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Screening prisoners for mental disorders

In this issue, Gavin *et al* (2003) present a study of the uses of a screening instrument for mental illness in remand prisoners. This is the latest in a long series of epidemiological studies concerning mental disorders in prisoners. They have produced a screening instrument for mental illness in remand prisoners that deserves to be more widely known. The same group has shown that routine screening methods miss substantial numbers of mentally-ill prisoners and on follow-up, even those identified seldom receive appropriate treatment (Birmingham *et al*, 1998). This was often because of the disruption to interventions caused by the prison regime and the unforeseen actions of the courts.

Why so many prison morbidity surveys?

Fazel & Danesh (2002a) published a systematic review of 62 surveys from 12 countries, including 22 790 prisoners. They report a 6-month prevalence of psychosis in 3.7% of men and 4% of women, and major depression in 10% of men and 12% of women. The differences between sentenced and remanded groups were small, as were differences between countries and differences over time. This contrasts with an increasing prevalence of mental illness over time in some series of surveys (Gunn, 2000). The more outlying results appear to be accounted for by differences in methodology, particularly in the time period used (Fazel & Danesh, 2002b).

This is somewhat surprising. It is generally assumed that many people with mental illness enter the prison system as a direct or indirect consequence of their mental illness, thereby accounting for the large excess of psychiatric disorder in this population. If this were the case, different jurisdictions might accumulate different proportions of severely mentally-ill individuals in their prisons, because of differing approaches to forensic mental health law across jurisdictions and differences in the overall imprisonment rates. The actual rate of serious violence due to mental illness does not appear to change much over time, even when the population rates of serious violence such as homicide increase substantially (Taylor & Gunn, 1999). There is also no evidence that rates of homicide by mentally-ill people vary substantially across countries, with a few exceptions (Coid, 1983). It is also assumed that the accumulation of mentally-ill people

in prison is due to the substantial change in the form of mental health service available in most countries today (Torrey, 1995; Gunn, 2000). However, there is little evidence for change over time in Fazel & Danesh's review.

There are so many published surveys of mental illness in prisons because of the obvious affront to humanitarian sensibilities and the apparent dangers to mentally-ill prisoners. Yet the most obvious danger, suicide in prison, appears to be accounted for not by the prevalence of severe mental illness, but by the prevalence of substance misuse problems – particularly opiate use and dependence in prisoners (Gore, 1999). Studies of psychiatric morbidity in prisoners seldom examine the serious physical illnesses prevalent in prisons and comorbid with mental disorders, such as blood-borne infections (Allwright *et al*, 2000). A recent trend in this direction can be detected, however (Fazel *et al*, 2001).

Fazel & Danesh (2002a) also report systematic review figures for personality disorder (65% of men, 42% of women), including antisocial personality disorder, but here the consistency in the results across surveys breaks down. Others have recently turned their attention to the prevalence of drugs and alcohol problems in prison populations (e.g. Allwright *et al*, 2000). Here, the reported prevalence rates vary substantially between surveys, though this might simply reflect the highly-variable methodologies used. Reliable studies of intellectual disability in prison populations are rare. Studies reporting comorbidity of mental illness and substance abuse problems are also very rare.

Is it a universal law that wherever a prison population exists, about 4% of men and women will have a 6-month prevalence of psychosis, while 10% of men and 12% of women will have major depression? Early textbooks reported a unique prison psychosis probably caused by the sensory deprivation of the early reformatory/penitentiary regimes (Scott, 1974). Although a specific prison psychosis is no longer recognised, it seems that psychosis in prisons is a very constant phenomenon. Psychiatrists who do not work with prisoner populations often assume that the patients referred on to them by forensic psychiatrists are somehow qualitatively different from those they find in the community. Gunn *et al* (1990) showed that the majority of these prisoner patients are already well-known to local services. Many others have



repeated this observation. But perhaps we are missing something about the natural history of mental illness in prisoners that needs a different type of study.

Future directions

The studies reviewed by Faizel and Danesh (2002a) may represent a resource for further analysis and a prompt for future studies. Perhaps useful information can be gleaned about the relationship between psychiatric morbidity rates and the regimes in prisons, where spatial density, social density and the experience of crowding (Baum & Paulus, 1987; Canter, 1987) may amount to toxic factors (Sommer, 1979; Cox et al, 1982).

Will the availability of enhanced screening instruments such as that used by Gavin et al (2003) lead to better health outcomes? Only if there is a real change in attitudes to mentally disordered offenders in mental health services generally. Apart from a general willingness to acknowledge the needs of prisoners with psychosis, the delivery of services to prisoners with anxiety and affective disorders, drugs and alcohol problems, brain injury, learning disability, challenging behaviour and repetitive self-harm has changed little or worsened. It could be argued that screening at reception in prison is no longer worth the effort and instead, systematic screening earlier in the pathway through the criminal justice system is a better strategy (Shaw et al, 1999; James, 2000). Obviously, better cooperation between all stages of the process is likely to be the most effective solution, and there is some evidence for this (Pierzchniak et al, 1997). Perhaps with the appearance of this screening tool to help quantify mental illness, we should now move on to other disorders in prisoners and other ways of asking what the problem is.

References

ALLWRIGHT, S., BRADLEY, F., LONG, J., et al (2000) Prevalence of antibodies to hepatitis B, hepatitis C, and HIV and risk factors in Irish prisoners: results of a national cross-sectional survey. *BMJ*, **321**, 78–82.

BAUM, A. & PAULUS, P. B. (1987) Crowding. In *Handbook of Environmental Psychology* (eds D. Stokols & I. Altman). New York: John Wiley & Sons.

BIRMINGHAM, L., MASON, D. & GRUBIN, D. (1998) A follow-up study of mentally disordered men remanded to prison. *Criminal Behaviour and Mental Health*, **8**, 202–213.

CANTER, D. (1987) Implications for 'new generation' prisons of existing psychological research into prison design. In *Problems of Long-term Imprisonment* (eds A. E. Bottoms & R. Light). Aldershot: Craver.

COID, J. (1983) The epidemiology of abnormal homicide and murder followed by suicide. *Psychological Medicine*, **13**, 855–860.

COX, V. C., PAULUS, P. B., McCAIN, G., et al (1982) The relationship between crowding and health. In *Advances in Environmental Psychiatry 4* (eds A. Baum & J. E. Singer). Hillsdale, NJ: Erlbaum.

FAZEL, S. & DANESH, J. (2002a) Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. *Lancet*, **359**, 545–550.

— & — (2002b) Mental disorders in prisoners (letter). *Lancet*, **360**, 573.

—, HOPE, T., O'DONNELL, I., et al (2001) Hidden psychiatric morbidity in elderly prisoners. *British Journal of Psychiatry*, **179**, 535–539.

GAVIN, N., PARSON, S. & GRUBIN, D. (2003) Reception screening and mental health needs assessment in a male remand prison. *Psychiatric Bulletin*, **27**, 251–253.

GORE, S. M. (1999) Suicide in prisons. Reflection of the communities served,

or exacerbation of risk? *British Journal of Psychiatry*, **175**, 50–55.

GUNN, J. (2000) Future directions for treatment in forensic psychiatry. *British Journal of Psychiatry*, **176**, 332–338.

—, MADEN, A. & SWINTON, M. (1990) *Mentally Disordered Prisoners. Report to the Home Office*. London: Home Office.

JAMES, D. (2000) Police station diversion schemes: role and efficacy in central London. *Journal of Forensic Psychiatry*, **11**, 532–555.

PIERZCHNIAK, P., PURCHASE, N. & KENNEDY, H. G. (1997) Liaison between court, prison and psychiatric services. *Health Trends*, **29**, 26–29.

SCOTT, P. D. (1974) Commentary on S. J. H. Ganser. In *Themes and Variations in European Psychiatry* (eds S. R. Hirsch & H. Shephard), pp. 74–77. Charlottesville, VA: University of Virginia Press.

SHAW, J., CREED, F., PRICE, J., et al (1999) Prevalence and detection of serious psychiatric disorder in defendants attending court. *Lancet*, **353**, 1053–1056.

SOMMER, R. (1979) Are crowded jails harmful? Field and laboratory on trial. *American Journal of Forensic Psychiatry*, **1**, 7–21.

TAYLOR, P. J. & GUNN, J. (1999) Homicides by people with severe mental illness: myth and reality. *British Journal of Psychiatry*, **174**, 9–14.

TORREY, E. F. (1995) Jails and prisons — America's new mental hospitals. *American Journal of Public Health*, **85**, 1611–1613.

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