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No man's land: the experience of life-sentenced prisoners transferred to high secure psychiatric care

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Disclaimer: This article reflects our professional clinical views and not the views of the Trusts which employ us. Patient names have been changed to protect the identity of individual service users.

Introduction: Mental ill health and placement of male[1] life-sentenced prisoners

In this paper, we describe the experiences of male life-sentenced prisoners (hereafter referred to as 'lifers') who find themselves caught between two systems: the prison estate and high secure psychiatric care. We will argue that these are two very different systems with different approaches to care and risk management, and we describe how lifers who want to progress may experience challenges and dilemmas that other prisoners transferred to hospital do not face. We have used vignettes based on real cases to illustrate these challenges and dilemmas and are grateful to the men who agreed to share their thoughts about their experience with us to help us generate the vignettes.

Mental disorder in life-sentenced prisoners

Admission data reported by two high secure hospitals in England indicate that 39 per cent of the patients in those hospitals are prisoners transferred under the relevant sections (discussed below) of the Mental Health Act 2007 (hereafter MHA).[2] This proportion has increased from 28 per cent forty years ago. Most of these prisoners will either be lifers (including, three of the 63 individuals in the prison estate serving whole life orders)[3] or men who are detained under indeterminate public protection orders (IPPs).

Although studies of mental disorder in life-sentenced prisoners report mixed findings,[4,5] they suggest that these prisoners struggle with higher rates of mental illness and psychological distress than individuals serving determinate sentences (those with a fixed release date).[6] Like other prisoners, lifers often report exposure to multiple forms of adverse childhood experience.[7] However, unlike other prisoners, lifers experience specific psychological 'pains' and distress that comes with indefinite detention[8] and they are at an increased risk of suicide, especially in cases where the victim was a family member or partner.[9]

It is therefore unsurprising that life-sentenced prisoners may require admission for inpatient psychiatric treatment during their sentence. Provision is made for this in sections 47 and 49 of the MHA, which give the Ministry of Justice (MoJ) powers to transfer

1. The focus here is solely on males because the authors' professional expertise and current practice with life-sentenced prisoners is grounded within the male estate. There is to our knowledge little comparable research or commentary on the issues discussed here within the women's psychiatric and penal estate.
2. Personal communication: official data provided by the Mental Health Act Office at Broadmoor Hospital
3. As at end of December 2020. Ministry of Justice (2021). *Offender Management Statistics Offender Management Statistics Quarterly: October to December 2020 and Annual 2020*. Available at: https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2020/offender-management-statistics-quarterly-october-to-december-2020-and-annual-2020—2 (accessed 27 August 2021).
4. Swinton, M., Maden, A. and Gunn, J. (1994). Psychiatric disorder in life-sentenced prisoners. *Criminal Behaviour and Mental Health* 4(1), pp.10-20.
5. Duffy, D., Linehan, S. and Kennedy H.G. (2006). Psychiatric morbidity in the male sentenced Irish prisons population. *Irish Journal of Psychological Medicine* 23(2), pp.54-62.
6. U.S. Department of Justice Office of Justice Programs (2017). I*ndicators of mental health problems reported by prisoners and jail inmates*, 2011-2012. Available at: https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf (accessed: 4 April 2021)
7. Ford, K., Bellis, M., Hughes, K., Barton, E. and Newbury, A. (2020). Adverse childhood experiences: a retrospective study to understand their associations with lifetime mental health diagnosis, self-harm or suicide attempt, and current low mental wellbeing in a male Welsh prison population. *Health & Justice* 8(13), p.6666.
8. Leigey, M. (2010). For the longest time: the adjustment of inmates to a sentence of life without parole. *The Prison Journal* 90(3), pp.247-268.
9. Fazel, S. Hayes, A. J., Bartellas, K., Clerici, M. and Trestman, R. (2016). The mental health of prisoners: a review of prevalence, adverse outcomes and interventions. *Lancet Psychiatry* 3(9), pp.871-881.

sentenced prisoners to secure NHS facilities. Section 47 authorises transfer, based on medical recommendations, and section 49 gives the MoJ powers to restrict the movement of prisoners, based on perceived risk of harm to others.[10] Usually lifers will be assessed as high risk because of their index offence and therefore are usually referred for admission to a high secure (as opposed to a medium or low secure) psychiatric service.

Lifers in high secure care: assessment for transfer

Many prisoners who receive a life sentence will have been assessed by at least one psychiatrist during the trial process, usually in relation to raising a psychiatric defence. However, this is distinct from any assessment for treatment of mental illness developed while serving a sentence. Referral to prison mental health services typically occurs if a lifer is perceived to be mentally unwell, and especially if they exhibit behaviours which are thought to be linked to mental illness and are unmanageable in prison. Prisons are rightly concerned about the risk of self-harm and suicide and/or disturbed behaviour that leads to risk to others (including assaults on fellow prisoners and officers). Further, if a prisoner has a mental disorder which requires treatment with medication, and the prisoner refuses such treatment, then referral to secure psychiatric care is needed because prisons are not recognised by the MHA as places where treatment (such as medication) can be given involuntarily (i.e., forcibly).

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Before lifers can be transferred, there has to be agreement about the level of secure care needed. Prison psychiatrists usually refer to high secure psychiatric hospitals because of the nature of the offence and/or the risk that the prisoner poses in prison. However, the high secure hospitals may feel that the prisoner could be treated in less secure services like a medium secure unit; leading to disputes about the level of security that the prisoner needs. These disputes are linked to the difference between the risk assessments made for security purposes by the MoJ and HMPPS, and the risk assessments needed for treatment to be carried out safely in high secure care. Typically, anyone who has killed is thought to need admission to high secure psychiatric care, but not everyone agrees about this. The high-profile nature of an offence may also lead to referral to high secure hospital, even if this is not clinically necessary. High secure services can decline to admit a prisoner if they feel that they are too high risk for them to manage, or conversely could be managed in less secure conditions. Further, the Secretary of State can direct admission of prisoners in rare circumstances

A lifer who is to be transferred under section 47 of the MHA must be assessed by two doctors who are approved as having expertise in mental disorder. In practice, one assessment is usually undertaken by the psychiatrist working in the prison, and the other by a psychiatrist in the secure psychiatric hospital which will offer a bed. To be detained, the prisoner must have a diagnosable mental disorder which is potentially responsive to treatment, and this diagnosis will form the basis for a treatment plan. These individual treatment plans will be reviewed regularly by Mental Health Tribunals.

Delays in transfer for treatment are common. Rarely, treatment may be delayed if a prisoner's mental health needs are not recognised; more commonly, delays occurs if prisoners refuse to be assessed. Even more commonly, delays occur because there are insufficient secure beds for prisoners assessed as needing treatment in secure conditions, and there are associated disputes about the level of security that a prisoner needs for his treatment. Other professional disputes may arise in relation to whether a prisoner has a disorder of the nature and degree that makes it appropriate for him to be treated in hospital, and whether appropriate treatment is available. This is a particular issue for lifers who repeatedly self-harm but who have no other obvious 'symptoms' or signs of disorder, and for lifers convicted of sex offences, who often present with little evidence of the requisite functional link between mental disorder and sexual violence.

There is little available information about how and whether life-sentenced prisoners progress if transferred to secure hospitals under section 47/49. Grounds[11]

10. *Mental Health Act 2007*. Available at: https://www.legislation.gov.uk/ukpga/2007/12/contents (accessed: 2 April 2021).
11. Grounds, A. (1991). The transfer of sentenced prisoners to hospital 1960-1983: a study in one special hospital. *British Journal of Criminology* 31(1), pp.54-71.

reviewed 380 cases referred to one secure psychiatric hospital and noted that 28 per cent were lifers. He also found that the nature of the offence could affect the length of detention; for instance, that sex offenders tended to be detained beyond the expiry of their original sentence. A study of 21 severely mentally unwell men in HMP Wakefield[12] reported that seventeen were referred for transfer to hospital, and that lifers were more likely to be refused. The author inferred that the indeterminacy of their sentences counted against them, and argued for increased provision for long-term psychiatric care for mentally disordered prisoners.

In conclusion, we do not have good quality information about outcomes for lifers transferred to secure psychiatric care. Referral from prison is often driven by concerns about risky behaviour, and not about improving mental health, and the combination of stigma plus bed shortages means that lifers may struggle to access the care that they need.

No man's land: tensions between two systems

Beginning treatment: assessment of risk and security needs

Treatment of lifers involves attention to improving mental health and reducing risk to self and others. Although each case is individually tailored and person-centred, most patients will be prescribed medication for obvious psychiatric symptoms. They will also be offered psychological therapies that address both trauma and violence; and this may be in groups or individually. They are also supported by mental health nurses and occupational therapy services. There are national guidelines about the treatment of various conditions which the secure hospital is expected to follow. Treatment ends when the person's mental state is considered stable.

The MHA Code of Practice[13] states that patients should be treated in the 'least restrictive environment' necessary for the restoration of their mental health, but this stance may — and in fact often does — conflict with the penal requirement which reflects both risk assessment and (usually) an element of punishment.

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We have met lifers whose clinical presentation could practically be managed in medium security, but whose index offence and public profile have been used by the MoJ as justification for detention in high secure care. This is an example of how the objectives of mental health legislation can conflict with the laws regarding the management of prisoners; and how public perceptions of risk and the need for punishment affect decisions made about lifers in psychiatric care.

The end of treatment and remission to prison

Once transferred to high secure care for treatment, individuals serving life can expect to remain there until their treatment is concluded and they are considered well enough to be discharged from MHA section and resume their sentence. The period of time in hospital counts towards their tariff. The Ministry of Justice guidance[14] on the use of section 47/49 recommends that prisoners should be remitted (returned) to the prison from which they came. For some prisoners this can feel like a backward step; but for others, it may mean that they can resume their progress towards parole.

In reality, however, there are many factors that extend the time that prisoners are held in secure psychiatric care, including the process of (a) deciding to remit and (b) actually finding a prison placement. This process is involved and often protracted, requiring attention to an interaction of complex factors including: the lifer, their offence and personal history; the views of the psychiatric team about the prisoner's mental state; the risk they may pose to others; and institutional concerns within NHS England about the cost of high secure hospital management. Concerns within the prison estate arising from the wider socio-political context of the prisoner's life and offence are also often relevant, such as the nature of the offence, the views of victims and the prisoner's public profile.

In practice, we have found that the remission process can be slow. Prisons can refuse to take back the men referred, even when there is good evidence that they wish to return, to progress in prison. This can leave

12. Hargreaves, D. (1997). The transfer of severely mentally ill prisoners from HMP Wakefield: a descriptive study. *Journal of Forensic Psychiatry* 8(1), pp.62-73.
13. Department of Health (2015). *Mental Health Act 1983: Code of Practice*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.pdf (accessed: 12 April 2021)
14. The Parole Board (2020) *Guidance on Restricted Patients and the Mental Health Act*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940449/Guidance_on_Restricted_Patients_and_the_Mental_Health_Act_-_October_2020.pdf (accessed: 1 June 2021).

men stuck between the two systems. Disputes are often about the presumed difficulty of managing a prisoner with mental illness in prison, e.g., in relation to medication, and the differences in perspective about health needs, as was the case for John:

> *John was convicted of murder aged nineteen, at a trial in which the legal doctrine of 'joint-enterprise' was used. He was sentenced to life with a tariff of fifteen years. After a few years, John began self-harming very badly and started striking out against prison officers with extreme violence. He was thought to be suffering from a psychotic episode on a background of emotionally unstable personality disorder, and admitted to high secure hospital. Initially, he struggled with the hospital regime but over time engaged well in therapy to regulate his moods more consistently, with the additional aid of medication.*
>
> *After seven years in hospital, John had stopped self-harming and commented 'I've grown up here, think it's done me good. I've learned how to manage my thoughts and I take better care of myself. But I need to get back to prison, it's boring here and I've got to do my offence-related work…I want to apply for parole and see if I can have a life outside'.*
>
> *John's remission to prison has been agreed but there are currently some disputes about whether he could have medication in prison, with some prison staff saying yes and others saying no. This has caused anxiety for John who self-harmed in response to his stress.*

For many lifers, admission to hospital for treatment is the first opportunity they have had to properly engage in their own mental health and to gain treatment in a milieu in which they feel cared for. If there is no mental health in reach team, then prison staff may be anxious about prisoners being on medication for conditions like psychosis. Some therapeutic community (TC) programmes in the Offender Personality Disorder (OPD) pathway have also refused to take prisoners on medication, arguing that it goes against the ethos of a prison TC. This can make progression difficult for a lifer with personality disorder who needs to complete work in the OPD programme and also benefits from medication. Some lifers, like John, are willing to take medication and cooperate with treatment in prison, and then are anxious about being taken off the treatment that has helped them.

Equally some men are extremely distressed at the thought of going back to prison when, for the first time, they feel mentally well, cared for and able to reflect on themselves and their offending. Taking medication can become a focus of this tension and distress, with some men stating that they will not take medication if they return to prison so they should not be remitted, effectively putting the treating team under pressure to keep them in hospital.

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Security and therapy disagreements

The decision to return a lifer to prison can generate specific tensions between the security ethos of the prison and the therapeutic ethos of the psychiatric system. For example, a lifer who presents as acutely psychotic in prison but who makes a good recovery in hospital would clinically be seen as needing transfer to a medium secure unit (MSU), as the next step in recovery from his ongoing condition. However, the Ministry of Justice may oppose a move to an MSU on the grounds of risk to the public and public anxiety, while MSUs are often already at full capacity with their own prison admissions, and reluctant to take lifers who may still have many years to serve.

MSUs also focus on recovery and community discharge, which is often unrealistic for lifers, who can then feel stuck compared to other patients, as Matthew described in his case:

> *Matthew, a 43-year-old man, was convicted of a double homicide and sentenced to life with a minimum tariff of several decades. He was in prison for the first five years of his sentence. He was then transferred to a secure hospital after presenting with a combination of anger, paranoia and fear, leading to a diagnosis of paranoid psychosis. Although he*

does not accept that he has a mental illness, he has accepted medication leading to a notable improvement in his mental state.

Matthew found the hospital system a place of solace for his mental health in multiple aspects. Despite this positive experience in hospital, Matthew knows he cannot move to an MSU because he has a very long sentence to serve. He is resigned to a return to prison at some point. But he still does not accept that he needs medication and so he will probably not take it if he returns to prison, which may mean that he relapses and has to be readmitted to hospital again.

Lifers often express a valid concern that the psychological therapy that they do in high secure care is not recognised by the prisons as accredited offender behaviour work. Only Offending Behaviour Programmes in prison, which are accredited by the Correctional Services Accreditation and Advice Panel (CSAAP), 'count' as evidence at a parole hearing or at a re-categorisation review. The CSAAP panel does not evaluate interventions in general mental health care, even those services managing offenders with mental health problems. For lifers, this lack of recognition of their treatment and its impact on their self-perceived risk level is deeply problematic; and they often express distress when they learn that their hard work in therapy will not be recognised as risk reducing in terms of any parole hearing.

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Lifers with no therapy options

There are particular challenges facing lifers with a diagnosis of personality disorder, especially those with lengthy tariffs. Personality disorder (PD) is unlike other mental illnesses in that it requires a specific kind of treatment programme, which involves attention to childhood adversity and relationships with others. A specific pathway of prison programmes for lifers with personality disorder has existed since 2012 (the OPD noted above programme).[15] However, the need outstrips demand, especially for those prisoners who have other mental health problems such as chronic psychosis or depression. The high secure hospitals have had some success in treating men with severe personality disorders using a combination of medication, trauma-based individual work and group-based interventions such as mentalisation based therapy.[16] However, it is often hard to convince other psychiatric services, including medium secure services, to admit prisoners with personality disorders, especially if they have many years to serve, so lifers can end up getting stuck in high secure care: too unwell to be in prison, but unable to move to less secure conditions.

Luke's case sets out the dilemma. He was very suicidal in prison, but his risk to others was thought to be too great for him to go to a medium secure service. He is now better but does not want to leave hospital.

Luke is a man in his 40s who was sentenced to life imprisonment for rape, and who has been detained many years past his tariff. This is because he has had several admissions to secure psychiatric care due to self-harm that is of a degree that prisons cannot manage, although the behaviour quickly stops in hospital. He has refused to do any offence related work, because he says 'it was a long time ago and not very serious'.

Luke's treatment team wanted to remit him back to prison as they see no evidence that he has any treatment needs. Luke wants to stay in hospital despite not wanting to engage in any treatment or believing that he has a mental health problem. The prison service is reluctant to taking him back, saying that he needs more therapy.

Luke is therefore detained under mental health legislation, while actively consenting to be there. His refusal to leave means that he is using a very expensive

15. See Joseph, N. and Benefield, N. (2012). A joint offender personality disorder pathway strategy: an outline summary. *Criminal* Behaviour and Mental Health 22(3), pp.210-217.
16. Newbury-Helps, J., Feigenbaum, J. and Fonagy, P. (2017). Offenders with antisocial personality disorder display more impairments in mentalizing. *Journal of Personality Disorders* 31(2), pp.232-255.

psychiatric bed (£400,000 per year) while other people who need it are unable to access care.

Getting unstuck: clinical considerations on future policy and practice

In November 2021, a new Directorate of Security was set up in HMPPS to address the needs of prisoners in high secure prisons; and they have recently issued guidance[17] about how best to ensure that prisoners with health needs do not get stuck between systems. Professional groups exist to identify pathways for prisoners which address both their mental health and offender rehabilitation needs. Meeting regularly allows for closer working relationships, which can identify examples of good practice as well as gaps in services.

The new guidance is especially helpful for those lifers who want to go back to prison and feel able to manage there. However, it cannot address the problems of lifers who from a clinical perspective need only medium secure care, but whose tariff and risk profile means they will need extended care and treatment. Because 'length of stay' is a key performance indicator for most NHS mental health Trusts, professionals who run medium secure units resist taking patients who may need costly long-term care. The new Directorate has no authority to challenge such decisions.

Recently, it has been proposed that NHS England, the Ministry of Justice and HMPPS work together as partners in pilot projects to improve the remission process. There would be a specific emphasis on reducing the number of changes in care over the course of a sentence, ensuring that patients are remitted to the most clinically 'appropriate' prison establishment (rather than propriety being dictated by prison security concerns), and permitting security re-categorisation to be reviewed and decided while the individual is still in hospital. Such pilots could achieve a reduction in pressure on individual establishments, fewer transfers of care between prisons and better discussion about how to provide the statutory aftercare in prison to which prisoners who have been detained under the MHA have a technical right of access under s117 of the Act.

Prisoners who are remitted back to prison describe problems and concerns about the abruptness and binary nature of the change: hospitals and doctors one day, prison and officers the next. We have heard prisoners describe a wish for something much more joined up, which might be described as transmural forensic mental health care. One of us (CR) proposed a remission model which involves setting up a 'Landing Pad' unit at a single prison, staffed by both HMPPS and NHS staff. Such a unit would allow the prison forensic psychiatrist to offer some continuity of care while enabling onward progression with regard to offence-related work and parole applications. The prisoner himself could feel more confident that his mental health is being considered important alongside 'doing his time'.

Our experience is that there are real ethical and clinical tensions between the demands of justice (completing one's sentence and returning to the community on parole) and the demands of the prisoner's welfare. The situation is not helped when well-meaning professionals (whether legal, medical, prison or nursing) tell prisoners that transfer to hospital means that they will be able to stay in hospital for the length of their sentence when, in reality, limitations on resources meant that this may not be possible.

We also wonder about our duties as forensic psychiatrists to respect the integrity of the justice process, and the claims of the civic society that sent a man to prison for an offence of serious (often fatal) violence. We consider there is something respectful about supporting a man to return to prison when he no longer needs to be in hospital, but still has work to do in prison about how to desist from future violence. We suggest that there are some patients who should be encouraged to think about their return to prison as soon as they are admitted to secure psychiatric care, and to integrate the likelihood of return into care-planning during their hospital admission. In return, we should work in such a way that mental health recovery is integrated with risk reduction work, and that there is transparency about what prisoners can expect from mental health services for prisoners.

Conclusion

In this paper, we have described how lifers who need psychiatric care may find themselves in a 'no-man's land' between secure psychiatric services and the demands of the prison service in relation to progression towards parole. We would strongly argue that treatment in secure hospital care should be recognised as part of an offence-related risk reduction programme, which can be used in re-categorisation decisions as well as parole hearings.

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17. Her Majesty's Prison & Probation Service. (2021). *Hospital Remission Strategy*. London: HMPPS.