Barred from treatment?

Women’s lives are being blighted because prisons are unable to meet their mental health needs. Kimmett Edgar and Dora Rickford outline the steps that could resolve this long-running problem.

The number of women in prisons (in England and Wales) is rising inexorably towards 5,000. Increasing numbers of these women have mental health problems and are being imprisoned inappropriately. For example, a major study found that four women prisoners in ten had received help or treatment for a mental health problem in the year before entering prison, while around one in six had been an inpatient in a psychiatric hospital (O’Brien et al 2001). The same study found that around one woman prisoner in 14 had been admitted to a locked or secure ward and two in three showed symptoms of at least one neurotic disorder.

The prison statistics for 2001 (England and Wales) provide a breakdown of the type of offences for which the women received into prison under sentence were convicted.

The small proportion of women in prison who have committed acts of violence (10 per cent), sexual offences (less than 1 per cent), burglary (3 per cent) or robbery (3 per cent) casts doubt on the view that these women must be imprisoned for the protection of society.

But, if this is the case, why are so many women with mental health problems in prison?

A wide range of services – crisis or home treatment mental health teams, social services, and court diversion schemes, for example – have been set up, in part, with the aim of preventing the inappropriate use of custody for people with mental health problems. But these schemes have failed to divert significant numbers of women from custody. Instead of support in the community, members of this vulnerable group are temporarily warehoused in prison, trapped in a system where the mental health care is of a lower standard than in the health service.

Women with severe forms of mental illness should not be in prisons. The problem is not new and reflects both the failure of NHS provision to provide sufficient places for the level of demand, and the lack of appropriate, accessible services which women are able to use. Women with less severe forms of mental illness do not necessarily need hospital accommodation but the prison environment can exacerbate their mental distress and is not the appropriate setting in which to provide care.

This article explores how the prison responds to the woman’s problem; and how her problems influence how she is treated in prison.

Despite the formal partnership between the Prison Service and the NHS that is being developed over the next three to five years, efforts to establish real equivalence with the NHS may not become a reality. This is because the gap between needs of women in prison and current practices in prison health care is too great to be met by the planned improvements alone, welcome though they are.

Reception

People remanded into custody often arrive late in the day after long journeys across the country, sometimes with inadequate food and drink. Those who were being prescribed medications may not have received them. It is not unusual for prisoners to arrive with no information about their health.

Reception is a critical time to identify those with mental health problems. Eight per cent of suicides occur in the first day of custody, 26 per cent in the first week, and 42 per cent in the first 28 days of custody (Marshel et al 2000). The inadequacy of reception screening has been recognised and new procedures trialled, but the lack of medically qualified staff with mental health training, remains problematic in most prisons.

Reed and Lyne (2000) inspected 13 prisons and found that no doctor responsible for the care of inpatients had completed specialist psychiatric training. Only a quarter of nursing staff had mental health training, and almost one-third of staff were in fact non-nursing trained healthcare officers.

Women with ‘dual diagnosis’ – having both a mental health disorder and a substance misuse problem – may find their first few nights in custody traumatic. The chief inspector of prisons for England, Anne Owers, raised concerns in her latest annual report that women’s prisons lack proper detoxification and appropriate therapy (HMCIP 2002).

Family ties

Family support is particularly helpful for people suffering mental health problems. Despite recognition that family ties can prevent re-offending, the prison system is adept at disrupting these networks. Although the number of visits overall has been falling over the years, this trend is marked for women. The small number of women’s prisons almost inevitably requires the prison service to accommodate any particular woman offender far from her home. Overcrowding has made the situation worse.

Prison discipline

On entering prison, a woman becomes subject to rules and punishments far more intrusive and controlling than she would encounter on the streets. For women with mental health problems, the web of discipline and the constant threat of punishments add to their distress.

The Office for National Statistics (ONS) survey found that the impact of the prison disciplinary system, which affects one-third of sentenced women, falls disproportionately upon those with mental health problems (O’Brien et al).

Ms Owers has also highlighted that the prison discipline system is sometimes misused to manage people whose underlying problems are mental health ones rather than a ‘breach of rules’, for example, by placing them in segregation when they should be in healthcare accommodation (HMCIP 2001).

Medication

The Revolving Doors Agency estimated that of the two thirds of women in Holloway Prison in north London who were not taking medication for stress, anxiety or depression when they entered prison, at least 90 per cent would have taken tranquillisers by the time they left (Revolving Doors Agency 2002). The ONS survey reveals that use of medication that affects the central nervous system is linked to custodial factors such as sentence length, time served, type of prison and time spent in cell (O’Brien et al 2001).

There is anecdotal evidence
that medication is used to contain a ‘problem’, sometimes being given by staff without special-
ist training in use of such drugs, and that women are rarely consulted or involved in their care and treatment.

Self harm
It is very difficult to measure the prevalence of self injury among women prisoners, as it is often hid-
dden from staff and other prisoners and what staff count as self injury may vary from prison to prison. Official figures probably under-estimate the scale of the problem. In gauging the extent of self injury, it is crucial to take into consideration both the number of women who engage in the behaviour and the severity of the harm inflicted. Attempts by the Prison Service to find more accurate meas-
ures of self injury in prison are welcomed. Staff who lack understanding of the problem can regard these women as a nuisance and as ‘attention seekers’. The prison service response has traditionally been to prevent self harm by removing items likely to be used by women. How-
ever, many of these women have used self harm prior to coming to prison and do so as a way of coping with their distress and hurt.

Suicide
Prisons inspector John Reed said there is ‘a belief that, whatever the deficiencies in prison health care, patients with serious mental illnesses are safe in a prison health care centre. This is not true. Over 14 per cent of all suicides in prison take place in a health care centre’ (Reed 2003).
There were nine self-inflicted deaths of women prisoners in England and Wales in the year 2002. By the end of March 2003, six women in pris-
ons in England had taken their own lives. Three were less than 21 years old.
Women prisoners are from 16 to 40 times more likely to die by suicide than women in the general population when adjustments are made for factors such as age and gender (though small figures require caution). Moreover, there is some evidence that the rate of self-inflicted deaths among women in custody is increasing faster than the population at large. Mackenzie et al (2003) reported that between 1996 and 2001 there was an increase of 67 per cent in the female prison population but an increase in self-inflicted deaths of 200 per cent.
Research has identified links between mental distress, the prison setting and suicide. For exam-
ple, the ONS study stated that ‘59 per cent of

The way forward
The Prison Reform Trust has developed a series of recommendations and an agenda for action. Set out in a forthcoming report by Rickford (in press), these proposals call on services to:
- respect and listen to women prisoners with mental health problems. For those who self injure, listen to what they say they need to cope more effectively, and implement changes where pos-
sible;
- meet NHS standards and protocols, partic-
ularly regarding use of medication, training for doctors and healthcare staff, with monitoring of mental health services by an independent agency;
- invest in accessible and appropriate mental health provision, drug treatment and supervision in the community specifically for women.

This would present a challenge to both the gov-
ernment and the Prison Service itself to begin to address the tragedy of wasted lives.

References

For further information about the Prison Reform Trust, visit: www.prisonreformtrust.org.uk