigate the harmful effects of imprisonment.
* Resources currently invested in the prison system should be redirected into the creation of compassionate and socially just communities.

To find out more about this research, please visit: **Mental Health in Prisons: Critical Perspectives on Treatment and Confinement** (Palgrave: 2018). Contact: a.mills@auckland.ac.nz

Adapted with assistance from Suzanne Woodward, PPI