MEMORANDUM OF EVIDENCE FROM THE BRITISH MEDICAL ASSOCIATION TO THE HEALTH
AND SOCIAL CARE SELECT COMMITTEE INQUIRY INTO PRISON HEALTHCARE

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 have worked for many years to promote fundamental human rights in relation to healthcare. This
has included advocating for individuals and populations experiencing infringements of their health-
related rights. It was in this context that we published Young lives behind bars, and our recent joint
statement on ending solitary confinement for children and young people.

We welcome this timely inquiry by the Health and Social Care Select Committee into prison healthcare.
This submission outlines our concerns and recommendations in relation to health and wellbeing
across the secure estate, highlighting the experiences and views of doctors working in prisons and
young offender’s institutions (YOIs).

Executive Summary

- There must be an equivalence of care in the secure estate compared to with the wider
  community is not respected.
- With instances of self-harm at its highest ever recorded level, it is crucial that more is done to
  meet the mental health and safeguarding needs of the prison population. Specifically, we
  would welcome measures to increase transparency and reporting of issues such as self-harm
  in a “league table” type format, which will improve accountability of individual prisons.
- Except in exceptional circumstances, doctors should always have access to a patient’s medical
  records. We welcome moves to establish information-sharing strategies and systems between
  prison and the community, to improve assessment of mental health needs, and to aid in
  prescribing. We hope to see these data management systems implemented over the next 12
  months and recommend that their effectiveness is reviewed regularly.
- Current provision and accessibility of mental health support in prisons is not sufficient to meet
  the above average need of the prison population. It is, therefore crucial that timely provision
  of relevant support services is improved.
- Targets should be introduced to reduce deaths in the secure estate and health provision
  should feature much more prominently in the commissioning, leadership and governance of
  prisons.
- Given the nature of an ageing prison population, there should be a statutory requirement for
  prisons to support the health and wellbeing of offenders, reinforced by expanding the scope
  of the prison population data set to monitor and record health indicators of the prison
  population including chronic conditions, mental health and instances of self harm.
- Difficulties in accessing external services are part of a much wider problem around the
  recruitment and retention of prison staff. Improvements in healthcare cannot be achieved
  without greater investment in ancillary staff and support.
- We are concerned by the disruption caused to prisoners’ healthcare when they are
  transferred from one prison to another, as this results in referrals and assessment processes
  often needing to be started again from scratch, a process which can impact on the delivery of
timely diagnosis and/or treatment.

1. The effectiveness of prisons and prison healthcare services in the management of the physical
health, mental health and social care needs of prisoners. This includes the extent to which
prisons and prison healthcare services effectively identify, treat and manage the health and
social care needs of prisoners, including prisoners with: long-term conditions; disabilities and social care needs; and urgent and emergency health issues, including incidences of suicide and self-harm.

Equivalence of care

1.1. One of the core concerns raised by doctors working within the secure estate is that the principle of equivalence of care in the secure estate compared to with the wider community is not respected. For instance, this can include doctors being required to routinely cancel both inpatient and out-patient treatment in NHS hospitals, often due to a lack of transportation and escorts. We believe that it is unacceptable for treatment to be delayed in this way. This issue will be explored further throughout this submission.

Assessment and identification

1.2. Many prisoners will arrive in detention with no accompanying medical history, which slows down and reduces the accuracy of the initial assessment undertaken on arrival. The result of this is that this first opportunity to provide someone with the type of support they need may be missed. To improve on the overall assessment of vulnerable prisoners, it is crucial that there is improved information-sharing with agencies who have previously interacted with the individual. Without access to medical records, prison GPs are in effect prescribing without the patient’s history of pre-existing conditions or drug use, including even whether they have a history of overdose. To address this worrying situation, we welcome moves to establish information-sharing strategies and systems between prison and the community, to improve assessment of mental health needs, and to aid in prescribing. We hope to see these data management systems implemented over the next 12 months and recommend that their effectiveness is reviewed regularly.

1.3. The reception area, where initial prisoner assessments take place, can be busy, hectic, and stressful and as a result of this the initial assessment may be rudimentary. Very often the staff member carrying out the initial screening and assessment process will not be a mental health specialist, meaning that crucial indicators of mental health problems are overlooked, or attributed to poor behaviour. Mental health practitioners should be seen as an integral part of the reception team, or in the case of overwhelming demand, that staff undertaking the assessment and screening process should receive specific training in recognising and identifying mental health problems.

Alternatives to prison for vulnerable people

1.4. We support the use of diversion and liaison schemes currently in place across England, to identify vulnerable people and to provide alternative routes other than prison for addressing their specific, often health related needs. In particular, we note that the initial evaluation of these schemes found an increase in the number of people with vulnerabilities who were identified.¹ We recognise that at present, these schemes are only available in some areas and so we welcome the additional investment from HM Treasury which will increase their coverage.²

1.5. Effective liaison and diversion from the criminal justice system are, however, dependent on the community services being in place to enable appropriate care and support, and we are

¹ Disley E, Taylor C, Kruithof K et al. (2016) Evaluation of the Offender Liaison and Diversion Trial Schemes. RAND Europe: Cambridge.
concerned that this is not always the case. A chronic shortfall in funding for mental health services (particularly child and adolescent services) continues to create problems of access for those in need of support. Prison should always be the place of last resort for those identified as vulnerable, particularly if underlying health conditions have a bearing on the individual’s likelihood to engage in offending behaviours.

**Mental Health**

1.6. Statistics on the prevalence of mental health disorders in the secure estate vary, but one, often cited, study suggests that at least nine out of ten prisoners have one or more of five psychiatric conditions (psychosis, neurosis, personality disorder, alcohol misuse and drug dependency)\(^3\). Despite this, individuals detained in prison are far less likely to have had meaningful interactions with community health services, their contact with the criminal justice system may be the first time their needs are identified and addressed.\(^4\) We believe that current provision and accessibility of mental health support in prisons is not sufficient to meet the above average need of the prison population. It is, therefore crucial that timely provision of relevant support services is improved. We have significant concerns regarding the rising number of incidents of self-harm and suicides in prison:

- Instances of self-harm are at their highest ever recorded level, in the 12 months to December 2017, there were 44,651 incidents of self-harm, up 11% from the previous year. The number of self harming individuals increased by 6% to a new record high of 11,630\(^5\).
- There were 299 deaths in prison custody in the 12 months to March 2018, down 13% from the previous year. Of these, 69 were self-inflicted deaths, down from 115 in the previous year, but still at an unacceptable high level\(^6\).
- 46 per cent of female prisoners and 21 per cent of male prisoners have reported attempting suicide at some point in their lives, compared to 6 per cent of the general UK population.\(^7\)

1.7 We recommend that specific targets are introduced to reduce deaths in the secure estate and that health provision is featured much more prominently in the commissioning, leadership and governance of prisons. To this end we welcome the prison reform announcements giving prison governors’ greater responsibility for commissioning services, whilst simultaneously improving transparency and believe this represents a strong opportunity to improve the current situation.

**Older Prisoners**

1.8 We would draw the Committee’s attention to the increase in the proportion of prisoners aged over 40, from 22% in 2005 to 33% in 2016 and note that this figure is predicted to increase further over the coming years.\(^8\) An ageing population generally has greater instances of ill health than a younger cohort. This is particularly relevant as the average life expectancy of a prisoner, reported by the Prisons and Probation Ombudsman, is only 56\(^9\). The BMA considers that while not attributable to being in prison, this is still a worrying reflection of the overall wellbeing of

---


\(^6\) Ibid


those in the secure estate and reflects the necessity of having healthcare arrangements suitable to meet the needs of an ageing population. This demonstrates there is a need to develop a national strategy to support older prisoners, as the fastest growing section of the prison population.

1.9 Currently the prison population projections model looks at the amount of time that offenders spend in prison to calculate the resulting prison population and simulates the ageing of the prison population over time. While this a useful tool for determining some support and resource needs within the secure estate, it fails to capture trends which link to specific health needs of prison populations, and whose inclusion could be of benefit. There should be a statutory requirement for prisons to support the health and wellbeing of offenders and this should be reinforced by expanding the scope of the prison population data set to monitor and record health indicators of the prison population including chronic conditions, mental health and instances of self harm. We particularly welcome the Nuffield Trust’s ongoing project to look at the health trends of the prison population and hope that government will consider carefully their findings once they are published, particularly how government can produce data which would allow better understanding of prisoner health.  

2. The safety of prisons and the impact of the prison environment on the physical, mental and social wellbeing of prisoners and prison staff, including the health implications of prison living conditions, overcrowding, time out of cells, access and use of psychoactive substances, and violence.

The prison environment and estate

2.1. The prison environment can be far from conducive to the promotion of good mental health or physical health. Prisons are often brutal, austere and spartan. Inmates have to share cells, changing cellmates frequently; the cells are often dirty and cramped and located on wings with terrible acoustics. This alone can impact on a prisoners wellbeing, particularly if they’re unable to access their minimum requirements for fresh air, daylight and exercise.

2.2. Our members report that prison doctors often lack the resources, infrastructure, and time to treat and assess the large numbers of detainees with severe mental health problems. Despite having, as a cohort, greater mental health needs than the general population taken as a whole, those detained will not have access to the same range of psychological therapies as somebody in the community. In addition, the ageing prison population means that increasing numbers of prisoners have greater physical health needs, as well as comorbidities. For this cohort older prisons, such as those built in the Victorian era, may lack accessible facilities, infringing on the human rights of those prisoners who require such provisions.

2.3 In the community, where primary care would be unable to meet a patient’s needs, it would be appropriate to refer a patient to a specialist. In the prison setting, it is complicated to refer someone to an external specialist due to security and resource considerations. Escorts to external services and appointments are critically insufficient to meet the level of need in prisons. This means prisoner transfers can vary greatly in time with either no notice or significant delay whilst awaiting hospital appointments or to be discharged from secondary care. Such arrangements and the processes can then be completely superseded by the lack of escorts meaning the treatment of some conditions will be delayed significantly if they are not life-limiting or life-threatening.

2.4. BMA members report that Individuals experiencing a serious mental health crisis will frequently be placed on bed watch, with a member of prison staff there to observe and ensure that they

---

10 Nuffield Trust, Prison Health Project [https://www.nuffieldtrust.org.uk/project/prisoner-health](https://www.nuffieldtrust.org.uk/project/prisoner-health)
do not attempt suicide or self-harm, but who are unable to provide therapeutic or clinical support. We believe difficulties in accessing external services are part of a much wider problem around the recruitment and retention of prison staff. Improvements in healthcare cannot be achieved without greater investment in ancillary staff and support.

2.5. Those who have a mental health disorder so severe that, if living in the community, would be sectioned face an additional complication that, in England and Wales, prisons (including healthcare wings) are excluded as places where patients can be given compulsory treatment under the Mental Health Act 1983. For this to happen, they must be referred to an external psychiatric hospital, a process that can take an extraordinary amount of time, in some cases, many months. Not to mention the position of the individual, this can be a stressful position for the prison doctor, who will be limited in what they can do to prevent a patient’s mental health from deteriorating further in the meantime. Commissioners should give attention to addressing this health inequality.

2.6. Many older facilities in the prison estate also present a serious safety risk for self-harm and suicide, and there is a definite need to modernise many facilities to reduce opportunities for this. While CCTV and ACCT (Assessment, Care in Custody and Teamwork) observations are a useful tool in preventing self harm and suicide, we are concerned by reports from doctors working in prisons that monitoring patients in this manner has had a perverse incentive of reducing active engagement with these vulnerable prisoners. The BMA believes that all staff need to work together to prevent self harm and suicide, and we recommend increased suicide awareness training, communication and shared working of prison with healthcare staff to facilitate this.

**Substance misuse**

2.7. Substance misuse and addiction can be a cause or contributing factor to an individual being sent to prison, with one survey estimating that 70% of offenders have reported misusing drugs before entering prison and just under one third of prisoners claimed it is ‘easy’ to get drugs in prison. This includes novel psychoactive substances (NPS) which, the Royal College of Psychiatrists emphasises, can have a significant impact on a person’s mental health and which have been reported in some instances as a trigger for self-harm. To address this the BMA advocates focusing sufficient resource on addressing substance misuse within the secure estate, coupled with ongoing and consistent support upon release.

2.8. Suboptimal security arrangements and the ease at which illicit substances make their way into the prison estate are also having a direct impact on the health and wellbeing of prisoners and amount of substance misuse. At best, patients will present with intoxication, anxiety or odd symptoms (unexplained leg swelling, rectal bleeding) and at worst, emergency services are having to be called whilst undertaking CPR. Improved security to prevent substances entering the prison must therefore also be considered.

**Segregation and restraint**

2.9. Conditions of segregation (social isolation, reduced sensory input, and increased control) can be harmful to an individual’s mental health and wellbeing. These conditions can be particularly damaging for vulnerable individuals with pre-existing mental health problems: Lord Carlile’s review described conditions of segregation units in the youth secure estate as “inducements to suicide”. The rules governing the use of segregation make clear that prisoners at risk of self-harm, suicide, or whose mental health would be severely affected should not be segregated. We are concerned, however, by reports that segregation continues to be used as a way of

---


12 Home Affairs Committee report: Drugs: Breaking the Cycle [http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/184/18409.htm#n224](http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/184/18409.htm#n224)
managing severe mental health problems in the absence of specialist care and support. We support a move away from the use of segregation for vulnerable individuals, and believe that therapy or counselling should be an integral part of their care and treatment pattern. Clear procedures should be developed for the use of segregation, with particular regard to safeguards for use on vulnerable individuals. The BMA has recently released a joint statement with the Royal College of Pediatrics and Child Health and the Royal College of Psychiatrists calling for an end of the use of solitary confinement on children and young people.

2.10. We are similarly concerned, by reports that the requirement for individuals to be seen by a healthcare practitioner after an incident of force or restraint is not always being met. This requirement is important to assess any physical injuries, but also to provide some assessment of a prisoner’s psychological state. Although a direct link was not made between the use of restraint, and self-harm and suicide, inquests into the deaths in custody of children and young people highlighted that the use of restraint and force against vulnerable individuals is severely distressing. Similar research has not been carried out into the use of restraint in adult prisons. The use of restraint and segregation are particularly harmful for vulnerable individuals. Clear policy and monitoring procedures should be developed for their use, with particular regard to safeguards for use on vulnerable individuals.

3. The effectiveness of the oversight, commissioning and regulation of prisons and prison healthcare services in safeguarding and improving prison health.

3.1. Individuals in prison have a right to a standard of healthcare equivalent to that provided in the community. We hope that the recent prison reforms, and the transfer of greater responsibility to prison governors, will go some way to making this aspiration a reality.

3.2. Members have highlighted to us that there can be issues with the provision/commissioning of certain health services in private prisons. For example, one member working in a private prison outlined that their in-reach psychiatry team will not accept prisoners who in their view should be managed by their Community Mental Health Teams (CMHTs). However, CMHTs tend not to accept these referrals because they believe this should be covered in-house in the prison. The result is that the individual may not be able to access the support which they need because of a lack of clarity as to who is responsible for commissioning these services.

3.3. Prison reforms highlighted in the Secretary of State’s recent speech in March of this year, represent a key opportunity to ensure that prison governors have the flexibility to design or reshape prisons with the health needs of prisoners and the safeguarding of medical staff in mind. Medical and nursing staff operating in the secure estate should have ease of access to emergency alarms when they are consulting alone with a prisoner.

May 2018

For further information, please contact:
Gemma Hopkins, Senior Public Affairs Officer
T: 0207 383 6287 | E ghopkins@bma.org.uk

---

13 BMA Joint Statement on Solitary Confinement

