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prisonHEALTH
PRISONS, HEALTH AND SOCIETIES RESEARCH

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WRITTEN SUBMISSION: Mental Health in Prison

1. I am currently a UK Research and Innovation Future Leaders Fellow examining *Prison Regulation, for Safer Societies*. In 2021 I commence a European Research Council Starting Grant on *Regulating Criminal Justice Detention*. I direct the Prisons, Health and Societies research group.

2. This submission is based upon my ongoing research with the Prisons and Probation Ombudsman (PPO) regarding the impact of PPO fatal incident investigation recommendations. I have been researching prison suicide since 2015. I have published two books and multiple peer-reviewed journal articles. My 2018 book provided the first account of the Police, Ombudsman and Coroner investigations that follow prison suicide/self-inflicted death. My 2017 book conceptualised the penal voluntary sector, winning the *British Society of Criminology* book prize. My research has been funded by the European Research Council, UK Research and Innovation, the Leverhulme Trust, the British Academy, the ESRC Impact Accelerator and the Universities of Manchester, Nottingham and Sheffield.

3. Of critical importance to your analysis, although not mentioned in your terms, are the interrelationships between **prisons and secure health care**. Deinstitutionalisation of mental health care has led to imprisonment as a 'substitution' for mental health care. As the Irish Inspector of Prisons recently noted, "prisons are prisons, they are not, and cannot be considered therapeutic environments for the provision of mental health care and treatment" (Office of the Inspector of Prisons, 2020:4). Human capacity for rationality (*mens rea*) is key to forming intent and underpinning criminal responsibility. Prison should not be treated as an entry point to secure mental health care.

4. Between 2016 and 2019, I analysed PPO and Coroner reports, which highlighted that **extremely ill people, who (very likely) lack capacity to engage with the criminal justice system (**at the time of their alleged offence and remand) **are too frequently remanded to prison.** This practice has resulted in self-inflicted deaths (I provide four concise examples in APPENDIX 1 below: Lewis Francis, Jason Basalat, Sarah Reed and Dean Saunders), places unfair demands and stress on untrained prison staff, affects service delivery for all other prisoners. Prisoner deaths matter intrinsically, to anyone interested in their fellow citizens' rights and well-being, and instrumentally, for societal health and safety: because unsafe prisons mean unsafe societies (Tomczak and McAllister, 2021). Prisoner deaths form a substantial economic burden upon public funds. Moreover, any deaths in locales can also lead to further deaths through 'clustering'.

5. However, the Crown Prosecution Service (CPS) problematically state that some offences are 'too serious' for diversion from prison (CPS, 2019). **Mechanisms facilitating those charged with serious offences to be transferred to secure health care from police custody are required nationally, along with expanded bed numbers in secure mental health care.** It is important to note that many prison staff are neither trained in nor have expertise in mental health work. However**, unlike mental health facilities, prisons cannot refuse anyone sent to them, no matter how unsuitable the facilities**. Even at its best, the containment-oriented criminal justice system is not a substitute for the care-oriented NHS and can be considered anti-therapeutic for prisoners.

6. In late 2020, we undertook interviews with prison Governing Governors and Safer Custody Group Leads (SCGLs). Our analysis of these interviews highlighted (severe) prisoner mental illness as a contextual hazard, or 'accident waiting to happen', that facilitates prison suicide across the prison estate.

7. Supporting point 5, interviewees discussed prisoner suicides where imprisonment had been deeply problematic from reception.

   GOVERNOR 2: The last two deaths in custody I've had, both of those guys were hearing voices, both of those had bizarre behaviour, both in my view should never have been in custody in the first place.

SCGL 2: There has been a couple, […] actually should they have been in custody?

8. Governor 4 noted that misuse of imprisonment in response to e.g. mental illness **diluted the amount of 'support' that staff were able to provide** to prisoners, also alluding to the anomalously high rate of imprisonment in England and Wales:
GOVERNOR 4: Less prisoners. […] That's the key to this, we are sending […] too many wrong people to Prison and that's contributing to all of this, if there was the right prisoners here, we would be able to support them much more effectively.

9. Four governors and one SCGL highlighted the common perception that **prisons are incorrectly viewed as places of safety**[1]:
SCGL 2: Often we have, you know, almost prison is a place of safety.
GOVERNOR 8: Often […] prisons are regarded as a place of safety.
GOVERNOR 2: Actually our prisons aren't safe places
GOVERNOR 4: Magistrates […] see prison as a place of safety. Prison is not a place of safety.
GOVERNOR 1: On mental health, if you look at some of the women […] that we get into custody, they're meant to be put in safe places and that's not what we are.

10. Governors went on to describe how using prisons as "a place of safety" leaves **vulnerable people with (severe) mental illness in "chaotic" prison environments** with e.g. high levels of noise, high drug availability and high violence:
GOVERNOR 2: We put them into a prison that's really noisy, put them in a cell with somebody else, they are already paranoid anyway, we are just fuelling that.
GOVERNOR 4: Prison is a chaotic environment where it is if you are unwell, struggling, there are lots of temptations in terms of drugs, it's just a hideous place.
GOVERNOR 3: We have got relatively high levels of violence in many establishments. […] You are taking vulnerable people […] taking their liberty away.

11. Using prison as 'a place of safety' for people with severe mental illness is also deeply **problematic for prison staff to manage**:
GOVERNOR 2: I've got a guy now in the constant watch cell, every time we undo the door, he's attacking staff, he's trying to kill himself.
GOVERNOR 8: We are being asked to manage large numbers of men and women who have got huge […] mental health issues and […] displaying incredibly complex behaviours.

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[1] See also https://www.thegriffinssociety.org/system/files/papers/fullreport/griffins_research_paper_2015-01.pdf and https://howardleague.org/wp-content/uploads/2020/10/APPG-For-their-own-protection-FINAL.pdf

GOVERNOR 1: We deal with some very, very complex, some very complex individuals.
SCGL 6: The majority that I see is the increase in mental health problems, especially in men, […] now – and that's where the suicide rate is increasing significantly, they are complex, they have got drug issues, they have got dual diagnosis, they have got mental health problems … the complexity of guys we have got.

12. **Prison staff are not trained to manage people with severe mental illness.** Moreover, prison mental health in-reach services are often only available in office hours, which of course mental health difficulties do not confine themselves to:

GOVERNOR 7: Our lack of training to know even how to start to deal with that. […] When significantly complex men….
SCGL 2: We deal with people who quite often, […] no one else wants. They don't want to have them in a mental health institute, they don't want to have them in a secure unit, they won't have them anywhere else. Yet we are supposed to have them in custody and keep them alive and manage them within a cost saving setting with none of that training, with none of that expertise. […] ***It's quite common****. […] Did they put them there because they didn't know what to do with them? […] Then they expect a group of prison officers to then manage them.*
GOVERNOR 5: I don't think it always comes down to individual prisons to get things right […] Unless we tackle like the causes and some of the people we are getting through the door, this (prison suicide) won't change. The people we have got, the level of mental health that we have coming through the door, the level of unwellness.

~~13.~~ Two governors highlighted inadequate mental health services and facilities in prison and the community, and argued that inadequate community mental health services led to the imprisonment of severely mentally ill people rather than diversion:

GOVERNOR 2: Actually do we divert people from custody? […] Looking at provisions for people that are mentally ill would be fantastic.
GOVERNOR 8: Mental health services in the community are absolutely overwhelmed and often prisons are regarded […] as a place of safety.

14. Two SCGLs discussed the difficulties of gaining health service recognition of prisoners' severe mental health problems and **attempting to transfer prisoners to secure health care.**

SCGL 2: The [death] I talked about, […] the work they had done to try and get them, the assessments they had done, the people they had in, they had the National Complex Board. […] They were raising continually: we don't think prison is the right place for them, we […] are really struggling to keep them safe and actually we don't have the expertise. […] You know there has been a couple.

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SCGL6: He had psychotic tendences. We tried to manage him on the wing. He sexually abused nurses. Well, we tried to manage him in healthcare, he assaulted staff. We tried again to manage him in healthcare, went backwards and forwards. We tried to get him sectioned and this went on.

15. Governor 5 discussed their prison's **substantive remittals from secure hospitals** at the beginning of the pandemic, which they believed to be due to a mental health ward re-roling as a COVID ward:
GOVERNOR 5: I think the level of readmission with it being a local prison from mental health hospitals, so we have particularly seen this during the start of COVID, we took in loads and I'm sure that wasn't they were all cured, I'm sure that's probably because mental health hospitals were trying to lessen their workload and probably trying to create social distancing. […] A mental health hospital in London, one of their wards re-roled as a COVID ward, so their capacity went down."

16. More generally, **many prisoners had mental health needs and there is limited mental health treatment/ service provision** in prisons:
GOVERNOR 2: I've got […] loads of guys with mental health issues.
GOVERNOR 6: There's a huge number of the population […] in receipt of mental health services.
GOVERNOR 5: Certainly the level of mental unwellness, […] the level of investment in mental health treatment in prisons is still pretty poor.

Many thanks for your consideration. Of course I am more than happy to expand if useful.

Yours,

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APPENDIX 1

A: Mr Lewis Francis (d. 24/4/2017) *"A prison doctor saw Mr Francis and recorded […] serious concerns as to whether prison was an appropriate environment" (PPO, 2018: 6).*

Mr Lewis Francis took his own life at HMP Exeter, England at 20 years old, having been remanded to prison despite a mental health assessment carried out on 16th February in police custody stating that he "lacked the mental capacity to engage with the criminal justice system" (PPO, 2018: 6). His alleged crime was committed whilst acutely psychotic on 15th February 2017, subsequent to which he was deemed unfit to be interviewed by police due to his continuing psychosis (Rheinberg, 2020). In police custody, Mr Francis' condition "mandated a transfer to a medium secure mental health hospital for an assessment and/ or treatment under section 2 and / or 3 of the Mental Health Act 1983", however "no ready facility existed for such a transfer and Lewis Francis was remanded in custody to HM Prison Exeter from where he was not transferred to a medium secure mental health hospital" (Rheinberg, 2020: 1). Although unfit to be interviewed, he was apparently fit to be imprisoned.

On 17th February 2017, the day of Mr Francis' remand, a prison doctor recorded that Mr Francis was "agitated and distressed […], displayed evidence of thought disorder and his behaviour was severely disinhibited" (PPO, 2018: 6). The doctor "recorded that he had serious concerns as to whether prison was an appropriate environment for Mr Francis […] (which) the pre-custody psychiatric report […] echoed […] and did not give a clear reason why Mr Francis was processed through the criminal justice system" (PPO, 2018: 6). The doctor "asked for an urgent mental health assessment to be carried out prescribed diazepam (for anxiety disorders) for three days" (PPO, 2018: 6).

This urgent mental health assessment was not carried out before Mr Francis' self-inflicted death, more than nine weeks after his reception at HMP Exeter. In the interim, on 24th February Mr Francis told a prison psychiatrist that he "believed that his current experiences had alien involvement, that he was being baked alive, and that he believed he was a ghost", and the psychiatrist recorded that Mr Francis "had suffered a psychotic episode and that his level of insight into his beliefs fluctuated greatly (PPO, 2018: 7). On 27th February, Mr Francis told a consultant psychiatrist and learning disabilities nurse that he "felt he was burning up inside, suffered from disturbed sleep, heard voices and was distressed as he did not know how to deal with these experiences" (PPO, 2018: 7).

In March 2020 at the inquest, the Coroner noted as a matter of concern that there *is no mechanism enabling those in police custody in the South West, charged with a serious crime to be transferred to mental health facilities* (Rheinberg, 2020: 1-2).

B: Mr Jason Basalat (d. 11/12/2016) *"Mr Basalat was arrested on 09/12/16 […] after he had grabbed the steering wheel of a coach. […] He was charged and remanded by Northamptonshire Magistrates Court. The reason that bail was refused was for his own protection. […] At 08:05 11/12/2016 he was found hanging from a bed frame […] in his cell" (Osborne, 2017: 1).*

Mr Jason Basalat took his own life at HMP Woodhill, England at 52 years old. He had been remanded into HMP Woodhill "for his own protection" on 10th December 2016. He survived for less than 24 hours in prison (PPO, 2017b). At the site of his alleged offence and in police custody, Mr Basalat was "behaving in a bizarre manner" (Osborne, 2017: 1). Mr Basalat was diagnosed with schizophrenia (PPOb, 2017). *At court, Mr Basalat's solicitor was informed that a mental health assessment was not possible due to it being Saturday morning* (Osborne, 2017: 1). Upon reception to prison on 10th December, staff "described his behaviour as "bizarre" and noted that he had defecated in the induction waiting room", but "did not understand that defecating on the floor was unacceptable" (PPO, 2017b: 9). An officer described Mr Basalat as "not 'compos-mentis'", whilst another recorded that "Mr Basalat asked him when they would go to the pub". (PPO, 2017b: 9). Mr Basalat "refused to co-operate" at an initial health screen with a mental health nurse, who then "suggested that he should share a cell because of his mental health issues" (PPO, 2017b: 9). Mr Basalat's cell sharing did not go well and his cellmate was moved that evening after telling a member of prison staff, whilst "very distressed, scared and physically shaking", that Mr Basalat was "crazy, […], had tried to light a fire, […] and had threatened to rape him" (PPOb, 2017: 9). During his short time in prison, Mr Basalat had multiple confused exchanges with prison staff, for example, on 10th December he told an Operational Support Grade (OSG) that "he could not find his phone and had lost his coat […]. During the night, Mr Basalat asked for his cell door to be left open as he needed his coat and had to go for a walk". (PPOb, 2017: 10). At 06.25 on 11th December, "Mr Basalat was confused and told the OSG he had to leave for work at 9.00am, and needed to buy an alarm clock"; and at 7.15am Mr Basalat "thought he was going to be kidnapped" and told an officer "not to lie to him, as he had been in the army and knew they were coming for him" (PPOb, 2017: 10). He was pronounced dead at 09.35 that morning. At inquest in November 2017, the Coroner highlighted that, at Criminal Court, "consideration should have been given as to the most appropriate place for the deceased to be held or to receive a mental health assessment" (Osborne, 2017: 2).

C: Ms Sarah Reed (d. 11/1/2016) *"This is a particularly troubling case of a seriously unwell woman being held in a prison setting which, despite commendable efforts by some staff, proved incapable of keeping her safe." (PPO, 2017c: iii).*

Ms Sarah Reed died at HMP Holloway, England at 32 years old. She "suffered from serious mental health problems" (PPO, 2017c: iii) and was remanded to prison on 14th October 2015 "solely for the purpose of obtaining one or more reports on her fitness to plead and stand trial" (Thornton, 2017: 2). Whilst on bail, she had not attended two psychiatrist appointments arranged to assess her fitness to plead and was remanded to HMP Holloway such that the Court could obtain these reports (Thornton, 2017: 2). By the time that Ms Reed died, three months after entering prison, only one report had been obtained and "a second report was due on 15 January 2016. No date had been fixed by the Crown Court for a hearing to determine the issue of her fitness to plead" (Thornton, 2017: 2). From 5th January 2016, Ms Reed's "mental health deteriorated further and her behaviour became erratic and unpredictable. She spent long periods shouting, chanting and making noises in her cell" (PPO, 2017c: 1). The Coroner noted: "had the Court obtained the psychiatric reports on fitness to plead earlier, the Court may well have imposed a hospital order (with or without a restriction order) under section 5(2)(a) of the Criminal Procedure (Insanity) Act 1964. The two necessary requirements would have been easily satisfied: the reports were to find her unfit to plead and she had admitted the act charged" (Thornton, 2017: 3).

D: Mr Dean Saunders (d. 4/1/2016) *"Mr Saunders was acutely mentally ill and all those involved in his care agreed that prison was not an appropriate place for him" (PPO, 2016: iii).*

Mr Dean Saunders died at HMP Chelmsford, England at 25 years old. He was remanded to prison on 18th December 2015 after being "identified as seriously mentally ill and need(ing) hospital treatment" and believing "his family were involved in a conspiracy against him" (PPO, 2016: 6). In police custody on 16th December 2015, the on-call psychiatrist recommended that Mr Saunders be assessed for admittance to a forensic mental health ward. However, "Rochford Hospital could not offer a bed for Mr Saunders", who then went to court on 18th December and was remanded to HMP Chelmsford. (PPO, 2016: 10). On 20th December, Mr Saunders was under constant watch by Officers. The evening officer noted that Mr Saunders was:

> "agitated and tearful and kept repeating 'this is a game'. […] He thought he was under surveillance, that one of the nurses had a microphone in her hair, and that another member of staff had a camera in her glasses. He threatened to pour a kettle of hot water over his head. He picked up a plastic knife and said he was going to draw blood for a paternity test for his son. He stood at the cell gate demanding answers about his son"
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> (PPO, 2016: 13).

In February 2017, the Coroner issued a Prevention of Future Deaths report which raised, as a matter of concern, that South Essex Partnership Trust (healthcare, SEPT) and NHS England consider "whether the transfer of individuals such as Dean to prison is indeed "best practice", taking into account the consequent delay in transfer and the suitability of the prison environment for mentally disordered individuals" (Beasley-Murray, 2017: 4). The Coroner also directed SEPT to establish a mechanism to transfer "mentally disordered people from police custody" to hospital, rectifying the "admitted lacuna in the SEPT admissions protocol (which) […] does not allow for the transfer of *any* individual from police custody" (Beasley-Murray, 2017: 4). As such, the Coroner had made a local and national healthcare recommendation to (re)consider the imprisonment of mentally unwell people and a local recommendation to establish a police custody – hospital transfer mechanism. Unfortunately the latter recommendation, made to SEPT, did not influence the similar case of Mr Lewis Francis in the South West.