Understanding the Mental Health Needs of Scotland’s Prison Population

Research summary

Research shows that people in prison experience mental health and behavioural problems at a higher rate than people living in the community. There are also certain groups of people in prison, including young people and older adults, as well as those with physical or learning disabilities, who are at a particularly high risk of experiencing poor mental health while in prison. These mental health needs experienced by people in prison range from common problems such as anxiety, depression and substance dependency to serious mental disorder including schizophrenia.

In many cases mental health difficulties precede imprisonment and are likely associated with risk factors that are more common in people who have been in prison, such as higher rates of adverse life experiences, head injury and substance use problems. Individuals who come into prison are also more likely to be from communities characterised by multiple deprivation, to have spent time in local authority care, and to have experienced interpersonal victimisation. These experiences are associated with an increased likelihood of having mental health difficulties. Imprisonment itself, however, can also be detrimental to someone’s mental health, particularly during the remand period. The prison environment, drug culture, and factors such as overcrowding, bullying, and discrimination can have further negative effects on mental health and wellbeing.

Scottish health policy embraces the principle of equivalence. This means that mental health services in prison should be equivalent to those in the community in terms of accessibility, quality, and the types and range of interventions available. While NHS Scotland is responsible for healthcare delivery in Scotland’s prisons, a ‘whole-prison approach’ is endorsed in the Scottish Prison Service (SPS) health improvement framework (Brutus et al., 2012). This approach advocates for comprehensive and integrated programmes involving a range of providers to improve the health of people in prison. According to this framework, prisons can be a setting to promote positive mental health, as well as the treatment of illness and protection against worsening of mental health needs.

Mental health service provision across Scottish prisons is known to be variable and in need of improvement to meet the scale and nature of need (National Prisoner Healthcare Network, 2014; 2016). Particular concerns have been raised for the care available for women and young adults in prison. It is recognised that there are problems implementing the whole-prison approach and that agencies providing services for people in prison are doing so in silos rather than jointly. There is

concern that the current mental healthcare model in prisons is not sustainable and that likely demand outstrips available resources. There have been repeated calls for an updated national assessment of mental health needs among Scotland's prison population, which has not been systematically studied since 2007 (Graham, 2007).

The Scottish Government has commenced a comprehensive health and social care prison needs assessment programme. As part of this wider programme of work, a national mental health needs assessment was commissioned for Scotland's prison population. This needs assessment will ensure that future changes to prison mental health services are evidence-based and person-centred. This work was undertaken by researchers at the University of Edinburgh with assistance from the Forensic Mental Health Services Managed Care Network ('Forensic Network'). The research was conducted in four phases: a literature review, service mapping exercise, quantitative analysis and engagement with professional stakeholders and people with lived experience.

Literature review

A literature review was undertaken to survey what is already known about the mental health needs of people in prison, focusing on evidence from the United Kingdom. The review aimed to summarise the prevalence of the range of current (rather than lifetime) mental health and behavioural needs and describe evidence on comorbid problems (having more than one type of problem at the same time). Factors associated with increased or decreased risk of experiencing mental health needs while in prison were also noted to inform subsequent study phases.

A rapid review approach was adopted. This is a pragmatic method commonly used to inform policy decisions and features elements of robust systematic literature reviews. Electronic academic databases were searched for possible studies using search terms customised for this review. Studies were included in the review if they were conducted in a UK prison during or after 2001 and used a validated assessment tool to establish the presence of a disorder or symptoms mapping onto diagnostic criteria for the disorder. Generally, studies which used screening tools rather than full diagnostic interviews tended to report higher prevalence estimates.

Problems with substances represented the most common mental health needs in the UK prison population; studies found 35 to 67% of people in prison were found to have a drug use disorder, and 33 to 81% an alcohol use disorder. Alcohol use disorders were more common for men than women. Substance use problems are highly comorbid with mental illness, with at least 18% of people in prison diagnosed both with a substance use disorder and a serious mental disorder. There was a noted gap in the substance use literature relating to novel psychoactive substances, a type of drug that is known to be used within Scottish prisons. This suggests the research literature has not caught up to changing patterns in drug use within prisons.

Between 3 and 18% of people in prison were found to have experienced psychosis within the previous month. Drug use in prison is thought to precipitate many of

these psychotic episodes. The prevalence of schizophrenia, a long-term psychotic disorder, is comparable to the general population at 1-2%. The prevalence of depressive disorder was 19-55% and anxiety 10-36%. A history of psychological or physical trauma is common in people who come into prison, and the psychiatric literature finds that 8 to 16% of people in prison in the UK meet criteria for post-traumatic stress disorder. Personality disorder (PD) is experienced by 34 to 77% of people in prison. Antisocial PD most common in men and borderline PD most common in women.

While the rates of substance use problems, mental illness and PD are generally higher for people in prison than people in the community, there was a mixed picture in research on neurodevelopmental (NDV) problems in the UK prison population. Between 0 and 3% of people in prison were found after clinical assessment to have an intellectual disability, though as many as 10% may have borderline ID. This is broadly similar to the general population. Three to 10% of people in prison screened positive for an autism spectrum disorder, which is described as a rate similar to people in the community. People in prison, particularly younger adults, experience attention deficit hyperactivity disorder, at a rate of 23-41%. This is noted to be substantially higher than community populations. Studies cited comorbidities between NDV disorders (i.e. comorbid autism and ADHD) and between NDV and mental health problems, indicating individuals with neurodevelopmental conditions often have multiple needs which could be addressed by mental health services.

There has been much research on the prevalence of traumatic brain injury (TBI) within Scottish prisons in particular. As many as 78% of people in prison in Scotland have experienced a TBI (usually multiple TBIs), and 24% have had a hospital admission relating to a TBI. Several studies focussing on the mental health needs of the population of people aged 50 and older in prison have found a prevalence of dementia between 2-7% and generally higher prevalence of other mental health problems in this group, particularly depression.

Overall the research literature evidences that people in prison have a wide range of needs which could benefit from engagement with prison mental health services. In most cases there is a higher level of need than that observed in the community. Several studies were able to demonstrate high levels of needs unmet by prison mental health services. This was more true for men than women, and for certain problems such as neurodevelopmental conditions and dementia. Women in prison have a higher likelihood of mental health need than men, except for alcohol use disorders and psychosis. People on remand were more likely to screen positive for mental health problems than people who have been sentenced. There were clear gaps in knowledge around the prevalence of certain NDV conditions, including foetal alcohol spectrum disorders, and in the prevalence of mental health problems in young adults in prison.

A mapping of mental health services available to individuals in and leaving prison

A national service mapping exercise was undertaken to describe the services available to support the mental health of people in and leaving Scotland's prisons,

and note any gaps or duplication in these services. The last previous mapping exercise was undertaken in 2012 shortly after the responsibility for healthcare delivery in prisons transferred to NHS Scotland. As in 2012, this mapping exercise was undertaken by the Forensic Network office.

The present mapping exercise was multi-informant, soliciting information from a range of providers. Prison health teams and prison-based social work teams in all 15 prisons in Scotland completed an electronic proforma inquiring about the services and support they offer for mental health and wellbeing interventions in their prison, and the challenges experienced in supporting people in prison in this way. The Criminal Justice Voluntary Sector Forum assisted in engaging third sector organisations in a virtual discussion to solicit their views and experiences of supporting people in and leaving prison.

The information provided by NHS teams indicated that there have been major positive developments in both the overall size and multi-disciplinary composition of prison mental health teams in Scotland. All but two prisons now offer both integrated primary and secondary mental health services. Nearly all prisons now have formal input from mental health nursing, psychiatry, and clinical psychology and approximately half have allied health professionals (AHP) as part of the mental health team. Compared to the previous mapping exercise, input from clinical psychology and AHPs has increased considerably. Social work teams indicated that in most prisons they do not provide formal mental health interventions but recognise they have a core role in working jointly with both prison staff and NHS teams in multi-disciplinary teams to support people with mental health needs.

NHS mental health workforce comparisons across establishments indicated that resource allocation was somewhat arbitrary and not closely linked to the number of residents within each prison. This was also a central finding of the 2012 mapping exercise. The inconsistency in mental health team resource allocation likely contributes to variation in the number and type of interventions available to people within Scottish prisons, which raises concerns of inequities care for people in certain prisons. The input of prison mental health discharge planning and throughcare was found to be limited and likely to leave many people without adequate support during this very difficult transition period.

Professionals highlighted a range of challenges in meeting the mental health needs of people in prison. Limited resources were cited as the most common barrier, by health, social work, and third sector providers. In particular, the current allocation of NHS resources directs support by necessity to the acutely mentally ill while leaving a large population of people in prison without support from which they could benefit. There are difficulties in recruiting health professionals to work in prisons, with posts (largely mental health nursing) going unfilled in many prisons. Pre-existing staffing challenges were exacerbated by COVID-19 related absences and have added further pressure on prison mental health services during the pandemic. Professionals reported limitations to service provision due to a need to work around the prison regime, e.g. including reduced hours for health centre clinics and reliance on prison staff to facilitate health appointments. The most frequently cited

challenges related to problems in joint working between professionals supporting people in prison. The findings showed that there is a role and willingness from non-health agencies to support the mental health and wellbeing of people in prison. However, it appears these efforts are hindered by reduced opportunity for relevant staff training, and limited cross-agency partnership working and information sharing between justice, health and third sector organisations.

Understanding the scale of mental health needs in the prison population

Robust data on the mental health needs of Scotland's prison population are required to develop services designed to meet the particular needs of this group. However, data on mental health needs of people living in Scotland's prisons are not routinely collected at the national level. This prevents the direct assessment of mental health needs of this population from existing data. Restrictions on research due to the COVID-19 pandemic ruled out an approach which directly engaged with people in prison to assess their mental health to understand the scale of mental health needs. In the absence of data collected from people in prison in Scotland, logistic modelling using the 2019 Scottish Health Survey, combined with known information on the prison population (extracts from SPS' prison record system PR2), was used to estimate the proportion of people in Scotland's prisons who likely have certain mental health problems.

Data was also provided by SPS on extensions on the use of Rule 41, which facilitates accommodation in specified conditions within the prison (for example, within the separation and reintegration unit) due to a mental health concern. Finally, data was accessed on transfers under Scottish mental health legislation of people from prison into forensic hospitals for assessment and/or treatment of acute mental health problems.

Logistic modelling found that 15% of Scotland's prison population likely has a long-term, diagnosed mental health condition. Seventeen percent likely has a history of self-harm behaviour or attempted suicide. Thirty percent of the prison population likely has a current alcohol use disorder. Finally, 16% of the prison population is likely to have experienced anxiety in the past week, and in 18% depression in the past week. Estimated prevalence of needs was generally higher in the remand population, in younger age groups, and in women relative to men, except for alcohol use disorder and symptoms of depression.

Extensions to the use of Rule 41 during 2018 to 2021 beyond the initial 14-day period indicated that such measures were used for a relatively few individuals compared to the prison population as a whole. There was no indication of an increase in the use of these measures during the COVID-19 pandemic. Data on hospital transfers indicated that, relative to Scotland's prison population as a whole, these individuals were disproportionately female and on remand. The vast majority were transferred for the treatment of a psychotic disorder.

Engagement with professional stakeholders and individuals with lived experience

Fifteen qualitative interviews were conducted with professionals across a range of organisations who have a role, either at an executive, senior-level or at an operational level, in supporting people in prison. Interview questions for professionals focussed on current mental health service provision and challenges related to this. Six qualitative interviews were conducted with people who have lived experience of mental health problems in prison. Lived experience was gained either directly through personal experience or by supporting a family member with mental health problems who was in prison. Interview questions for people with lived experience focussed on their experience of the mental health support available throughout the prison journey (from reception to liberation), and a particular focus on the impact of prison environment and culture on their mental health. All interviews were undertaken remotely using videoconferencing technology.

Professionals indicated there was a drive from the top of SPS to operate a more trauma-informed environment in Scotland's prisons though this was not always observed to be successful at the operational level. The COVID-19 pandemic highlighted that the health and wellbeing of individuals in prison is foundational to the underlying aims of the prison service. Operationally, prison officers and NHS teams perceived residents as presenting with more complex mental health needs as well as a history of trauma, and were doing their best to support residents with limited service resources. There was evidence that the onus remains very much on individuals to choose to engage and share information with mental health services to gain any support from prison mental health services.

Professional stakeholders working across justice, health, third sector organisations and other partner agencies called for a 'cultural shift' and cited that 'a big sea change' would need to happen for mental health to be more meaningfully supported within Scotland's prisons. They also highlighted the need for increased resources across the SPS and NHS mental health teams, and improved access to relevant training for SPS staff to support the implementation of a trauma-informed approach within prisons.

People with lived experience indicated that reception was a time of extreme stress and that beyond establishing acute needs (i.e. immediate suicidal intent), mental health needs should be explored more deeply a few days later. Being on remand was a draining experience for people, characterised by uncertainty although for some it provided respite from homelessness. Some prison officers were acknowledged as going above and beyond to support mental health needs. However, people with lived experience recalled a reluctance to share their mental health concerns with prison officers due to a perceived general lack of dignity and respect from officers, or perceived lack of training to provide the support they are seeking. Respondents stated they found mental health teams supportive when these teams were not operating under an excessive workload.

People with lived experience described liberation as most successful where third sector and community services provided in-reach support ahead of them being

released and during the high-risk first few weeks. Respondents stated that providing adequate support, including for non-mental health needs such as housing, during the liberation process could help to break the cycle of returning to prison.

Conclusions and recommendations

Findings from each of the four phases of this needs assessment converged in many instances to make several key conclusions. This needs assessment found that current mental health service provision does not adequate address the high levels of need within Scotland’s prison population. The considerable, somewhat arbitrary variation observed in the resources available to prison health teams likely contributes to variation in the number and type of interventions available to support mental health needs across prisons. This situation unintentionally creates inequities of care experienced by people in different prisons. Services are not designed to be proactive and the current service model places too much responsibility on the individual to engage and choose to share information with mental health services to gain necessary support. The findings indicate that fundamental change in the approach to prison care and prison mental health services is required to adequately address the mental health needs of people in prison in Scotland.

Several reports published in the last decade have highlighted concern around many of the same problems identified by this needs assessment, e.g. insufficient mental health resources, limited training for non-health providers relating to mental health, and providers working in silos instead of in partnership. Despite repeated scrutiny of the same issues, most recommendations from previous reports have not been fully implemented. This suggests that current structures and operational arrangements do not facilitate the development of innovative practice or are too restrictive to enable the change required.

This report concludes in a series of evidence-based recommendations relating to the changes required to adequately meet the prison population’s mental health needs. Six major recommendations are proposed which, if enacted, would offer the high-level and strategic change required to overcome many longstanding challenges.

1. A single model of care should be adopted across all of Scotland’s prisons that focuses on assessing and meeting individual needs, supporting individuals’ wellbeing, and provide a caring and supportive environment.

2. This model of care should have individuals’ needs and wellbeing at its centre and strive to make the prison environment more therapeutic, with a focus on meaningful activity.

3. The resources available for NHS mental health services should be increased. In determining future resource allocation, instead of standard community-based formulations, the modelling approach should account for demographic and social characteristics of the prison population which are known to contribute to high levels of mental health needs.

4. Funding for clinical psychology and allied health professionals within prison mental health teams should be increased in many prisons where current input is either none or limited.

5. Prison mental healthcare standards should be adopted to ensure consistency in the care available across the prison estate.

6. A formal partnership should be developed between SPS (and private contractors), health and social care providers, and third sector organisations. This partnership should be empowered to deal with strategic and operational issues across prison and health services and include a mechanism to empower decision making across all NHS boards. There should be mechanisms for governance and processes embedded to enable routine quality improvement and assurance.

Further to these six major recommendations, twelve operational level recommendations are to be enacted within the proposed new service arrangements and structures just outline. These operational level recommendations address specific issues such as staff recruitment and staffing challenges, unnecessary barriers to service provision posed by the prison regime, improved mental health screening, increased utilisation of technology to expand the mental health services available to people in prison, and mechanisms to improve information sharing between health and non-health providers.