MENTAL HEALTH AND CRIMINAL JUSTICE

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The scope implied by the title of this paper, Mental Health and Criminal Justice, is extremely broad but the subtitle to this section of the National Outlook Conference places constraints and provides some focus. As a practising forensic psychiatrist one develops a concern for the health and welfare of prisoners some of whom are serving life sentences, detainees and minor offenders. An awareness of the impact of mental illness and incarceration on a significant proportion of these offenders gives a viewpoint on crime, mental illness, services and institutions not granted to and usually not sought by most psychiatrists and other medical practitioners.

Psychiatry, and in a special sense, forensic psychiatry, have always confronted, straddled or attempted to define one boundary or another, probably to a greater extent than any other branch of medicine. Rosenman (1998) in examining some of the relationships between psychiatry and law, discusses the problematic voyages psychiatrists take when they leave the safe ground of making a clinical diagnosis of mental disorder then proceeding with treatment, voluntary or involuntary, for the benefit of the patient.

There are many boundaries in psychiatry and few are fixed. Diagnoses arrive, their criteria change, and some disappear, not always for purely scientific or clinical reasons. Homosexuality as a diagnosis is gone: post-traumatic stress disorder and borderline personality disorder are flourishing. Psychiatry has boundaries not only with the law but also with other health services, custodial and community correctional agencies and public opinion and perception.

In the United States the availability of the death penalty has brought into focus the ethical dilemmas of forensic psychiatrists who may be requested to treat prisoners on death row or assess their fitness for execution. The recent suggestion by a prominent psychiatrist that in these situations the doctor serves the state and can operate outside normal medical ethics has caused fierce argument about ethical boundaries and threats to the foundations of medical practice. The proposal that such a psychiatrist could be called “forensicist” is almost a comment in itself.

To limit the scope of this paper I decided not to deal with psychiatric issues which arise in the criminal courts. In this arena the most contentious issues involve disorder, illness and not health. My principal focus will be on matters affecting the mental health of offenders and how those requiring treatment can best be assisted and protected from further harm or disability. I have made no attempt to review and assess mental health services provided to Australian prisoners. There are wide variations from state to state in services, institutions and relevant legislation.

In preparing to write this paper I sought to gain an impression of what might be the central mental health and criminal justice issues which have been exercising the minds of psychiatrists and others over the last half dozen years. As the search had to be done single-handedly, I scanned databases, predominantly medical and psychiatric, seeking review articles, editorial comments and selected research reports. It was not a comprehensive review: the choice of sources reflects my biases as well as the availability of reference material. I was struck by the large number of references easily found on the mental and physical health of prisoners.
Current medical interest in health and prisons is evidenced by two conferences being held between the writing of this paper and its presentation. One in Sydney is Minimising the Harm: Health in Prisons, convened by the Public Health Association; the other, in Melbourne, is the International Conference on Forensic Mental Health. The conferences promise to deal comprehensively with issues mentioned only briefly in this paper.

I intend to draw attention to important issues in a number of areas:

- Health problems in prison.
- Mental health of offenders, both severe disorder (psychosis and mood disorder) and other conditions.
- Strategies for managing mentally disordered offenders.
- Mental health and other legislation affecting psychiatric practice with offenders.
- Service needs in prisons and the community.

No apology is necessary for concentrating on prisoners, detainees and offenders requiring compulsory care in psychiatric institutions. It is vital that they are seen as members of our broader community. From the public health viewpoint, prison walls are permeable. The majority of prisoners are absent from the general community only briefly, many returning with the same psychiatric and medical problems they had before incarceration. Unfortunately, some return less well, psychologically damaged and perhaps having acquired a life-threatening infectious disease.

**Prison as a health hazard**

The environment is a vital factor in the maintenance of health and the treatment of physical and psychological illness. We perceive some environments as dangerous to our health, and physical and mental integrity. Prison is one of these.

A research paper which identified serious inadequacies in the treatment of recently arrested diabetic prisoners provoked an editorial in the Journal of the American Medical Association (Anno, 1993). Comment was made on the broader question of prisoners’ “life-style choices” and socio-economic status which made them susceptible to serious illnesses, debilitating conditions and injury and violence. Institutional conditions - varying considerably with region and size and type of institution – influenced the provision of health services. A special risk identified was infectious disease – hepatitis, HIV and drug resistant tuberculosis acquired or exacerbated in prison. Overcrowding and the huge increase in prisoner numbers in the United States had not been matched by funding to provide the care to which American prisoners are constitutionally entitled.

Many publications refer to the seemingly universal health problems affecting prisoners. About one-third of adult male prisoners received into New South Wales institutions may be infected with hepatitis B or C with higher rates for those with a history of injecting drug use (Butler et al, 1997). The prisoners surveyed had a poor appreciation of risk factors.
In prison injury by assault, attempted suicide and self-mutilation are frequent. Deaths occur with official responses ranging from coronial inquests to Royal Commissions. Suicidal and self-mutilating behaviour are resorted to by many prisoners without a history of such behaviour before imprisonment. For many prisoners fear of physical and sexual assault are continuing and potent stressors.

A study of fifty-six prison homicides in Australia from 1980 to 1998 (Dalton, 1999) showed the homicide rate of prisoners was up to seven times higher than in a comparable non-prison population. In the period studied the national average prison population increased by 76% and the national average rate of imprisonment by 85%. Prisons are faced with massive overcrowding.

The mortality rates for released Finnish prisoners (Joukamaa, 1998) were found to exceed general population rates for different disease categories (natural and accidental death or suicide). Efforts to assist released prisoners and to improve collaboration between different health care systems were recommended.

Prisoners are the not the only convicted offenders at risk of excessive mortality rates. Biles et al (1999) examined a study of Victorian offenders serving community corrections orders. Those offenders in the younger age groups were at "a much greater risk of death than prisoners or members of the general community".

One of the hazards of incarceration is exposure to illicit drugs. Those prisoners with a drug problem may continue use in prison while others begin to abuse drugs. There are suggestions that prisoners subjected to testing for drugs may shift from use of cannabis, chemical signs of which linger in the body, to heroin, traces of which are quickly gone. Also, prisoners are usually unable to take precautions they might when in the community. Proposals for the provision of clean injecting equipment and condoms to prisoners provokes great controversy. Placed in a hazardous environment, prisoners are denied the opportunity to take sensible effective precautions against serious infectious disease.

The prison health scene is well summed up by Levy (1997):

Prisoners are far from being representative of the general population. They are predominantly male, young (15-44 years), and poorly educated and belong to minority or migrant groups. Many have lived on the margins of the community, and there they are likely to return. This complex of factors ensures the greater chance of ill health, optimal conditions for infection to progress to severe disease, and minimal opportunity for early diagnosis and adequate treatment. Not surprisingly, excess prevalence of hepatitis, tuberculosis, HIV and mental illness are reported among prisoners from many countries. In fact, a prison sentence can turn into a death defying experience. And the increased risk of illness and death continues after release.

Yet the period of imprisonment could offer opportunities to improve the health of prisoners and at least minimise the risk of poorer health to the community...

Health services in prison should therefore be free and readily accessible.

In his comment Levy goes on to write of problems in providing suitable services.
Mental disorder in prisoners

Severe mental disorder in prisoners is a matter provoking much study and debate. Also receiving attention are the attendant themes of the role of de-institutionalisation of psychiatric patients, the efficacy of psychiatric services in the community and how procedures such as diversion or a transfer to secure or other psychiatric hospitals might minimise the imprisonment of mentally ill persons. Underlying these issues are community perceptions about violence by the mentally ill.

Important surveys of the psychiatric health of prisoners have been reported and reviewed in recent years. Lamb and Weinberger (1998) considered all pertinent references from 1970 as contained in two large databases. They found that the problem of large numbers of mentally ill persons in American gaols and prisons is relatively recent: it was not noted in the 19th century and reports began in the 1970s. The studies reviewed showed high rates for severe psychiatric disorder (schizophrenia, depression and mania), far above general community rates. They summarised this aspect of their review: “Generally, clinical studies suggest that ten to fifteen percent of persons in state prisons have severe mental illness” and suggest the improved ability of correctional staff to identify mental illness and refer sufferers may have affected prevalence rates.

On the question of the part played by the de-institutionalisation of psychiatric patients in the increase of mentally ill persons in prison (a process elsewhere unattractively described as “trans-institutionalisation”), they quote Teplin (1983) who wrote, “It is concluded that the research literature, albeit methodologically flawed, offers at least modest support for the contention that the mentally ill are being (increasingly) processed through the criminal justice system”. Many working in forensic psychiatry would agree with their comment that although the evidence is clinical and inferential it is highly suggestive.

Other briefer reviews of the mentally ill in prison paint a similar picture, for example, Maden (1996) and Metzner (1997). A recent editorial comment in the British Medical Journal (Fryers et al, 1998) well expresses the magnitude and implications of the problem. The Editorial responded to the results of a national survey of mental disorders in prisons funded by the Department of Health (Singleton et al, 1998). The results are described as “a shocking indication of inappropriate and inadequate psychiatric care on a huge scale”. It is worth quoting the editorial’s summation of the rates of psychiatric disorder in prisoners in Great Britain as it seems these reflect the problem in other Western countries:

The survey, funded by the Department of Health was based on semistructured clinical interviews and is the latest in the important series of studies of psychiatric epidemiology in Great Britain carried out by the Office for National Statistics. Its most dramatic finding is the high rate of functional psychosis: 7% of sentenced men, 10% of men on remand, and 14% of women in both categories were assessed as having a psychotic illness within the past year. Although methodological differences render comparisons with previous studies of prisoners difficult, the key comparative figure is 0.4% for adults in the general population. People with a dual diagnosis of mental illness and substance abuse pose a special problem, also a current concern in the United States.

Some may discount neurotic symptoms as inevitable – even the rate of 75% of women on remand – for who would not be depressed or anxious? But the 20% of men and 40% of women who have attempted suicide at least once (over
25% of women in the previous year, 2% men and women in the previous week) suggests that these symptoms are not wholly related to their current situation. The high prevalence of antisocial personality disorder also may not cause much surprise in this population: 63% of remanded men, 49% of sentenced men, and 31% of women in both groups. But it suggests that longer term strategies are needed beyond punishment for specific offences.

There is a risk that in attempting to arrange adequate programs of diversion, treatment and housing for prisoners with severe mental illness (serious mental illness is a term sometimes used, but no longer preferred), that prisoners with less severe disorders may receive insufficient attention and services. Prisoners less seriously affected often do not come to notice in prison or, if they do, may be considered as suffering expected responses to confinement, isolation from the community and the effects of adverse prison conditions. Less attention may be given to psychiatric problems as they may not be diagnosed and, if they are, not always treated. Examples are the less severe depressive and anxiety disorders, distressing to the sufferers but less troublesome for the authorities than severe disorders.

Some prisoners suffer distressing and disabling psychiatric problems as a result of environmental and vulnerability factors. Kupers (1996) found that prisoners suffering physical or sexual trauma in prison, or witnessing traumatic events, may develop serious post-traumatic symptoms, even a post-traumatic stress disorder, but diagnosis is uncommon as is treatment. He emphasises the role of poor and depriving prison conditions, limited services and the vulnerability acquired by a considerable portion of prisoners who have a long history of traumatic experiences, often beginning in childhood and continuing.

A study of 95 older inmates, men over fifty years of age in a US Federal Prison, found that 53.7% met the one-month criteria for the diagnosis of a psychiatric disorder, a much greater prevalence than in a community sample (Koenig et al, 1995). Few of these, even those with a history of previous psychiatric disorder and treatment were being treated in prison. Depression and anxiety disorders including PTSD were among the important disorders found in this group with older prisoners most affected. Recent arrest, sentences giving no chance of parole and histories of alcohol and drug abuse were significant risk factors. The researchers were surprised at the low rate of treatment.

There is a tendency in forensic psychiatric services – a trait also observed in some community services – to exclude those having personality disorders especially if they are disruptive or antisocial. As personality disorders are not generally considered treatable, the management of them in prison is problematic not only for correctional authorities but also psychiatric services. In prison, often in the absence of independent and corroborating information, the diagnosis of personality disorder may result in co-existing psychiatric disorders receiving less attention or being overlooked.

Although this paper does not purport to deal with the issue of mental illness and crime, especially violent crime, brief comment is required. Literature on the subject is extensive and easily accessible. An important factor emerging from a number of studies is the association of substance abuse with offending in general and significantly in many cases when it co-exists with severe mental illness. In a case linkage study conducted in Victoria by Wallace, Mullen et al (1998), persons convicted in the higher courts had their psychiatric histories explored by means of a public psychiatric services register. The authors summarised the clinical implications of the results:
• Significant proportions of those convicted of serious crimes have had contact with the mental health services.

• The bulk of this association is explained by personality-disordered and substance-misusing individuals, most of whom had begun their criminal careers prior to their first psychiatric contact. Among those with major mental illness coexisting substance misuse may be the most important contributor to the risk of offending.

• The chance of any person with schizophrenia or an affective disorder committing a serious crime, though greater than the general population, is tiny. This places in question aspects of the current enthusiasm for risk assessment and makes nonsense of attempts to use the criminality of the mentally ill as an argument for greater coercion and containment.

Although acknowledging the methodology could lead to an underestimation of the association examined they concluded:

Better care and greater clinical awareness of the needs of some of our more challenging mentally-ill patients would improve the patient’s lot as well as making a small contribution to public safety. Confusing this with a need to turn back the clock on the care delivery systems in psychiatry and on the hard-won civil rights of our patients is, however, more dangerous than the dangers we seek to combat.

The role of co-existing substance abuse by psychiatrically-disordered persons who commit serious offences appears well established. The management of substance abuse has been in and out of the ambit of psychiatry over the years and some commentators have wondered whether it should be reclaimed, given current interest in dual diagnosis.

Trends and problems in the treatment and management of mentally ill offenders

If it is accepted that a host of factors contribute to the high numbers of severely mentally ill offenders imprisoned, then for intervention to be effective it must be at a number of levels in the criminal justice and mental health systems.

In their review, Lamb and Weinberger (1998) suggest actions which could be taken mostly within the criminal justice system. These include:

• Steps to prevent the inappropriate arrest of mentally ill persons.

• The routine screening for severe mental illness of all arrested persons placed in gaol.

• Correctional administrations should negotiate with mental health agencies for the provision of multi-disciplinary mental health teams.

• Mentally ill detainees who have committed minor crimes should be diverted either entirely to the mental health system or at a minimum for treatment.

• Voluntary compliance with treatment including medication may not provide adequate structure so outpatient commitment and court monitored treatment supervision may be needed.
• Mentally ill persons discharged from correctional or psychiatric institutions have multiple problems and so need case management and advocacy services.

• Mentally ill offenders with a history of violent behaviour should be provided with a variety of treatments.

• Highly structured twenty-four hour care for released mentally ill offenders should be available. This means an increase in mental health services.

In addressing what they described as a persistent problem needing a concerted and long term response, Fryers et al (1998) advocated a similar approach of diversion, adequate security hospital accommodation, effective treatment of remand prisoners (and speeding up of the criminal justice process itself) and alternatives to prison for those whose primary need is for good psychiatric treatment with long term care. Like Lamb and Weinberger (1988), they advocated an effective service combining individual care and public protection which would have to be a flexible twenty-four hour service, assertive and, if need be, more paternalistic than current practice. The responsibility for these services rested with many government departments.

A London based study of the role of police in deciding the initial disposition of mentally disordered detainees was reported by Robertson et al (1996). The decision to divert persons to mental health services tended to be influenced by violence or a threat of it at the time of arrest. Petty offenders were often recycled to the streets without the benefit of care.

Draine and Solomon (1999) described and evaluated gaol diversion programs in the United States for persons with serious mental illness. Programs included both diversion during the arrest process and later from custody to mental health and substance abuse services. They found few services had been adequately studied. They discussed important issues and suggested how evaluations should be done. Metzner (1997) commented on the experience of hospital transfer and diversion programs in Great Britain.

Mental health issues in correctional institutions were considered by Welch and Ogloff (1998) with concentration on service needs, treatment issues and problem areas in corrective services. The importance of proper inmate screening at intake was emphasised with a multi-tiered evaluation by the admitting officer, a mental health staff member and a mental health professional thought the most successful and cost effective. Particular problem areas in correctional services were identified as suicide and the threat of it, high rates of self-mutilation (a new behaviour in many prisoners), and the psychological distress caused by the isolation and restrictions of various forms of administrative and punitive segregation. They mentioned that in the United States litigation against correctional authorities can be an agent of change when prison conditions had not been improved by other means.

A useful brief review of the problems of women prisoners can be found in Welch and Ogloff. They cited Teplin (1997) who reported high prevalence rates of female remand prisoners requiring mental health services with less than a quarter receiving them while in custody. They also cited Lindquist & Lindquist (1997) who found women reported more environmental stresses in prison, higher levels of mental distress but environmental stress was equally detrimental to the mental health of both men and women.
Denton (1995) reported a study of Australian women prisoners. A high prevalence of psychiatric morbidity was found, specifically for mood disorder and substance abuse. A need for comprehensive psychiatric and substance abuse services was identified. Jones et al (1995) reviewed the records of all female prisoners in Tasmania between 1981 and 1990. Thirty-five percent had previously attended the state's psychiatric services and showed greater impairment of social adjustments and relationships than other prisoners.

In an audit of medical records in an English prison, Mitchison et al (1994) found much to cause concern. They quoted a pertinent remark by Judge Tobin, "Medical officers must have sufficient time to hold a conversation with inmates." Kupers (1996) remarked on the "cursory mention of rape and no mention of PTSD" in the hundreds of medical and psychiatric records he reviewed in three American states. Birmingham et al (1996) remarked on the low detection rate at reception for mental illness in a sample of 569 prisoners with a high prevalence rate for severe mental illness. The result was poor psychiatric treatment.

**Legislation and other problems**

It is difficult to resist mention of factors which at times make the life difficult for forensic psychiatrists and, more importantly, adversely affect the well-being and management of prisoners either with a psychiatric disorder or suspected by correctional and other authorities of some abnormality. At times the problem is simply trying to apply to an offender or patient the relevant legislation's legal definition of mental disorder. Even allowing for differing psychiatric and legal understanding of the uses of psychiatric diagnosis, deciding to apply legal terms such as mental illness, mental impairment, or worse, mental dysfunction, remains difficult. It is difficult to assess one's own bias or to know if one can, or should, take into consideration possibly extraneous factors such as the consequences of one's opinion for the individual and the community.

In the wider perspective, how should the psychiatrist or a professional organization react to proposals to amend a Mental Health Act so as to permit what amounts to be preventive detention of a mentally dysfunctional person, not a mentally ill one, who has not been convicted of an offence but whose behaviour offends or frightens. Particularly perilous for the peace of mind and reputation of psychiatrists are attempts by bureaucrats to influence the processes of handling troublesome or disturbed individuals, often prisoners, by the making of public statements, the urging of restrictive measures and at times passing special legislation aimed at one person though perhaps more widely applicable. The cases of the late Gary David of Victoria and Gregory Wayne Kable in New South Wales are illustrative. Also relevant are the implications of the American case Kansas v Hendricks as discussed by Felthous and Gunn (1997).

The involvement of psychiatrists and the use of psychiatric opinion in these cases had some extraordinary aspects, especially in the matter of Gary David. In other cases, often when parole is being considered, deliberations are at risk of being clouded by the statements of politicians and bureaucrats, and psychiatric opinion may be used selectively, sometimes with the real weight and import of opinions being discounted, distorted or ignored (Lucas, 1993). The effect such circumstances have on prisoners with or without a history of mental illness is considerable. How the attitudes and practices of the psychiatrists involved are affected is a matter for speculation.
The practice of psychiatry involves a consideration of biological, psychological and social factors in the initiation, perpetuation and treatment of disorders. Individual psychiatrists and professional bodies have been active in the identification and amelioration of social conditions leading to illness. Prison for most people is a stressful, depriving and frequently fearful or traumatic experience, quite unconducive to the maintenance of mental health and the treatment of existing mental disorder. Kupers (1996) has much to say about the stress of American prison life, stress in excess of what can be reasonably expected due to the deprivation of liberty and which aggravates psychiatric disorders. Even decades ago American prison conditions, especially with regard to matters of segregation and solitary confinement led to much litigation.

Individual psychiatrists can do little to improve overall conditions, so the responsibility must fall on the administrators of mental health services, and public health specialists and officials who have increasing concerns about infectious disease and other health problems in prison and the impact on the general community.

One might ask what is being done at present by health services to reduce or remove the harmful aspects of imprisonment? These are pressing problems demanding the attention of mental health and public health services.

**Conclusion**

The studies and commentaries cited demonstrate that high prevalence rates of mental disorders amongst prisoners are such that adequate mental health services for correctional systems are of vital importance. Medical problems in the prisoner population have special features particularly in relation to infectious disease and are of obvious relevance to health problems in the general community. It must be said that any correctional system without a health service geared to the complex of problems found in prisons will not serve the needs of prisoners or the interests of the general community. Although this statement is obvious in relation to infectious disease it may be less so when one speaks of psychiatric disorder. Whatever the reason for the high prevalence of mental disorder of all severities among prisoners, it is clear that correctional systems in a sense collect a disproportionate number of the ill, disordered and disturbed from the community. Most of these people return to the community after relatively short sentences.

An opportunity for mental health assessment and intervention is offered if an offender is imprisoned or given a non-custodial sentence with supervision and conditions. Identification of cases by correctional intake screening and the use of psychiatric and other assessments prepared for courts can be used for programs of diversion, prison classification and, especially if severe mental disorder is present, transfer to a special psychiatric unit or hospital. Forensic psychiatrists frequently see offenders whose first presentation with a psychiatric disorder is to a court, sometimes tragically following the killing of a family member.

Imprisonment itself presents hazards to life and health which may test the most healthy and well-integrated new arrival. There is evidence for excessive mortality rates not only for prisoners but also released prisoners and offenders serving non-custodial sentences in the community. Thus, there is disturbing evidence of high morbidity and mortality rates in the convicted offender group as a whole. These offenders have passed through the courts so the provision of psychiatric and medical opinions to assist with sentencing may be of great value.
Thus there is an onus on legal and judicial officers to seek and use appropriate assessments. Because of the socio-economic status of many offenders authorities controlling legal aid funding have a special responsibility. Funding for any procedures to improve screening at an early stage in the criminal justice process is well spent: imprisonment or custody in secure psychiatric units is very expensive.

In the United States there has been an extraordinary increase in the incarcerated population, a trend observed to a lesser extent in other western countries including Australia. Felthous and Gunn (1997) remarked, "The challenge of ensuring appropriate psychiatric services to mentally disordered and emotionally disturbed prisoners is critically important and without international borders."

The accepted standard for prison health services is one of equivalence with the services accessible by the general community. As well as covering assessment and treatment services, the standard should ensure that proper preventive health measures are available in prison. One would also hope that health authorities and advocates of prisoners’ rights might influence correctional authorities to ameliorate aspects of prison life causing or perpetuating psychiatric disorder and distress.

Medicine and psychiatry are not easy to practise in institutions which have as a primary aim the confinement and control of an often difficult inmate population. Standards of practice in prison medical services vary from service to service and institution to institution. The problems described by Reed and Lyne (1997) as a result of their "semi-structured inspection" of nineteen prisons in England and Wales will be not be unfamiliar to medical and correctional staff. There is a need for the setting of clinical, administrative and ethical standards capable of being monitored and audited. Special programs such as ones involving diversion need careful evaluation.

In Australia there is a move to the setting of standards for the psychiatric care of prisoners and other offenders. A national forensic mental health policy is in the draft stage but I am not in a position to comment on it. Apparently the need for it was recognised some time ago in the process of formulating the National Mental Health Policy. As a result of the recent conference on prison health convened by the Public Health Association it is expected that "an agenda for action" will be prepared and published. These are hopeful signs.

With reference to the setting of standards and practice guidelines for mental health services for prisons, if efforts are simply concentrated on those suffering from severe mental illness, and there is a failure to address adequately the needs of prisoners suffering a lesser degree of disorder, then the desired standard of services being equivalent to those available in the community will not be achieved. Prisoners suffering from depression and anxiety or other complaints which are less obvious or troublesome cannot choose their doctors, psychiatrists or other mental health professionals and they have no access to services outside prison. They cannot turn to community organizations providing advice and support and as well have little or no say in their living circumstances or choice of companions. Psychologists and social workers employed in various capacities within the correctional system may not be perceived as independent or able to maintain confidentiality. Prisoners in this group may suffer great distress and in a number of ways cause the authorities more problems, for example, by suicidal or self-harming behaviour, than those with severe disorder.
There is a division of opinion about how prisoners suffering psychiatric disorder should be managed when they are released to the community: some advocate follow-up by a forensic psychiatric service, others by placing them in the mainstream services unless there are special circumstances. In either case there will be a number of mentally disordered offenders who will require a service designed for their needs, perhaps one available twenty-four hours a day and willing to be restrictive and directive in a way probably no longer fashionable in community mental health.

A final comment is necessary in an era when prison populations are increasing, new prisons including ones under private management are planned and, regrettably, old prisons previously closed are being reopened. In the light of studies described in this report, the planning and development of a new prison must make provision for adequate medical and psychiatric services able to cater no less than adequately for the health needs of the prison population. The setting of standards with monitoring procedures which apply to both government and privately managed prisons must ensure complete transparency for health services.

The views of Anno (1993) on health care for prisoners in the United State are apposite:

It is incumbent on us as a society to provide for the health needs of prisoners precisely because they are not free to seek care on their own. Furthermore, since criminal justice agencies are expected to serve as health care facilities, they must be funded as such and tied to other health agencies in the community. Isolating lockups, jails, and prisons from mainstream health resources and from each other means duplicating services for some inmates and limiting access for others. For health care reform to be truly efficient and effective, we must develop a seamless approach to the provision of care.

To do less will amount to a failure to meet a duty of care to prisoners, a failure with consequences affecting the wider community.
References


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