Mental Health in Prisons
Some Insights from Death in Custody Investigations

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As a young man, inspired by the anti-psychiatry movement and the so-called counter-culture as a whole, I was a strong supporter of closing mental hospitals in favour of what came to be known as ‘care in the community’. The depressing state of many of those hospitals and the way they treated patients were indeed shameful. Colloquially, they were known as ‘bins’, an echo of the phrase ‘penal dustbin’ famously applied to his prison by the then Governor of Wormwood Scrubs, John McCarthy, in a letter to The Times in 1981.

Yet it now seems that many of the supposed beneficiaries of care in the community are to be found languishing in the healthcare centres and segregation units of prisons. Care in the community has equated to care in custody, with most prisoners exhibiting some psychiatric symptoms and some suffering from very serious psychotic and neurotic illnesses.

Sadly, this is anything but a new phenomenon. Mental health and prisons have always been bracketed together. Here is what John Howard (frequently regarded as the father of prison reform, although labelled the father of solitary confinement by Michael Ignatieff in A Just Measure of Pain) wrote 230 years ago in The State of the Prisons:

In some few jails are confined idiots and lunatics … many of the bridewells are crowded and offensive, because the rooms which were designed for prisoners are occupied by lunatics … The insane, when they are not kept separate, disturb and terrify other prisoners. No care is taken of them, although it is probable that by medicines, and proper regiment, some of them might be restored to their senses, and usefulness in life.

Howard based his views on many visits to prisons (we would perhaps term them inspections). In this contribution, I want to consider what my investigations into deaths in custody as Prisons and Probation Ombudsman may say about the state of mental health services in prisons today.

First a caveat. Those who die in prisons may be representative neither of all those with mental health problems nor of the prison population as a whole. However, my investigations and just about every published study of suicide in prisons has shown how those who have a history of mental illness or substance abuse (and, all too often, of both) are more at risk. Indeed, I have spoken to at least one psychiatrist who argued that suicide is in some circumstances to be regarded as an inevitable outcome of depressive illness, just as death by other means is the inevitable consequence of a physical disease like lung cancer. (I do not warm to this argument personally, but I understand the point. It is self-evident that not all self-inflicted deaths can be avoided save for deploying the most extreme methods of physical prevention.)

Biases in the sample aside, what is revealed in the 600-plus investigations I have conducted since I took on responsibility for investigating deaths in custody in 2004? The first theme is that prisoner-patients are at the back of the queue when it comes to access to NHS psychiatric facilities. Whether this is because there is a shortage of secure mental health beds, or because there is direct discrimination against prisoner-patients, or for some other reason, I leave for others to debate. However, that there continues to be a problem in transferring prisoners to mental hospital I take to be self-evident. (I am aware that the number successfully transferred is in fact now at an all-time record. My point is that the record number of transfers still lags behind the need.) This is illustrated by the case of Mr A.

Mr A had been sentenced to life imprisonment and at the time of his self-inflicted death was diagnosed as suffering from severe and enduring mental illness. I regard my report on the death of Mr A as being one of the most important I have issued.

Mr A was a prolific self-harmer. His self-harming behaviour led to black eyes, lacerations to his face and wrists and he would reopen old wounds. He twice took an overdose of prescribed medication and swallowed foreign objects which required removal at outside hospital.

Staff in the local prison where Mr A was found hanging cared exceptionally well for him. But his needs were too great for the local prison, or for any prison, and he required treatment in a secure mental health setting. In my report I wrote:

1. I listed some of the characteristics of those who have died at their own hands in an earlier article for this journal (Self-Inflicted Deaths in Prison Custody: Lessons from the Ombudsman’s Independent Investigations, Prison Service Journal No 169, January 2007). To give just one example of differences between those who die and the general population, white prisoners are significantly more likely to take their own lives than black prisoners.
Healthcare staff at the prison demonstrated great empathy with Mr A. The Head of Healthcare and Mental Health Lead were tireless in their attempts to have Mr A transferred to a secure mental health facility. They were operating in a system that worked against them. It appeared as though prisoner-patients dropped to the bottom of a long waiting list. Whilst in prison their supervision was guaranteed, offering a degree of protection. In all other respects, the prison environment was completely unsuitable for Mr A.

I believe that the National Health Service failed to acknowledge its responsibilities towards Mr A. In my recommendations I urged the Department of Health to use Mr A’s case as the basis for a fundamental mental health pathway review.

A second theme of my reports concerns the quality of mental health assessments. Like many lay people, I find some of the judgements of clinicians very difficult to credit. Take the example of Mr B.

Mr B’s home country is one of the most dangerous places on earth. He arrived in Britain as an asylum-seeker. While still a teenager, he was sent to prison for the first time.

Mr B went on hunger strike and was subject to repeated use of force. He was psychopathologically assessed on three separate occasions by two different psychiatrists. At the time of those examinations, he was apparently not suffering any mental illness. However, his recorded behaviour was bizarre, including acts of violence, urinating in his clothing and chanting ‘I’m white, I’m white’ whilst completely naked. He was effectively kept in solitary confinement for three months without any peer group company.

Those that knew him well, including his family and solicitor, had serious concerns regarding mental health. Leaving that matter to one side, I believe the establishment itself missed an opportunity to engage with Mr B’s family in his care plan.

Mr C was another man where the extent of his mental illness was at issue.

Mr C had a long history of self-harm. He had been assessed many times by mental health professionals and there was continuing debate about whether he was mentally ill or not. He died at a prison that was considering whether to make a mental health referral. Before this, he had been for a long time in a local prison where he was kept in the segregation unit (during periods of prolific self-harm), and where there was a refusal to consider that Mr C was mentally ill at all.

Even when a mental illness is diagnosed, clinicians differ as to the extent to which the condition can be treated. Some of the most distressing investigations I have undertaken concern prisoners, especially women, who have lengthy psychiatric histories but are not considered treatable when appearing before the courts.

Like Mr B and Mr C, Ms D spent much of her time in segregation as a consequence. Ms D, a woman in her early 30s, was found hanging in her cell in the prison’s segregation unit. She had been sentenced to life imprisonment for setting fire to the curtains of the sheltered accommodation where she lived. Her flat was near a psychiatric hospital to which she had been admitted as an in-patient on a number of occasions. When she was a teenager, Ms D had been detained at a secure psychiatric hospital for over four years and treated on a ward for mentally impaired patients.

A report to court by a forensic psychiatrist shortly before Ms D received her life sentence said that the damage to her personality was severe enough to be diagnosed as psychopathic disorder. The psychiatrist added that there was no evidence to suggest that the woman was treatable. His opinion was that Ms D did not suffer from serious mental illness, and did not suffer from a form of mental disorder for which she could be detained in hospital. In his sentencing remarks the judge told Ms D that, in prison, ‘you and your mental state will require and receive constant supervision and assessment and monitoring.’

Ms D was a prolific self-harmer and at the time of her death was in a prison where the very high level of prisoner self-harm meant that the staff, both prison officers and healthcare specialists, were under severe and unremitting pressure. The jury at Ms D’s inquest

2. This case also appears, under a different pseudonym, in my 2006-07 Annual Report.
returned a narrative verdict in which they said that prison was ‘unsuitable for someone with [Ms D’s] problems, as the constant supervision and monitoring that she required was lacking in the prison environment.’ In my report, with careful understatement, I said it was very difficult to imagine that a solitary cell in the segregation unit was an appropriate location for such a vulnerable and mentally unstable woman.

The special riskiness of segregation is a theme I have emphasised ever since 2004. However, I also acknowledge the challenge of caring for someone who is both a danger to themself and to others. The case of Mr E is an illustration. His story also shows that concerns about the harshness of the custodial experience and the impediments to delivering humane care are not confined to cases where prisoners take their own lives.

Mr E died of natural causes in hospital, one week after being transferred there from a local prison. He had arrived at the prison three months before his death, charged with an assault on police officers and threats to kill his mother, who died following an incident at their home.

Prison staff were made aware that Mr E had an established history of epilepsy and mental health problems. He had frequently been admitted to psychiatric hospitals and there were over 100 episodes recording violent outbursts against those involved in his care. For the first month Mr E was successfully managed as an inpatient in the prison’s healthcare centre, but he was then moved to the segregation unit following episodes of violent and abusive behaviour.

It was acknowledged early on by various of those involved in Mr E’s care that the segregation unit was not the most appropriate place to manage him. It was also noted in his records that his mental health generally deteriorated when he was located there. However, neither the normal location houseblocks, nor the medical inpatient wing, were considered appropriate locations because of Mr E’s aggressive behaviour.

As his mental health continued to deteriorate, Mr E had more frequent psychiatric assessments. Attempts were made to obtain a suitable non-prison placement for Mr E, preferably in a secure psychiatric hospital. It was very difficult to find such accommodation due to his history of aggression and verbal threats to staff.

During the month before his death, it was noted that Mr E had more frequent epileptic fits which were more severe. Just over a fortnight before his death, he was still in the prison’s segregation unit despite the apparent deterioration in his mental state. A nurse who saw him for a segregation review noted that he was naked in his cell and was agitated and aggressive. Mr E’s Clinical Record said that his behaviour was becoming increasingly bizarre and hostile. He was talking about being God and said that prison staff were the devil’s disciples.

Despite strenuous efforts by a number of doctors and psychiatrists to find a psychiatric hospital bed for Mr E in the weeks before his death, no such bed was obtained. Exactly one week before he died, Mr E was taken by ambulance to a general hospital after suffering a series of seizures which were difficult to control and long lasting.

A further theme emerging from my investigations is the question of how far it is proportionate, reasonable and — let us be candid — financially feasible to prevent someone hurting themselves by keeping them under constant observation. This is the same question posed in respect of a number of high profile prisoners whose names I do not need to mention here. But it is illustrated by the case of Mr F.

Mr F was deeply suicidal and had tried to end his life on a number of occasions. He repeatedly said that his aim was to kill himself and some might feel this was a matter of rational choice (he was already serving an indeterminate sentence and facing extradition to another jurisdiction on murder charges).

Mr F was diagnosed as severely depressed and as having a personality disorder but, despite two referrals for psychiatric assessment, was not judged to be sufficiently mentally ill to warrant being transferred to hospital. (We seem to have heard this before.) Mr F was on medication but often refused to take it. He was managed by a combination of intermittent and constant observation and was on an F2052SH or ACCT form almost continuously.

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3. Footnote 2 also refers.
About a week after being put on normal location with three observations per shift he hanged himself.

Another recurrent feature of my investigation reports is the lack of communication between clinicians and discipline staff and between clinicians themselves. In the case of Mr G, there was a catalogue of problems. There were delays in issuing medication. Mr G was put on diazepam reduction even though he had been receiving diazepam from an outside GP for about 18 months. And there was a lack of communication between clinical teams (on two occasions, Mr G disclosed suicidal ideation to a visiting psychiatrist, but this information was not passed to the primary health team).

Finally, I report without comment the case of Mr H. He had threatened that, if he was not prescribed and given olanzapine (an anti-psychotic), with which he had been successfully treated in the past, he would kill himself. He wasn’t and he did. Clinicians at the prison spoke about the inappropriateness of prescribing solely in response to patient demand. They said they were awaiting a psychiatric assessment (and that the visiting psychiatrist preferred to assess patients in their natural, un-medicated state).

What overall conclusions do I reach? On the basis of my investigations, I do judge that there has been good progress in the delivery of secondary care. Mental health in-reach has been a very significant development and more prisoners are being moved into hospital (albeit after delays, and I am alarmed how quickly some are transferred back).

But primary care is less impressive. Given the extent of the need, perhaps that is inevitable. Including drug dependence and alcohol misuse, nine out of ten prisoners have at least one significant mental health problem. But I wonder how far depressive illness is correctly diagnosed or regarded as an inescapable aspect of the prison condition.

As one of my most experienced colleagues said to me recently, prisons are full of people not ill enough for secondary care but too difficult (or too transient) for primary services. It is perhaps in that area that services for prisoners with mental health problems are most in need of strengthening.

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