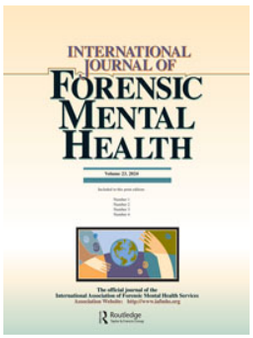

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"Prison Life Can Make You Go Crazy": Insights Into the Situation for People With a Mental Illness in the Malawi Prison System

Marie Claire Van Hout[a], Ruth Kaima[b], Chisomo Magwejani[b], Vivian Kasunda[b], Kesten Nyson[b], Peace Khoviwa[b], Malumbo Phiri[b], Victor Mhango[b], and Stephanie Kewley[a]

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ABSTRACT

Little is known with regard to due process and forensic assessment capacities in Africa, where over one million are deprived of their liberty on any given day. A rapid situation assessment explored multi-stakeholder perspectives regarding the situation of people with a mental illness in the Malawi prison system. In-depth interviews were conducted with 10 regional professional stakeholders, 18 former prisoners, and five prison staff from two maximum-security prisons. Reflexive thematic analysis yielded five themes; *occurrence of mental illness among people living in prison; prison environment exacerbating harm and levels of mental illness; security responses to the presence of psychiatric disorders; availability and coverage of specialist psychiatric and psychological care;* and *diversion, other non-custodial measures and continuity of care on release*. Narratives highlight the substantial causal impact of the prison environment in amplifying existing and new mental illness, vulnerability and exploitation of people with a mental disorder. Malawi prisons are hampered by lack of specialist forensic capacity nationally; centralized mental health surveillance system; and insufficient skilled staff to conduct evidence-based screening and care. Security operations implement the use of pharmacological and physical restraint measures at times. Faith-based organizations play an important role in providing psychological and spiritual support. Release and reintegration require family involvement. A cross departmental intersectoral partnership response spanning government ministries, key civil society organizations, the Malawi Prison Inspectorate and Malawi Human Rights Commission is warranted. Recommendations include alleviation of prison congestion, prison staff capacity building and investment in forensic mental health services with adequate geographic coverage.

KEYWORDS

Malawi; prison system; mental illness; forensic mental health

Background

There are over 11.5 million people living in prisons and other detention settings globally (Penal Reform International, 2023). People with mental illness in conflict with the law experience a broad range of health and social vulnerabilities and challenges (Baranyi et al., 2019; Barrett et al., 2014; Butler et al., 2022; Fazel & Seewald, 2012; Fazel & Wolf, 2015; Houston & Butler, 2019; Mundt & Baranyi, 2020; Zhang et al., 2011). Prison populations are substantially affected by mental illness and co-morbidities (Fazel et al., 2016; Fazel & Seewald, 2012; Jack et al., 2018). This is unsurprising given rising rates of mental illness globally (WHO, 2022) and where documented regionally in prisons (WHO, 2023).

In Africa, the rights of people with a mental illness and people deprived of their liberty are provided for in various international and regional human rights frameworks (Organization of African Unity, 1981; African Commission on Human and Peoples' Rights, 2002). Their rights to humane and dignified detention, due process and substantive equality rights are further affirmed in the 2018 African Disability Rights Protocol (signed by Malawi on 6 February 2022). Systematic reviews however document a concerning prevalence of mental illness among people detained in African prisons (Lovett et al., 2019; Mundt et al., 2022). Ineffective functioning of criminal justice and mental health systems and difficulties in ensuring specialist forensic

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assessment of triability are reported (Schwikkard & Van Der Merwe, 2016; Van Hout & Wessels, 2021) and contribute to over-representation of mental illness among those in contact with justice and penal systems, including lengthy and often arbitrary, whilst awaiting assessment, detention with little access to medical support and psychiatric intervention (Ethiopia, Ghana, Malawi, Nigeria, South Africa, Zambia, Zimbabwe and Kenya) (Abdulmalik et al., 2014; Agboola et al., 2017; Armiya'u, Audu, et al., 2013; Armiya'u, Obembe, et al., 2013; Beyen et al., 2017; Calitz et al., 2006; Dejene-Tolla & Sisay-Taddese, 2021; Hayward et al., 2010; Ibrahim et al., 2015; Kanyanya et al., 2007; Menezes et al., 2007; Modupi et al., 2020; Naidoo & Mkize, 2012; Nseluke, 2011; Osasona & Koleoso, 2015; Van Hout, Kaima, Mhango, et al., 2023).

Malawi is a least developed country in sub-Saharan Africa (OECD, 2022). There is no direct provision specific on the right to health in the 1994 Constitution (2020 amendment) with exception of the provision of right to health care as a fundamental principle under Section 13. Section 12(d) provides for equality rights before the law and Section 13 provides for principles of national policy, concerning, inter alia, gender equality, persons with disabilities, children, and the elderly; and enjoins the state to "actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation." Furthermore Section 30 (2) provides for the right to development which further requires the Malawi government to take necessary measures for the realization of development which includes measures to ensure equal access to health services. This includes ensuring adequate evidence based mental health care commensurate with the needs of the Malawian population.

The National Mental Health Policy of 2000 has been revised several times since 2014, and remains in draft format (Malawi Human Rights Commission, 2022). Mental health legislation and policies to uphold the rights of the mentally ill and/or mentally incapacitated in the Malawi criminal justice system are however underdeveloped (and under-resourced) (Van Hout, Kaima, Mhango, et al., 2023). At the constitutional level, rights accorded to those in prison include the right to live in a humane and dignified environment (Section 19), right to adequate nutrition and access to medical services (Section 42(b)). Whilst the 1948 Mental Treatment Act (Chapter 34:02) provides for the general care of persons who are "suffering from mental disorder or mental defect" in psychiatric hospitals; it distinguishes between self and court referral for care; and does not contain specific provisions regarding the treatment for any particular group, such as individuals in contact with the criminal justice system once they are admitted. Furthermore, whilst mental health disorders are recognized as a disability under the Disability Act (No. 8 of 2012) and the Act does not contain explicit reference to prisons, the Act does give power to the Court to make an order for an alternative place to stay in for a patient in detention at the police station or prison, whilst waiting to be transferred to the mental hospital following a reception order (Section 23). In reality, such places do not exist in Malawi hence the routine detention of mentally ill offenders in police holding cells and prisons.

Current provisions in the Criminal Procedure and Evidence Code (Section 133), and the Malawi Penal Code (Section 12) do not comply adequately with the United Nations Convention on the Rights of Persons with Disabilities and the Protocol to the African Charter on the Rights of Person with Disabilities in criminal proceedings (Van Hout, Kaima, Mhango, et al., 2023). At the time of writing, the new Correctional Services Bill is drafted and not yet tabled at parliament. Part IX of the existing 1956 Prison Act Section 64(g) refers to the separation of prisoners suspected or certified as being of unsound mind; with Sections 72 referring to mentally disordered or defective prisoners; and 73 (removal of sick prisoners to hospital) and 74 (serving sentence while in hospital) potentially applicable in the event of serious illness (despite no explicit reference to mental illness).

There are 30 prisons in Malawi, with the system operating at 234% capacity (as of most recent data from October 2022) (World Prison Brief, 2023). Conditions have deteriorated substantially in recent years due to inadequate government resourcing of basic needs provisions, continued congestion despite COVID-19 release schemes, and dated colonial infrastructure damaged by various adverse weather events such as cyclones and drought (CHREAA, 2021, 2022; CHREAA et al., 2023; Gadama et al., 2020; Gauld, 2021; Jumbe et al., 2022; Malawi Inspectorate of Prisons, 2019, 2021; Malawi Law Commission, 2018; United States Department of State, 2020; Van Hout, 2022; Van Hout, Kaima, et al., 2022; Van Hout, Mhango, et al., 2022, Van Hout, Kaima, Mhango, et al., 2023; Van Hout, Southalan, et al., 2023). Food insecurity and cramped cells particularly in male prisons fuels exploitation of the weak and interpersonal violence (Nkambule et al., 2023; Van Hout, Kaima, et al., 2022; Van Hout, Kaima, Mangwana, et al., 2023; Vizsolvi, 2021).

There is no official health surveillance data on rates and profiles of mental illness in Malawi prisons. The prison system relies on the only state operated psychiatric hospital (*Zomba Mental Hospital*) and one private psychiatrist hospital (*St John of God Center*), with only two prisons providing ad hoc mental health screening and treatment (*Maula* holding circa 2906 prisoners in the Central Region; *Mzuzu* holding circa 894 prisoners in the Northern Region) (Van Hout, Kaima, Mhango, et al., 2023). In 2021, anecdotal reports from civil society organizations suggested the presence of mentally ill prisoners in Maula prison and Chichiri prison (holding circa 2389 prisoners in the Southern region). These individuals were observed to be suffering from depression, psychosis and other mental health conditions (CHREAA, 2021). Building on a 2023 socio-legal assessment of the judiciarisation of the mentally ill and mentally incapacitated in the Malawi criminal justice system which revealed procedural gaps and flaws of human rights protection (Van Hout, Kaima, Mhango, et al., 2023), the aim of the study was to explore and document multi-stakeholder such as professionals, prison staff, and former prisoner perspectives regarding the situation and lived experience of people with a mental illness living in Malawi prisons.

Methods

Ethical approval for the study was granted by Liverpool John Moores University (23/PHI/012) and in the College of Medicine Research & Ethics Committee, University of Malawi (P.03/21/3281) in April 2023.The project was led by the Center for Human Rights Education Advice and Assistance (CHREAA) a research active civil society organization which works with prisons and supports former prisoners in Malawi. A qualitative rapid situation assessment (RSA) research design (United Nations Office for Drug Control & Crime Prevention, 1999) was developed by the team in an equitable collaborative manner. RSA are useful in producing "real time" accurate, contextually rich evaluations and identifying actionable information in short timeframes; especially pertinent when assessing organizational aspects of public health and healthcare in development or humanitarian contexts (Cifuentes et al., 2006; Green et al., 2015). We adopted a multi-level RSA approach by using multi-stakeholder interviews to scrutinize three levels of determinants to garner insights and assess the complexities of mental illness in the prison system from the perspectives of people living, working and managing facilities (professionals and policy makers, prison staff and people with lived experience of incarceration). Multi-stakeholder interviews aimed to explore diverse perspectives (professional, prison staff and lived experience of incarceration) regarding how the Malawi prison system manages adult prisoners with mental illness. A set of draft questions were developed by the lead author based on prior review of African literature, civil society reporting and socio legal assessment of the Malawi situation (CHREAA, 2021; Van Hout, Kaima, Mhango, et al., 2023), with further refinement by the research team prior to ethical approval and subsequent data collection.

Convenience sampling was used to recruit former prisoners and prison staff participants (Trochim, 2002). Former prisoners accessing CHREAA for post release support activities were invited to volunteer to partake in the study. Inclusion criteria centered on adults of both genders with a prison discharge within the past six months and having served a custodial sentence of longer than three months. Available prison staff which included security and management staff were invited to take part in the study on the appointed day of security clearance for the research team to enter male and female wings of the two largest maximum-security prisons in Malawi (*Chichiri* in Blantyre, Southern Region; *Zomba* in Zomba, Southern Region).

A purposive sample of key informant professional stakeholders with national and regional level knowledge/experience of correctional services in Malawi were identified by CHREAA and invited to partake in the study. Participants represented the Malawi Human Rights Commission, Malawi Prison Inspectorate, Ministries of Justice/Health, judiciary, senior prison system officials, senior law enforcement officers, non-governmental organizations (NGO) and relevant United Nations agencies, and all had recent experience within the Malawian prison system (within the last six months).

All participants were provided with written and verbal information on the study and were advised of the option to withdraw at any time or to not respond to any question if they felt uncomfortable. Verbal and written consent was secured prior to participation and participants were assured of anonymity and confidentiality. Interviews with former prisoners were conducted in a private and trusted space in the CHREAA offices. Prison staff and professional stakeholders were interviewed in private in their own offices. Interviews were facilitated by two trained researchers with one posing questions and probes, and the other taking detailed notes. Conversations were also audio recorded with

permission of the participant. All identifiable information was removed to ensure anonymity, with generic labels ("former prisoner," "male prison officer") applied to participants. Where the inclusion of gender or prison location might identify a participant (e.g. in the professional stakeholder group) this information is not presented. Likewise, while participants were encouraged not to make any disclosures that might identify themselves or others where this did occur, information was redacted from the transcript. See Table 1 for a breakdown of the participant characteristics.

A paradigmatic framework of interpretivism and constructivism guided data collection and analysis. Researchers worked reflexively throughout the process. Periodic briefing sessions were scheduled throughout the duration of the project where researchers could raise and discuss experiences with members of the team. Individually, researchers collecting and analyzing data were encouraged to keep reflective logs. Whilst there was no requirement for these to be included into the data corpus, these were used as a personal aid for individual researchers' own process. Interviews were conducted to data saturation and then analyzed carefully and sensitively respecting the subjectivity of participants' narratives around their observations of people with mental illness in Malawian prisons, and related prison system operations. Audio recordings were transcribed verbatim in the language the interview was conducted (English or Chichewa). A sample of five transcripts were back translated into English by two members of the CHREAA research team to ensure original meaning was not lost during the translation.

We recognize several subjective factors could influence the research process. We understood participants' reality to be constructed by their own lived experiences and thus, an existence of varying degrees of power and inequality between researcher, participant, and the worlds in which they both experience. These include gender, culture, mental health status, social standing, and age. Researchers were, therefore, attuned to the idea that participants would likely hold varying political, social, and cultural values around mental health, incarceration, justice, power, vulnerability and so on. Consequently, the team worked sensitively and respectfully with research participants, while also recognizing the potential of power inequity.

Reflexive thematic analysis of data was undertaken with scientific rigor ensuring adherence to the six phase steps (Braun et al., 2019). This involved data familiarization and early identification of ideas via manual transcription, reading and re-reading the transcription by researchers (individual and in pairs); initial development of coding schemes and the systematic coding by two researchers followed by iterative theme and sub-theme generation; team refinement of themes as a collective and examination of coherence across themes; finalization and naming of themes, and organizational writing up (Byrne, 2022). At the initial coding development phase two researchers worked independently through a selection of interview transcripts and inductively generated a set of codes. Codes were subsequently compared and where discrepancies were noted, these were discussed within the team during periodic briefing sessions to reach consensus. Reflexive thematic analysis yielded five themes; *Occurrence of mental illness among people living in prison; Prison environment exacerbating harm*

Table 1. Participant characteristics.

	Gender		Prison	
Participant type ($N = 33$)	Male (*n*)	Female (*n*)	Chichiri (*n*)	Zomba (*n*)
Former prisoners	10	8	16	2
Malawi prison officials (senior management and prison levels)				
Senior prison system: healthcare*	1	–	–	1
Senior prison system: administration*	1	–	–	1
Clinical health officer	–	1	1	–
Prison officers	1	1	2	–
National professional stakeholders**				
Malawi Prison Inspectorate (1)	–	–	–	–
Judiciary (2)	–	–	–	–
Malawi Human Rights Commission (1)	–	–	–	–
District Health Office (1)	–	–	–	–
Director of Public Prosecution (2)	–	–	–	–
Human rights NGO (2)	–	–	–	–
Mental health NGO (1)	–	–	–	–

Note. Former prisoner participants were on average 35.5 years old ($SD = 7.8$). Females were on average younger than male prisoners. Females ($M = 33.6$, $SD = 8.0$) Males ($M = 37$, $SD = 7.8$).
Prison staff and professional stakeholders were on average 42.4 years old ($SD = 7.7$).
*Zomba is the Malawi Prison Services Headquarters. www.mps.gov.mw.
**National professional stakeholders included six males and four females but to protect anonymity individual gender are not provided.

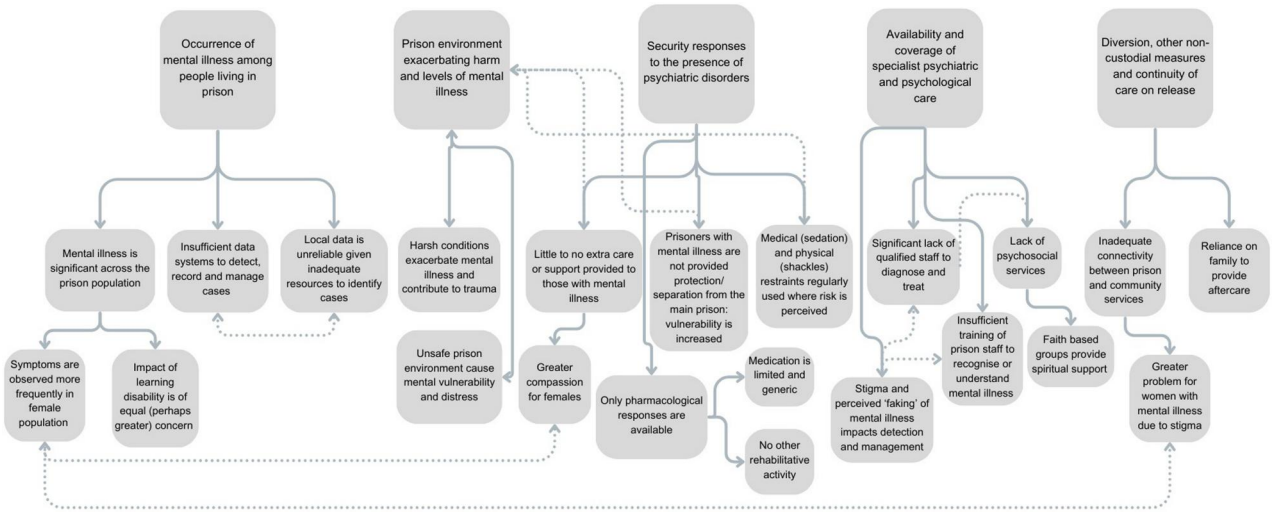

Figure 1. Thematic map.

and levels of mental illness; Security responses to the presence of psychiatric disorders; Availability and coverage of specialist psychiatric and psychological care; and *Diversion, other non-custodial measures and continuity of care on release* (Figure 1).

Results

Occurrence of mental illness among people living in prison

There was consensus across participant narratives that all had observed the presence of a number of mentally ill individuals living in prison. Perceived prevalence is perhaps more evident in the female population. One female former prisoner was aware of up to 20 women with mental health issues living in the female wing of *Chichiri* prison, thus, with approximately 35–40 women housed on this wing, more than half appeared to her to experience mental ill health. Perspectives varied with regard to perceived prevalence of mental illness as opposed to learning disability in the Malawi prison population. A male participant formerly detained in *Chichiri* prison observed; "You know (chuckles) those you will be talking to … at times they don't follow through a proper/coherent conversation … " Indeed, many participants thought that the number of individuals with learning disabilities was much greater than those suffering with psychiatric illness; " … during the time I was serving my sentence the number of mentally ill prisoners was 12 only. …. those with mental disabilities are many … " *(Male former prisoner, 36 years, Chichiri).* A male prison officer at Chichiri prison supported this by estimating that in his prison: "we have about 23 who have different mental disorders, but I don't know about across the Malawi Prisons system."

Understanding the current occurrence rates of mental illness across the prison system is problematic as several professional stakeholders observed the Malawi prison system has no centralized data system in place to collate routine mental health surveillance data, both, in prison or when discharged into the community. One senior prison staff was optimistic that while "we do not have a centralized data system, we are developing one general one so we should be able to include data on the mentally ill as well" *(Senior prison system staff: Administration, Zomba).* This would be a critical resource for helping report health data as each prison was described as currently maintaining its own health data system, which is then shared with the prison system headquarters on monthly request; "I have worked closely with Maula prison, we had data that was compiled showing those with serious insanity, as well as other mental illnesses like depression, anxiety, those on treatment" *(National professional stakeholder: Human Rights NGO).*

Some challenges were documented by health professionals with regard to the credibility and robustness of the mental health data held at site level given the lack of capacity for psychiatric diagnosis by prison healthcare staff, and the (over) reliance on visible behavioral signs and symptoms. Some prison officers and other professionals working in the prison system at senior levels speculated that there is substantial likelihood that the number of those with underlying and undiagnosed psychiatric illnesses is actually much greater than reported because: ".in a country like Malawi, we only look at mental illness as the severe

one where it is very clear that one has actually lost their mind" *(Male prison officer, Chichiri).*

Prison environment exacerbating harm and levels of mental illness

There was consensus across the sample that congestion and the deteriorating prison conditions in Malawi, particularly in the large prisons (*Chichiri, Zomba, Maula*) already heavily over capacity, elevate prevalence and incidence of mental illness, and further contribute to trauma, new disease and worsening of existing psychiatric conditions; "I mean, (pauses a bit) it is no secret that prison conditions are harsh, so mostly depression, anxiety is very common" *(Male prison officer, Chichiri).* One former prisoner reflected on his time in prison noting how " … in our time, the number of these people was very small, but now, as we hear what is happening in prison, the number is gradually increasing" *(Male former prisoner, 35 years, Chichiri).* Official recognition of the impact of prison environment on mental health appears to be deprioritized, due to more pressing securitization concerns relating to inter-personal and custodial violence and disease mitigation (tuberculosis, human immune deficiency virus: HIV, syphilis, COVID-19) priorities. A senior prison official confirmed this, reporting how: "Unfortunately, we tend not to pay much attention to such prisoners … unless it comes to the worst. Most people do not know that depression is a disease, and it kills. In our prisons such conditions are mostly downplayed" *(Senior prison system staff: Healthcare, Zomba).*

Many participants and particularly former prisoners described how prior to incarceration people are in general good mental health. The harsh congested and abusive prison environment, homesickness and the prospect of serving severe custodial sentences exacerbates levels of mental stress and anxiety, mental health vulnerability and illness among those deprived of their liberty. One former prisoner declared:

> Most came into prison while normal, but it's the challenges faced in prison that can make a person go crazy … a lot become confused or crazy … a sentence too stiff … families that left out there … treatment, especially from fellow prisoners, we abuse each other. People become crazy and mentally disturbed (Male former prisoner, 35 years, Chichiri).

Some former male prisoners illustrated the impact of unsafe conditions for people with mental illness. They reported how they are at substantial risk of exposure to theft of supplies brought by family members, exploitation, and sexual abuse:

> Many are not safe because they taken as imbeciles; people do to them things they don't want. They are not well protected and they don't have a choice, they are always told what to do … they are not safe on their own … if relatives bring food and other necessities, then they will be taken away by other prisoners (Male former prisoner, 42 years, Chichiri).

Prison cell leaders [*prisoners in-charge*] were described by former prisoners as exploiting people with mental health conditions for various purposes (sexual, food, provisions) because " … they are so greedy because they only take care of someone who they think they can benefit from. I have never seen those prisoner's in-charge attending to the mentally ill" *(Male former prisoner, 38 years, Chichiri).* There is little intervention from other prisoners or prison guards.

Most former prisoners (of both genders) observed how others around them developed some degree of mental health problem shortly after entry to the prison (including when on remand), which worsened over time when serving the custodial sentence. One former male prisoner felt; "there are a lot of such people, they go crazy because of the [stiff] sentence that was meted out to them" (*Male former prisoner, 35 years, Chichiri).* There was substantial concern around healthy individuals with good mental health entering prison and deteriorating into various (untreated and serious) psychiatric disorders: " … they suffer a lot … in the morning, you will find a person dead because he was trapped and pressed amongst the crowd" *(Male former prisoner, 49 years, Chichiri).*

Security responses to the presence of psychiatric disorders

Many participants with lived experience of incarceration reflected on the almost non-existent special or preferential treatment by prison officials toward those with mental illness. This was especially the case in congested male prisons; "I have never seen a prison warder helping someone who is mentally ill. There is no special treatment, they treat everyone the same" *(Male former prisoner, 49 years, Chichiri).* In contrast, in female wings, prison officers were observed to care for vulnerable women in a more sensitive and empathic manner; " … they treat you different from others, they do understand that these are mentally disturbed, and we shouldn't treat them badly" (*Female former prisoner, 23 years, Chichiri).*

Many participants referred to the security risks of cramped cells housing substantial numbers of prisoners, in some instances including people with a mental illness. Some professionals observed the need for prisons to acknowledge risks associated with mental illness in the congested stressful prison environment and to request referral back to court, one mental health NGO stated that:

> The prison should really bring it to the attention of the court when they discover that someone with severe (and potentially violent) mental illness. That would really help to ease the situation. Otherwise, we will have a number of them who will harm others and cause chaos (National professional stakeholder: Mental Health NGO).

Indeed, officials observed that segregation of people with a mental illness from the mainstream prison population or use of solitary confinement for the purposes of control is not frequently implemented in Malawi prisons due to excessive congestion. Most prisoners are left to mix with others regardless of their mental health status, however, exceptions occur in the event of serious and potentially violent conditions that may pose a danger to the other prisoners. In those instances, the individual is referred to the Zomba Mental Hospital subject to availability and; "… we don't separate them … we combine them … we don't have cells separate for those mentally ill … unless the level of mental illness is high" *(Male prison officer, Chichiri).*

In response to people perceived to present a danger to others, several prison system officials referred to the routine implementation of restrictive physical (shackles) to confine mentally ill individuals; "we do not have special cells, so most are mixed with the rest of the normal prisoners. Some will even be bound … even with leg iron when they are very violent and uncontrollable. What can we do [chuckles] if we let them loose, they will be a danger to the rest of the prisoners" *(Senior prison system staff: Healthcare, Zomba).* Another approach used to manage people with mental illness is the use of pharmacological measures (sedation); "… that prison doctors are just trained to sedate the prisoner … they are constantly just under heavy sedation" *(National professional stakeholder: Prison Inspectorate, Zomba).*

Availability and coverage of specialist psychiatric and psychological care

There was consensus across all narratives that the Malawi Prison system does not have capacity to adequately detect, diagnose, monitor and treat individuals with psychiatric illness. Referral capacity is challenging due to the lack of psychiatric hospitals in the country (*Zomba Mental Hospital, St John of Gods*). Many professional participants observed the lack of forensic mental health specialists; "… we don't have them here" *(Female prison officer, 42 years, Chichiri)* or at national level, and this deficit significantly impacts the judicial processes, prison occupancy levels and prison safety and security itself.

The capacity of clinical staff working in prisons was deemed insufficient, mainly due to the lack of staff with specialist psychiatric qualifications; "the simple answer is that they don't have the training" *(Senior prison system staff: Healthcare, Zomba*). This is an issue because staff are unable "… to adequately support prisoners experiencing mental health conditions and/or psychosocial disabilities" *(National professional stakeholder: Mental Health NGO).* Several national professional stakeholders described efforts to sensitize and upskill prison healthcare staff in recent times and work in a more coordinated manner with psychiatric hospitals, district health officers and NGOs. Substantial challenges were described in terms of geographic coverage across the 30 prisons in the system meaning that despite having "… four clinicians that have undergone psychiatric training, but this is nothing compared to the number of prisons that we have" *(Senior prison system staff: Healthcare, Zomba).*

Medical detection of mental illness appears to be minimal and ad hoc. A senior prison official said, "… we do not have qualified psychiatrists equipped with expertise to do thorough screening. We do conduct screening, but it is not comprehensive, it is only easy to note if one has some serious symptoms of insanity … we do not have proper screening tools" *(Senior prison system staff: Healthcare, Zomba).* Screening uptake by prisoners on entry into prison and during sentence was observed by many participants to be affected by both stigma of mental illness, and of efforts to fake mental illness in order (in both instances) to be sent for referral:

> Anyone who goes to Zomba Mental hospital is deemed to be insane, even if it is a mental illness like depression. Most prisoners would rather not even partake in screening sessions when a chance arises in fear of being told that they have a mental illness and be looked down upon by their fellow inmate (National professional stakeholder: Mental Health NGO).

The majority of professional stakeholders observed a prison system reluctance to recommending referral of prisoners to *Zomba Mental Hospital.* Some

comments were made by male former prisoners that people living in prison exaggerate mental symptoms in order to be released early; "People say that aah! They are just pretending to be mad so that they will be pardoned" *(Male former prisoner, 28 years, Chichiri).* One national professional stakeholder was in favor of early release schemes on the basis of mental illness; "I do not think we should have a problem releasing them for a certain period of time because keeping them in prison is hazardous" *(National professional stakeholder: Judiciary).*

Narratives underscored the system preference to manage prisoners pharmacologically inside the prison due to the lack of resources for psycho-social therapy or other rehabilitative activities. Drug supply to support pharmacological intervention of symptoms was however observed to be problematic; "Prisons do not have a variety of psychotropic drugs to meet the mental health needs of different prisoners" *(National professional stakeholder: Mental Health NGO).* Many former prisoners described the important adjunct role played by faith-based organizations who access prisons regularly in support of the prison system and provide vital provisions (food, clothing, soap, porridge, juices) and therapeutic supports to the prison community: "We do have church groups and even pastors who visit us and cheer up the prisoners. Others provide counseling but then this is spiritual counseling. Sometimes I think you need more than that. … but the distraction does help to some extent" *(Female former prisoner, 23 years, Chichiri).*

Diversion, other non-custodial measures and continuity of care on release

Participants observed the limited utilization of community-based alternatives to incarceration for persons with mental illness, despite the active and effective juvenile diversion system for young people in conflict with the law. All national professional stakeholders and prison officers observed great concern with regard to linkage to care of individuals with mental illness on prison release, and their involvement in the revolving door of incarceration. Transitional mental healthcare planning and follow up in the community was reported to be challenging for various reasons (capacity of probation and parole systems, lack of communication with family due to stigma). This was especially the case for women who were observed to experience the impact of double deviance as a result of both the stigma of mental health illness and label of prisoner:

> … they are just released out, and they may not get to their home; some of them are found in the street, the mental illness becomes worse when they get released … they forget the direction to their home village because there was no relative to take them home. They just let them go without notifying their relatives to come to pick them (Male former prisoner, Chichiri, 38 years).

Many male former prisoners observed the importance of family in supporting those on release and in timeframes after incarceration; "… my elder brother was in prison and he became mentally ill but when he came home after 6 months of taking care of him; he got better, now he is fine" and "… people that I know were crazy while in prison, many of them, but have recovered and are well."

Discussion

In 2022, the Malawi Human Rights Commission promulgated its concerns around lack of capacity to response to mental illness in the community and the potential for human rights violations of people with mental illness detained in closed settings. We present the first known RSA investigation of the situation of people with mental illness in Malawi prisons; building on earlier civil society reporting and socio-legal examination of this issue; which highlight systemic and structural challenges with regard to arbitrary detention of persons with mental illness for lengthy periods, often without timely access to specialist forensic assessment and access to mental health treatment whilst detained (CHREAA, 2021; Van Hout, Kaima, Mhango, et al., 2023). Our qualitative multi-stakeholder findings contribute to a much-neglected area of prison and justice health research on the continent and are intended to support legislative and policy reforms to better uphold the human rights of those deprived of their liberty. In terms of strengths and limitations, while the study does not claim to be representative of the system, the triangulation of multi-stakeholder narratives largely relevant to the prison headquarters and three largest prisons in Malawi, holding between 2,300 and 3000 prisoners each (*Chichiri, Zomba, Maula*) is a particular strength of this work. Limitations center on the lack of access of the research team to prison medical records regarding confirmed psychiatric diagnosis, gaps in available data where mental health assessment is documented at facility level, participant observations originating from individuals not medically qualified, and potential for power imbalance despite application of rigorous ethical protocols between researchers and former

prisoner participants. The practitioner-academic collaboration of the research team went someway to mitigate these limitations. As noted by Clarkson et al. (2023), the blend of both legal practitioners and penal academics provided a useful blend of "insider/outsider" perspectives, this was important particularly during the analysis process.

Crucial findings from our study indicate that in reality forensic mental health capacity in Malawi is very limited. The Malawi criminal justice continuum including its prison system is stretched and under-resourced with regard to basic operations, and particularly in terms of national specialist forensic competency and capacity to support court operations (Pienaar, 2022; Van Hout, Kaima, Mhango, et al., 2023; Van Hout & Wessels, 2021). This impacts substantially on the efficiency of court forensic mental health assessments, contributes to congested remand conditions and the capacity (and competency) of prison security and health staff in the Malawi system to deal in a sensitive, competent, and therapeutic manner with mentally ill detainees (CHREAA, 2021, 2022; Van Hout, Kaima, Mhango, et al., 2023; Vizsolvi, 2021). Our study reports directly from two of the largest prisons in the country, operating at over 200% capacity. The remand proportion of the Malawi prison system remains high (17.6%) (World Prison Brief, 2023). The situation for people with a mental illness housed in such congested prisons in Malawi is life threatening; at best harsh.

The study is reflective of the complex interactions and direction of causality of mental illness rates related to importation of mental illness compounded by pre-adversaries, and deprivation due to the prison environment and exposure to trauma (Armour, 2012; Cunha et al., 2023; Fazel et al., 2016; Gabrysch et al., 2020). Of great concern are the narratives of persons with lived experience of prison in our study who observed the deterioration of mental health of their peers on entry and during their sentence, and prison level inability to adequately support these individuals and ensure their safety. Deprivation and harsh living conditions in Malawi's prisons appears to act as a catalyst as increased numbers of cases of mental illness are reported. Life-threatening and traumatic impact of the Malawi prison environment amplifies trauma, mental vulnerability, and existing and new psychiatric illness (see also Nkambule et al., 2023; Van Hout, Kaima, Mhango, et al., 2022; Van Hout, Kaima, Mangwana, 2023; Vizsolvi, 2021). Evidence of prisoners with mental illness being abused by other prisoners is a cause for concern, not least with regard to the spread of HIV and syphilis (Gondwe et al., 2021; Nkambule et al., 2023; Van Hout, Kaima, et al., 2022, Van Hout, Kaima, Mangwana, et al., 2023; Vizsolvi, 2021). Furthermore, there is substantial likelihood that rates of underlying and undiagnosed psychiatric illnesses are far greater than those observed due to the lack of evidence-based screening tools used by prison staff and their reliance on observing visible behavioral symptoms. Despite small cohorts of 30–40 female prisoners in Malawi prisons (1.1%, World Prison Brief, 2023), a concerning high presence of mentally ill women in the minority female prison population was observed by some former prisoners we interviewed. From a trauma deprivation perspective, literature elsewhere indicates that women are particularly vulnerable to the detrimental impacts of prison on their mental health and have higher rates of psychiatric disorders (Armour, 2012; Wallace & Wang, 2020).

Notwithstanding the deplorable congested conditions experienced by those living in Malawi's prisons, the lack of special care of mentally vulnerable prisoners is concerning. Prison system measures to deal with mental illness in Malawi are hampered by lack of centralized mental health surveillance and the absence of routine evidence-based screening processes on committal and at various timepoints during sentence. Internal efforts to capacitate prison staff as reported here are encouraging and ongoing cascade training is required to support further sensitization and provision of adequate evidence-based therapeutic care to affected individuals. Prison "Peer Education" programs can support stigma reduction and awareness raising, dissemination of mental health information and could assist in mental health screening uptake. Faith based organizations as elsewhere in Africa play an important adjunct support role to the official system response in providing basic provisions and spiritual support (Muntingh, 2020). Finally, prerelease planning and follow up in the community is challenging and requires involvement by families and ongoing mental health support and treatment.

Our study also points to various rights violations of mentally ill persons in Malawi prisons according to the United Nations normative standards of detention (e.g. spatial congestion, inadequate food provision); right to dignity and respect (of the mentally ill); right to humane treatment and prohibition of torture (e.g. involuntary pharmacological and physical restraint measures); and right to access free nondiscriminatory healthcare (e.g. psychiatric treatment, drugs) when deprived of liberty (CHREAA et al., 2023; Vizsolvi,

2021). In particular the routine administration of sedatives and shackles of the mentally ill for security purposes by staff violate the fundamental human rights of people with disability and those deprived of their liberty; and contravene medical ethics pertinent to the role of prison health personnel in the protection of prisoners from torture, and various United Nations treaties regarding the rights of the disabled and norms and standards of detention of special prisoners contained in the Nelson Mandela Rules (United Nations, 1983, 2007, 2016). Arbitrary and lengthy detention of the mentally ill (e.g. due to delays in court ordered forensic mental assessments) also constitutes an excessive sanction and is potentially classed as torture (Goomany & Dickinson, 2015; Gulati & Kelly, 2023; Pienaar, 2022; Van Hout & Wessels, 2021).

Conclusion

Improving living conditions in Malawi prison is a fundamental imperative to mitigate escalation of mental illnesses that develop in prison due to abuse, trauma and the harsh environment, and consequent exposure to inter-personal violence. Judicial application of formal diversion options and non-custodial measures is critical (Pienaar, 2022, Prinsloo, 2013; Prinsloo & Hesselink, 2014; Schutte & Subramaney, 2013; Van Hout & Wessels, 2021). A cross departmental government and intersectoral partnership response is recommended to alleviate unsafe conditions and prison congestion, invest in building a comprehensive forensic mental health service with adequate geographic coverage to support justice system operations, and operationalize a centralized data base on mentally ill persons in prison and linked to community care. Stakeholders should include the Ministry of Justice; spanning the justice continuum (police, court, prison); Ministry of Health (public and mental health structures), Ministry of Gender, Community Development and Social Welfare (community reinsertion and Throughcare) and Ministry of Finance, key civil society organizations, the Malawi Prison Inspectorate and Malawi Human Rights Commission. Further in-depth monitoring and evaluation, clinical auditing and research is required.

Conflict of statement

The authors have no conflicts of interest to report.

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Data availability statement

Data not available. Participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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