Written evidence from the British Medical Association (YDS0018)

The BMA is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

We welcome this timely inquiry by the Joint Human Rights Committee into solitary confinement and restraint in the youth secure estate. This submission outlines our concerns and recommendations, based on the experiences and views of doctors working across the secure estate.

Executive Summary

For children and young people who are still in the crucial stages of developing socially, psychologically, and neurologically, the health effects of isolation, solitary confinement and restraint can be particularly damaging.

There is an unequivocal body of evidence on the negative health effects of solitary confinement, including anxiety; depression; rage and aggression; cognitive disturbances; paranoia; and in the most extreme cases, hallucinations and psychosis.[i][ii][iii].

We are calling on Government to end the use of solitary confinement, segregation, removal from association or any similar practice which amounts to a child or young person being physically and socially isolated for prolonged periods of time of a punishment.

National data on the use of solitary confinement within the youth secure estate are not currently collected centrally and as such no accurate data exists as to how many children and young people are being held in isolation and for what period of time.

The United Nations Committee on the Rights of the Child,[iv] the European Committee for the Prevention of Torture,[v] and the United Nation’s Special Rapporteur on Torture[vi] have said that solitary confinement should never be used on children and young people. The UK must act to ensure it complies with its obligations under international human rights law

Non-solitary confinement options for managing behaviour must be created within the youth secure estate, with adequate resources and staff, to meet the needs of children and young people.

We call for a fundamental culture shift in the use of force and restraint in the children’s secure estate, and calls on the Youth Justice Board and individual institutions to take steps to address this. Restraint in medical treatment.
Does the use of restraint and segregation in youth detention lead to children’s rights being commonly breached?

1.1. The BMA has joined with the Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists to call for an end to the use of solitary confinement of children and young people detained in the justice system, launching a joint statement to this effect in April 2018[vii]. We believe that the use of solitary confinement, segregation, removal from association or any similar term, which amounts to a child or young person being physically and socially isolated for prolonged periods of time as a punishment, amounts to a breach of their human rights.

1.2. Between 2003 and 2011, six young people under the age of 18 died in the children’s secure estate[viii]. Five of those deaths were ruled as self-inflicted by hanging; the other was the result of “positional asphyxia” during the use of restraint. The Prison Reform Trust’s (PRT) report into the deaths of children and young people in custody, Fatally Flawed, found that almost universally, the children and young people who died were:

- amongst the most disadvantaged in society, with a history of mental health problems, substance misuse, and/or self-harm; and
- had been exposed to bullying and treatment such as restraint and segregation. The PRT report concluded that these children and young people had been failed by the systems designed to protect them from harm.

1.3. In one instance, a visiting psychiatrist conducted an assessment through a cell door, which we are finding to be a too frequent occurrence, showing how easy it is for children and young people in detention to become dehumanised and to receive a standard of care which would be wholly unacceptable in the community. It is also a clear breach of the individual’s human rights.

1.4. Since 2013 there have not been any self-inflicted deaths for under 18s, however, we are deeply concerned to see that this trend is not true of self harm or in other age groups. There were 195 instances of self harm reported for under 18s in the secure estate in 2017, a figure which has increased every year since 2014.[ix] In addition, for young people under 21 there were three deaths in custody in 2017, all of which were reported as self-inflicted and six in 2016, of which five were reported as self-inflicted[x]. In under 21s instances of self-harm numbered 1094 in 2017. We consider this to be an unacceptably high level.[xi] Given the reported links between solitary confinement and restraint and mental ill health, we believe that moves to eradicate the use of these processes are likely to have a positive impact on reducing instances of self-inflicted harm.
Solitary confinement

1.5. There is an unequivocal body of evidence on the negative health effects of solitary confinement, including anxiety; depression; hostility, rage and aggression; cognitive disturbances; hypersensitivity to environmental stimulation; paranoia; and in the most extreme cases, hallucinations and psychosis. A smaller number of physiological effects are reported and include cardiovascular, respiratory, gastro-intestinal and sleep disorder complaints. Formal data on the rates of self-harm and suicide in or following solitary confinement are not collected on a national basis, but there is compelling anecdotal evidence that the prevalence of such incidents are particularly high.[xii] Negative health effects can occur after only a few days in isolation, but the severity of symptoms increases with the length of confinement.[xiii]

1.6. For children and young people, who are still in the crucial stages of developing socially, psychologically, and neurologically, the health effects of isolation and solitary confinement can be particularly damaging. Very few will have developed the resilience necessary to withstand solitary confinement.[xiv] Evidence from the US shows that young people experience symptoms of paranoia, anxiety and depression even after very short periods in isolation, and that young people who spend extended periods in isolation are more likely to attempt or commit suicide.[xv]

Restraint

1.7. The use of restraint is highly controversial. There have been numerous calls for independent investigations into the use of restraint in the children’s secure estate[xvi], with some organisations calling for a complete ban of the practice, or at least severe restrictions and rigorous safeguards on its use[xvii]. We believe restraint should not be used on particularly vulnerable individuals, nor those aged under 18.

1.8. The Ministry of Justice policy framework states that restraint should only ever be used on children as a last resort where it is absolutely necessary, and where no other form of intervention would be appropriate[xviii]. The Ministry of Justice also states that it should only be used to prevent a child from causing harm to themselves or others, and should never be used as a form of discipline or for securing compliance. The use of restraint other than out of absolute necessity is in direct contravention of Article 3 of the European Convention of Human Rights, which protects the freedom of people from torture and inhumane or degrading treatment or punishment[xix]. The European Court of Human Rights affirmed this in Keenan v UK, stating that the use of physical force on a prisoner which has not been made strictly necessary by his own conduct diminishes human dignity and is an infringement of Article 3 rights[xx].
1.9. In 2016-2017 there was an average of 702 instances of Restrictive Physical Interventions (RPI) per month, with an average of 17% of children and young people held across the secure estate affected[xxi]. We consider this indication that just under one in five children is subject to restraint to be unacceptable. The House of Commons Justice Committee expressed concern that despite restraint being definitively linked to the death of at least one young person in custody it is still being used.[xxii] 2016-2017 statistics revealed that 100 instances of restraint in 2017 resulted in injury.[xxiii]

1.10. Aside from its physical effects, the use of restraint can also have a profound psychological impact. Lord Carlile’s review found that children and young people felt “violated and abused” following restraint, while patients with a history of mental disorder linked to abuse often associated restraint with earlier traumatic experiences. Even witnessing the use of restraint led to a divisive “us and them” attitude between staff and children. The links between the use of restraint and self-harm and suicide are insufficiently explored and substantiated and unsubstantiated. However, the evidence which emerged during the inquests of the deaths of some of those in custody points to the severe distress caused by the use of force against vulnerable children, particularly those who have suffered physical or sexual abuse[xxiv].

1.11. Prisoners are entitled to the same rights of healthcare as wider society. This includes a right to dignity and privacy. Despite this, there have been several high-profile cases where seriously ill prisoners were routinely restrained in hospitals[xxv]. When receiving medical treatment outside a secure setting, there should be a presumption that prisoners should be examined and treated without restraints, and without prison officers present, unless there is a high risk of escape or the prisoner represents a risk to themselves or others. Discussion and assessment of this risk should take place between the health team and prison officers on a case by case basis. Healthcare professionals are entitled to ask for handcuffs to be removed during assessment and treatment, and for accompanying officers to leave the room. More detailed information on the restraint of detainees in NHS facilities can be found in our guidance, The medical role in restraint and control: custodial settings.[xxvi]

2. Is the guidance on restraint and segregation compliant with human rights standards?

2.1. Any mechanism, whatever it is called, which results in a child or young person being physically and socially isolated for prolonged periods of time is solitary confinement, and has no place in the criminal justice system. The scale of the use of solitary confinement is difficult to assess as there are no central data on its use. Some estimates suggest that one in three detained children and young people will spend time in solitary confinement, with the duration of confinement ranging anywhere from an average of 8 days,[xxvii] up to 60 or even 80 days.[xxviii] [xxix]. Given this lack of data it is very hard to establish how solitary confinement is applied and whether its use is in line with existing guidance. We believe that as current methods of recording solitary confinement are not robust, there is a clear need for this to be standardised and believe this is a key point for the committee to consider.
2.2. Overall the UK is increasingly out of step with a growing international consensus that solitary confinement should never be used on children and young people. The United Nations Committee on the Rights of the Child,[xxx] the European Committee for the Prevention of Torture (CPT),[xxxi] and the United Nation’s Special Rapporteur on Torture[xxxii] have said that solitary confinement should never be used on children and young people and that the UK Government must act to ensure it complies with its obligations under international human rights law. Furthermore, worsening staff shortages mean that many children and young people are held in their own rooms on accommodation wings in conditions akin to solitary confinement, for upwards of 22 hours per day, as institutions impose more restrictive regimes to manage the detained population.[xxxiii] Following the 2016 CPT report on UK prisons which included Young Offenders Institutes (YOIs),[xxxiv] there were clear examples of boys being held in isolation for many hours. We are particularly concerned that government continues to reject that these instances qualify as solitary confinement, as they reiterated in their response to the 2016 CPT report[xxxv] and their response to the recent Westminster Hall debate on the use of solitary confinement on children and young people in the justice system.[xxxvi]

2.3. Existing guidance should be modified to ensure that where a child or young person must be separated from others as an immediate response to violent or disruptive behaviour, or for their own safety or that of others, it should take place in a non-solitary confinement environment with adequate resources and staff to meet the needs of children and young people. Their physical, mental and educational needs must continue being met.

2.4. Lord Carlile’s review found that there was a range of terms used for solitary confinement across the youth secure estate, including segregation, single separation, isolation and “time out.” It also acknowledged that it can be a very useful tool for deflecting tension and possible conflicts[xxxvii]. Whilst the use of segregation was time limited in both Secure Training Centres (STCs) and Secure Children’s Homes (SCHs), the review found that it was routinely used in YOIs, and seen primarily as a tool for punishing poor behaviour rather than dealing with an immediate threat. One example of this was included in the 2016 CPT report on Cookham Wood where boys were reported as being held for 23 hours in solitary confinement[xxxviii]. Lord Carlile’s Review described the most basic conditions of segregation units as “inducements to suicide.”[xxxix] It also expressed concern over their use of solitary confinement children with mental health problems.

2.5. Traditionally, codes of medical ethics have stressed that a doctor’s primary loyalty is to the welfare of the patient. The GMC’s Good Medical Practice states that doctors should make the care of their patients their first concern.[xl] For many doctors working in secure settings, ordinary obligations to individual patients can come into conflict with the demands of the secure setting. Dual loyalties arise where a conflict emerges between professional duties to a patient and obligations, express or implied, to the interests of a third party, such as an employer, insurance company or government. Doctors who work in secure settings are faced with dual loyalties due to the structure in which they work, and the tension between providing an appropriate secure setting, and ensuring that children receive the help and welfare they need. The UK is free from some of the more obvious human rights abuses which permeate the justice systems in many other countries, for example, using medical skills on behalf of the state to inflict harm or the denial of medical treatment to those
in need. However, the danger in the UK of subordinating a patient’s interests in favour of those of the institution can lead to more subtle pressures that undermine the rights of individual patients.

3. Is the Government doing enough to ensure rights compliant standards are applied across the estate, including in privately run institutions?

3.1. As highlighted earlier in this submission we do not believe that solitary confinement has a place within the secure estate and believe that restraint must only be used in exceptional circumstances. Current use of restraint is still unacceptably high and lack of data make it impossible to understand the extent to which solitary confinement is used, and to what extent its use is compliant with government guidelines.

3.2. In addition, the doctor’s role in supporting young people in these environments can encounter conflicts of interest when they are asked to certify if an individual is fit for solitary confinement (which doctors should refuse to do) or are unable to secure appropriate mental health support for a child or young person held either in solitary confinement or subject to restraint.

3.3. It is crucial that these issues are addressed to ensure that children and young people’s human rights across the secure estate are upheld,

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[xxix] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2017) Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 30 March to 12 April 2016. Council of Europe: Strasbourg. Paras. 96-97.


[xxxiv] Council of Europe, Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 30 March to 12 April 2016 https://rm.coe.int/168070a773

[xxxv] Response of the Government of the United Kingdom to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to the United Kingdom from 30 March to 12 April 2016, https://rm.coe.int/pdf/168077fa13

[xxxvi] Westminster Hall debate, Use of solitary confinement on children and young people in the justice system, tabled by Seema Malhotra MP, 01 May 2018


[xxxviii] Council of Europe, Report to the Government of the United Kingdom on the visit to the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 30 March to 12 April 2016, p. 9 https://rm.coe.int/168070a773