

The State of the Prisons

The mental health of prisoners

II—The fate of the mentally abnormal in prison

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All prisoners are seen by a prison doctor on entry into prison, and he will attempt to weed out those who might be mentally disordered within the terms of the Mental Health Act. These are the prisoners who can be transferred to mental hospitals if a place can be found for them; the problem is, of course, to find a place.

Those who are considered dangerous may be transferred to special hospitals. But dangerousness is a hard thing to measure, and there is ample room for disagreement among prison doctors, forensic psychiatrists, and the doctors who determine admission to the special hospitals as to who is dangerous and who is not.¹ The special hospitals are not keen to take mentally disordered prisoners whom they do not consider merit such secure conditions, and nor are they keen to take prisoners whom they see as untreatable. They are thus not keen to take psychopaths. Many of the applications for transfer to special hospitals are turned down, and the total number of applications has been declining. This may be because the prison doctors are increasingly pessimistic about the chances of getting certain prisoners into special hospitals. When transfer is agreed it can if necessary be carried out very fast, but usually there is a short waiting list.

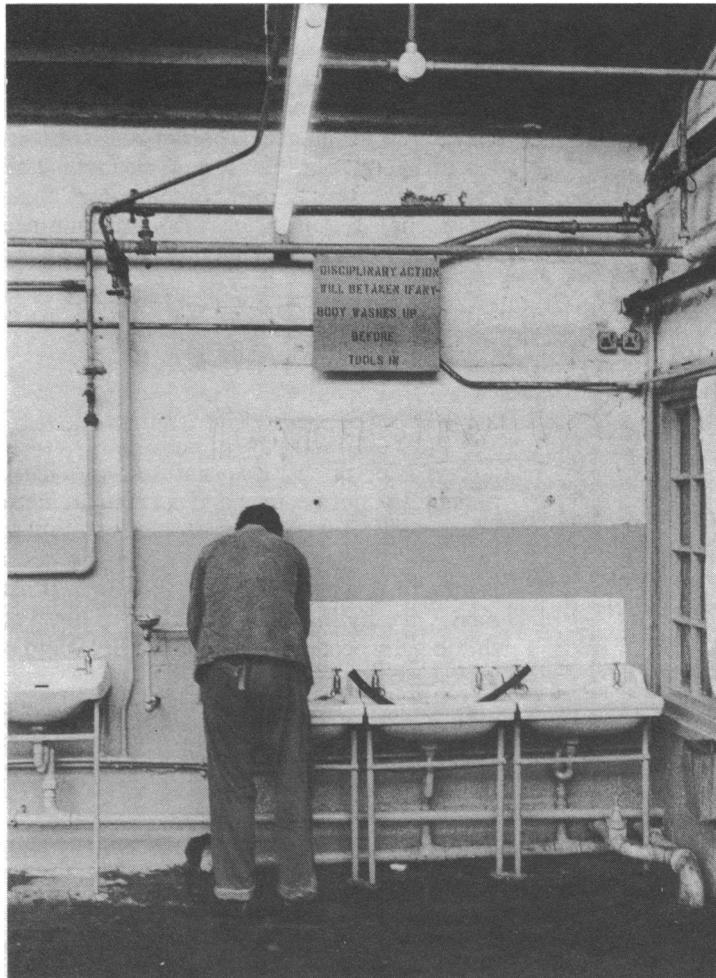
Most of those who are considered mentally disordered in the terms of the Mental Health Act do not merit transfer to a special hospital. This is the group that has caused prison doctors some of their biggest headaches and caused them to come out and appear in print complaining of the difficulties

they experience in transferring these prisoners to NHS hospitals.^{2,3} Some of these prisoners are transferred with comparative ease, but many are not. The problem does, however, seem to have eased a little since the published complaints of the prison doctors, and the latest prison department report acknowledges this.⁴

The first cause of the difficulties has to do with changes in the nature and organisation of mental health services in the community.⁵ Over the years fewer and fewer psychiatric patients have been detained in hospital against their will, and the tendency is very much towards management in the community. Many psychiatric hospitals thus have few or no facilities for detaining patients, nor do they have the skills for managing difficult patients. Another organisational problem has been the division of psychiatric services into sectors. The prison doctors must now contact the psychiatric team responsible for the area where the prisoner lives (given that he has an address, and some of course do not); if it happens that that team has no interest in taking patients from prison then transfer is made very difficult if not impossible. In days before the sector system was introduced prison doctors would

develop good relationships with particular psychiatrists, often the ones who had an appointment with the prison service, and the psychiatrist would transfer prisoners to his NHS beds regardless of where they came from. This system still operates in a small way, but it is much more difficult than it was.

Many psychiatric teams are unwilling to take prisoners, and accusations are made against psychiatrists, nurses, and the unions of being unwilling to take on their responsibilities. Sometimes one group is held to be the intransigent one and sometimes another,⁶ but the truth is probably that all groups are



reluctant in one case or another. The health authorities, too, may be held responsible, and the Home Affairs Select Committee recommended in 1981 that legislation should be introduced to force regional authorities to take prisoners for whom the courts made hospital orders.⁷ Under the new Mental Health Act authorities cannot be forced to take prisoners but they can be summoned to court to explain why they cannot. How effective this provision will be remains to be seen. The government seems to hope that the much delayed regional secure units will solve the problem.⁸

The story of the scandalous delay over the building of regional secure units will be familiar to *BMJ* readers.^{5 9 10} Some of the units are now being built and should be opening soon. Some psychiatrists doubt, however, that the units will provide a full answer to the problem of finding hospital places for mentally disordered prisoners. We must wait and see what admission criteria these units adopt, but they are likely to see the need for high security, treatability, and expected length of stay as important factors, and there may still be a group of prisoners who fall between the stools of special hospital, secure unit, and ordinary mental hospital.

In most of what I have written so far I have had England and Wales in mind, but in Scotland and Northern Ireland the problems are not so acute. In all of Scotland except Glasgow the relationship between the prison doctors and the NHS psychiatrists is better than it is in England and Wales, and there are not the same problems in transferring mentally disordered prisoners to NHS hospitals. In Glasgow the problem has worsened since a particular case a few years ago when a prisoner transferred to hospital escaped and committed further serious crimes. Another reason for the better conditions in Scotland is that Carstairs, the Scottish special hospital, always has empty beds and is more able and willing to take prisoners than the special hospitals in England and Wales. Furthermore, Scotland has proportionately twice as many psychiatrists as England and Wales: this gives Scottish psychiatrists more time to deal with prisoners. In Northern Ireland the problem seems to be less acute because despite its high prison population many of the prisoners are terrorists and the terrorist organisations do not take the mentally disordered.

The remainder of the mentally disordered

Most of the mentally abnormal in prison do not fall within the terms of the Mental Health Act and they must serve out their sentences in the prison system. They are managed day by day by prison doctors, who are supported by visiting psychiatrists. These doctors use the same treatment methods as doctors outside the prisons. These include drugs, and one of the commonest accusations levelled against the prison doctors is that they drug prisoners as a method of control.¹¹⁻¹⁴ These accusations have had such an impact that in the last few years the prison department has taken to publishing figures on the amount of psychotropic drugs prescribed in various prisons.^{2 15} These figures have been criticised as revealing very little about patterns of prescribing in prison.^{13 16} My impression is that underprescribing may be as much a problem as overprescribing, and that prison doctors are often under great pressure to prescribe but usually resist. The decisions that the prison doctors face about when to prescribe drugs are not so different from those faced by general practitioners with their patients, except for the pressure cooker atmosphere of the prisons, and prison doctors vary in their prescribing habits just as do ordinary general practitioners. The problems of prescribing in prisons, although undoubtedly difficult, have been exaggerated by many media reports—they have also been oversimplified.

Apart from these routine methods of managing mental health problems that are available in the community the prisons have little extra to offer their population with its heavy load of mental abnormality. Parkhurst has a wing reserved for prisoners with mental problems, and its most notorious inmate

It is usually not worth arguing whether the addict, or the pervert, or the delinquent is ill or not, for the answer either way is inconclusive. . . . The prisons are slowly showing changes comparable to those which have occurred in the hospitals and asylums during the last century. . . . Most people harbour the basic phantasy of, on the one hand, a warm, permissive, liberally equipped hospital system where treatment is applied by doctors and nurses to persons who are suffering through no fault of their own; on the other hand are the prisons where people are punished for wicked behaviour which they could renounce if they wished, and who should therefore be prepared to accept rigorous conditions and custodial turnkeys. Obviously neither side of the picture is correct. . . . The fact is that it is easy and gratifying to treat acute illnesses and injuries in pleasant surroundings, especially if you can send home those who don't respond. It is also easy and, unhappily, gratifying to punish wicked people, and if they "turn nasty" to lock them up and go home to your tea. What is very difficult is to treat long term problems of irrational or undesirable behaviour in persons who do not want to be treated.

Peter Scott²⁴

is Peter Sutcliffe. He raises a special problem because the doctors who have seen him have agreed that he should be transferred to Broadmoor for treatment and the Broadmoor authorities have agreed to accept him but the Home Secretary refuses to grant permission for the transfer. He says that it would not be in the public interest, which seems paradoxical as Sutcliffe is likely to be more dangerous untreated in Parkhurst than he would be treated in Broadmoor—and neither institution is easy to escape from.

In addition to the Parkhurst wing there is the psychiatric prison at Grendon Underwood,¹⁷⁻¹⁹ which is a specialist prison for managing those who are mentally abnormal but not mentally disordered within the terms of the Mental Health Act. It is having some success in taking difficult prisoners out of the system and making them more manageable but little success in reducing reconviction rates. In addition, Wormwood Scrubs contains an annexe where group therapy is offered to sex offenders and those addicted to drugs or alcohol. The Butler committee on mentally abnormal offenders considered the idea that a second specialist psychiatric prison should be opened but rejected it, calling instead for improved psychiatric provision in all prisons together with more specialist units.²⁰ The Home Office is nervous of improving its facilities too much in case it finds itself saddled permanently with mentally abnormal offenders which it believes should be treated in the hospitals.

Sex offenders are a group whose problems are often seen as being medical—particularly by non-doctors. But apart from the Wormwood Scrubs annexe and Grendon no special treatment facilities are offered to sex offenders. In most prisons the sex offenders are segregated to protect them from other prisoners, and in addition there are three special units in the prison system in England and Wales. These offer protection, not treatment.^{21 22}

What prospect for the future?

The long delayed opening of the secure units provides one light on the horizon for the mentally abnormal within the prisons, but how much they will help is open to doubt. It is not even certain that they will help those who can be defined as mentally disordered under the terms of the Mental Health Act, and they will certainly do nothing for the majority of mentally

abnormal prisoners who do not fall within the Act. The question arises, as it has risen many times before,^{23 24} whether the prisons should themselves provide better facilities for the mentally abnormal. The two boxes that accompany this article and the last (28 January, p 308) contain some of the statements of the late Dr P D Scott, who was a psychiatrist at the Maudsley Hospital and at Brixton Prison. He was an independent thinker who believed strongly that the prisons should make better provision for the mentally abnormal. His argument was that you could never neatly divide up prisoners into mad and bad and lock up the bad and send off the mad to mental hospitals. It cannot be done, and the prisons will always contain mentally abnormal prisoners, many of whom will want and deserve treatment.

At the moment the tide seems to be running against Dr Scott's ideas. The prison authorities continue to want to move as many as possible of the mentally ill out of prison and they do not want to provide too many facilities for the mentally abnormal for fear it will weaken their hand in the move to get the mentally abnormal out. Indeed, Grendon seems to be being steadily denied resources so that many who work there fear that it will cease to be able to function as a psychiatric prison.²⁵⁻²⁷ In addition, penal experts have become disenchanted with psychiatry—perhaps because they once expected too much of it. The trend is for prisons simply to contain people without any overtones of treatment. But this philosophy perhaps fails to recognise that the aim of psychiatry is simply to help the health of the individual not control him or make him less likely to offend.

Dr Scott was surely right that more should be done to help the mentally abnormal in prison. But this need not be incompatible with easing the transfer of some categories of mentally abnormal prisoners into NHS or special hospitals. Nor need it be incompatible with reducing the number of prisoners, improving conditions in the prisons, and bringing much closer together—if not actually fusing—the prison medical service and the NHS.

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MATERIA NON MEDICA

Frontiers

To the young, frontiers have no meaning: all that matters is the point of arrival, usually an airport. In Delhi is delay and frustration; in Colombo, in normal times, cheerful chaos is made more difficult by the virtual impossibility of securing small denomination Sri Lankan currency before entry. Because of this baggage handlers in the restricted area have to be paid in 10p coins, naturally rather grumpily received. On emerging and waiting for a taxi, however, one is diffidently approached by a youngster with ten 10p coins neatly packed in a palm leaf, a £1 note is handed over—sterling notes are readily negotiable—and honour is satisfied; in this context carrying a few empty aluminium film canisters to store temporarily unwanted coins is a useful tip.

Entry to China can be a mild problem. Firstly, a two page visa form has to be completed, in answering which discretion is advised—under "Occupation" to write "journalist far to the right of Attila the Hun" would be unsuitable; something like "retired" is in order. This by no means provides you with a personal visa but only acceptance of your name and person on the tour guide's manifest. Chinese immigration officers have difficulty with English script and the often wildly inaccurate photographs, but our guide, though only a slip of a thing, was clearly an old China hand: she just pasted numbers on the outside of our passports in accordance with her alphabetical visa list and presented us, lined up platoon or revue chorus wise, with passports held up in front of us. The point was taken immediately, there were smiles all round, and we passed through to a cheerful obligato of

rubber stamping. Exit may be less easy: if from Canton one may travel in a sealed train of tourists and Chinese right through to Kowloon in Hong Kong, where a bevy of immaculately dressed female immigration officers await. I was regarded severely if not actively disapprovingly—one does get rather scruffy after an energetic Chinese holiday—so an outside sort of telephone book was consulted, and happily there was some sort of connection so I was reluctantly nodded through.

This outside sort of reference book is common in America, too, but if obviously English and hair cut reasonably short one is passed through with "Have a good time." Iron Curtain countries vary from the dour and severe to the relaxed, as in Hungary. Entry is easy here if you have plenty of hard currency—you can even get a visa and photograph done if you have not taken this necessary step beforehand. Exit is equally easy: the coach toilet is examined but merely, I infer, as a matter of form. Private cars are examined more closely in case any valuable object had been purchased with unregistered hard currency. My last and most recent contact was at the Norwegian-Russian frontier around lat 71N; here the actual entry is rather like a pair of estate park gates, unguarded but padlocked. There was a watchtower not too far off, doubtless to arrange for opening later that day to allow three convoys of butter to get through. The mosquito reigns supreme in these parts and is no respecter of persons; the perimeter fence is quite token on the Russian side, and a tourist found wandering four miles within it was promptly returned without formality on the assumption that he was trying to escape these pests. The area is politically sensitive and cameras and binoculars are not allowed, but a recommendation might be made for wearing a traditional bee keeper's outfit, even for a fleeting visit.—ROBERT CUTLER, Surbiton, Surrey.