BMA response to the Joint Human Rights Committee inquiry into Mental Health and Deaths in Prison

About the BMA
The British Medical Association (BMA) is a 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.

Executive Summary
The BMA represents doctors who work in prison settings, and has also worked for many years to promote fundamental human rights in the context of healthcare, including advocating for vulnerable groups who experience infringements of those rights. This BMA response to the Committee’s inquiry encompasses expertise from across our membership, and focuses on the health needs of those within the secure estate. This response only addresses those questions which we consider is within our members’ scope of expertise.

The BMA welcomes this inquiry by the Joint Committee and believes that, given the above average number of those living in the secure estate who have experienced mental ill health and/or attempted suicide, it is imperative all possible action is taken to offer appropriate mental health support, when they first come into contact with the criminal justice system. In particular, it is crucial that all prisoners receive equivalence of care to that provided in the wider community and, where particularly vulnerable people are concerned, that there is greater exploration of alternative treatment routes outside the secure estate. Key points contained within this submission are:

- Specific emphasis should be put on supporting people when they first come into contact with the justice system, particularly where health interventions are necessary, allowing health services a role in diverting vulnerable individuals from custody.
- 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.
- Certain aspects of the prison environment, such as 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.
- Specific targets should be introduced to reduce deaths in the secure estate, with health provision featuring more prominently in the commissioning, leadership and governance process of prisons.
- Mental health practitioners should be seen as an integral part of the reception team assessing prisoners on their arrival, with staff undertaking the assessment and screening process also receiving specific training in recognising and identifying mental health problems.
- Improvements in healthcare cannot be achieved without greater investment in ancillary staff and support, as well as additional mental health training for all staff.
- Health care providers within a prison should have regular contact and meetings with each other and with the governor and senior managers, to discuss and review processes and cases.
- Prisons should be incentivised to sign up to the Royal College of Psychiatrists’ College Centre for Quality Improvement Quality Network for Prison Mental Health Services. This network implements a framework which can be used to assess the quality of prison mental health services via a process of self- and peer-review.
1. The appropriateness of prison: What more can be done to ensure that vulnerable people who should never be in prison do not get sent there in the first place. What are the practical alternatives to prison for people with mental health problems?

1.1 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). It is clear that the prevalence of mental health problems in the prison population is significantly higher than in the general population, and this applies equally to rates of suicide: 46 per cent of female prisoners and 21 per cent of male prisoners having reported attempting suicide at some point in their lives, compared to 6 per cent of the general UK population. Despite this, individuals detained in prison are far less likely to have had meaningful interactions with community health services, meaning that their contact with the criminal justice system may be the first time their needs are identified and addressed.

1.2 Evidence shows that the isolation, institutionalisation and emotional stress of the prison environment can have a deleterious impact on mental health and wellbeing. For more vulnerable individuals, including those with mental health problems, that impact can be catastrophic – as evidenced by the increase in prison deaths which led the Committee to initiate this inquiry. We believe that providing healthcare of an equivalent standard to that provided in the community in a secure environment is crucial for meeting the mental health needs of prisoners. However, we know that due to the inherently non-therapeutic environment of the secure setting, this will be difficult to achieve without a culture shift and redesign of the secure environment. It is therefore imperative that vulnerable individuals are identified as soon as they first come into contact with the criminal justice system on suspicion of having committed a crime. This ensures that their needs are identified, an appropriate and effective package of support offered, and any decisions on charging, sentencing, or disposal are based on accurate information of their needs and vulnerabilities.

1.3 We support the current use of Diversion and Liaison schemes currently in place across England, and note that the initial evaluation of these schemes found an increase in the number of people with vulnerabilities who were identified, and better sharing of that information with magistrates and police officers involved in decision-making. 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. We particularly welcome the publication of the Review of the Youth Justice System in England and Wales by Charlie Taylor, and the government’s commitment to working with NHS England and community health providers to improve the provision of early interventions and to aid in the diversion of children and young people from custody.

1.4 Effective liaison and diversion from the criminal justice system are dependent on the community services being in place to enable appropriate care and support, and we are concerned that this is not

---

5 Disley E, Taylor C, Kruithof K et al. (2016) Evaluation of the Offender Liaison and Diversion Trial Schemes. RAND Europe: Cambridge.
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.

2. Identification and assessment of risk: How can the systems for identifying and assessing risk for vulnerable prisoners with mental health conditions be improved, e.g. by improving the Assessment, Care in Custody and Teamwork process (“ACCT”), better information sharing, or earlier identification of mental health problems?

2.1 The BMA has significant concerns regarding the rising number of suicides in prison: between June 2015 and June 2016 there was an increase in the number of suicides of 28% compared to the previous year\(^8\) and overall the rate of self-inflicted deaths has doubled since 2012.\(^9\) To address this we recommend that specific targets are introduced to reduce deaths in the secure estate and that health provision needs to feature much more prominently in the commissioning, leadership and governance of prisons. To this end we welcome the recent prison reform announcements and believe that giving prison governors’ greater responsibility for commissioning services, whilst simultaneously improving transparency, represents a strong opportunity to improve the current situation.

2.2 To improve on the overall assessment of vulnerable prisoners, it is crucial that there is improved information-sharing with agencies which have previously interacted with the individual. Currently many prisoners will arrive in detention with no accompanying medical history. The effect of this is to slow down and reduce the accuracy of the health assessment, meaning that this first opportunity to provide someone with the type of support they need may be missed. In addition to this, without access to medical records, prison GPs are in effect prescribing without any information about the patient’s history of pre-existing conditions or drug use, including whether they have a history of overdose. To address this we recommend establishing information-sharing strategies and systems between prison and the community, to improve assessment of mental health needs, and to aid in prescribing.

2.3 We recognise, however, that this cohort often has sporadic contact with healthcare services in the community, which can mean that this information simply does not exist. This places greater importance on the initial screening and assessment process as a means of identifying vulnerabilities. In accordance with Prison Service Instructions, all incoming prisoners must be medically examined with a view to identifying short- or long-term physical or mental health needs which need to be addressed.\(^10\) The reception area, where the assessments take place, can be busy, hectic, and stressful and the initial assessment may be rudimentary as a result. There is also a reliance on self-reporting as part of the initial health screening and many newly arrived prisoners may not disclose information, either out of concerns about being identified as “vulnerable”; because of the stigma attached to mental health problems; or because they are simply unaware of problems that exist.\(^11\) Further barriers to that information sharing can come in the form of language, with significant numbers of prisoners speaking little or no English and subsequently requiring the services of an interpreter to allow them to participate in the assessment process.

2.4 Additionally, 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 or the stress of arriving in prison. We believe that 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.

2.5 Many older facilities in the prison estate present a serious risk for self-harm and suicide, and there is a need to modernise many facilities to reduce opportunities for this. While CCTV and ACCT (Assessment, Care in Custody and Teamwork) observations are useful tools 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. This includes fewer physical or face-to-face interactions between staff and those being monitored, which is concerning given the additional stress that isolation can place prisoners under. The BMA believes that all staff need to work together to prevent self-harm and suicide, and recommends increased suicide awareness training, communication and shared working of prison with healthcare staff to facilitate this.

3. Access to specialist mental health services and other treatments/interventions: Is access to specialist mental health services adequate and consistent?

3.1 The prison environment can be far from conducive to the promotion of good mental health and wellbeing. Members report to us that prison doctors often lack the resources, infrastructure, and time to treat and assess the large numbers of detainees with severe mental health and drug addiction problems. We believe that prisoners’ health is currently being put at risk by a system that fails to address the causes of criminality.

3.2 It is also crucial to note that 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 many cases this is unavoidable, as providing that range of services by commissioning in-reach programmes is simply not feasible due to the lack of physical space in prisons. 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 UK prisons. The consequence of this is that patients have to be triaged, with escorts reserved only for the most urgent of cases.

3.3 There is subsequently a lack of resources to manage those who have complex mental health problems, but are not considered sufficiently ‘severe’ to transfer. Individuals experiencing a serious mental health crisis, for example, will frequently be placed on bed watch, with a member of prison staff there to observe and ensure that they do not attempt suicide or self-harm, but unable to provide therapeutic or clinical support. We believe that the 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. In the absence of being able to commission in-reach programmes in prisons, the focus should be on ensuring enough prison officers to provide escorts to prisoners accessing secondary care services.

3.4 Problems in ensuring equivalence of care can be particularly acute for patients who have a mental health disorder so severe that, if living in the community, they would be sectioned. 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. In order 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. 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. We believe that commissioners should give particular attention to addressing this health inequality.

3.5 Where commissioned support services are available it is not unusual for prisons to commission different agencies to support prisoners with different aspects of their health. While in principle this is not an...
issue, the BMA does consider it crucial that these different agencies engage with each other and that there is joining up and that continuity is formalised in the shape of a healthcare plan. For example, a single prison may have general practice, mental health provision and addiction services all operating simultaneously but not necessarily in conjunction with each other and prison staff. We recommend that health care providers have regular contact and meetings with each other and also with the governor and senior managers of a prison, to discuss and review processes and individual cases. This can, for example, be done through complex case meetings and ACCT reviews. Currently there are few incentives for prisons to prioritise meetings between health professionals and other staff; however, we believe that this will become even more crucial as prison governors are given greater autonomy.

3.6 It would similarly be helpful for prisons to be issued guidance and to introduce a minimum standard of delivery for key health services, particularly in relation to mental health. The BMA recommends that prisons are incentivised to sign up to the Royal College of Psychiatrists’ College Centre for Quality Improvement Quality Network for Prison Mental Health Services. This network implements a framework which can be used to assess the quality of prison mental health services via a process of self- and peer-review. Such a measure is also in line with government’s intention to improve transparency and accountability for governors of prisons.

3.7 It is also important that specialist mental healthcare provision is not seen in isolation from other services. Mental health problems and substance misuse and addiction very often go hand in hand, with one survey estimating that 70% of offenders have reported misusing drugs before entering prison and just under one-third of prisoners claiming it is ‘easy’ to get drugs in prison. This includes novel psychoactive substances (NPS or “legal highs”), which the Royal College of Psychiatrists emphasises can have a significant impact on a person’s mental health and which the BMA considers to be of particular concern, as an increasing number deaths in custody have been linked to the use of legal highs. We therefore believe that more must be done to facilitate substance misuse support services to operate uniformly within the secure estate.

4. Segregation/solitary confinement and appropriate use of restraint: Is enough being done to ensure that the practice of isolating prisoners is never used inappropriately for prisoners with mental health conditions? E.g. by new structures, processes or mechanisms which facilitate learning such as the collection and publication of data on the deaths of prisoners with mental health conditions.

4.1 We recognise that segregation may often be necessary for safety and security reasons within prisons, but this does not mitigate the fact that the conditions of segregation (social isolation, reduced sensory input, and increased control) can be harmful to 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 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.

4.2 The BMA believes that clear policy and monitoring procedures should be developed for the use of segregation with regard to safeguards for use on those with mental health problems. We would be concerned, however, by any arrangement which required doctors to certify whether an individual is fit to withstand solitary confinement for punishment or disciplinary purposes. We do not believe this is an appropriate procedure for prisons to implement, given physician involvement in disciplinary matters can blur the line between welfare and punishment, with negative consequences for the doctor-patient relationship. Doctors should, however, be consulted so they have the opportunity to raise concerns where segregation will adversely affect individuals. Where solitary confinement does go ahead, we recommend that it should be administered for the shortest time possible and carefully monitored. Where prisoners are segregated, they should still have access to a doctor.

4.3 Restraint, when used appropriately, can similarly be a useful tool in ensuring the safety and security of the prison environment. We are concerned, however, 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 not only to assess any physical injuries which might have occurred, but 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 force against vulnerable individuals is severely distressing. Similar research has not been carried out into the use of restraint in prisons, but is an area the committee may wish to explore further as part of their inquiry.

5. Learning lessons for the future: What more can be done to ensure that lessons are learned for the future about the deaths in prison of people with mental health conditions?

5.1 The current provision and accessibility of mental health support in prisons are 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. Specific emphasis should also be put on supporting people when they first come into contact with the justice system, particularly where health interventions are necessary, allowing health services a role in diverting vulnerable individuals from custody.

5.2 Where individuals do end up in detention, there is far more that could be done to ensure that vulnerable individuals are identified, and that they receive the medical treatment and care they need. Recommendations made throughout our submission emphasise the importance of appropriate and timely assessment of the mental health needs of individuals, and of ensuring that they can access consistently high-quality care. We hope that recent prison reforms which place greater responsibility for commissioning on governors, will provide an opportunity for reflection on how this can be achieved.

5.3 The use of segregation and restraint should be carefully monitored, and their use limited to the protection of prisoners and staff, rather than as a method of punishment. Where these approaches are taken, medical support should always remain available both during and following their use. Reporting should also be a key tool in identifying trends and behaviours which may be indicative of increased likelihood of suicide amongst prisoners, and where this flagged as a potential concern, appropriate, timely support must be provided, either within the estate or outside it.

February 2017

For further information, please contact:

Gemma Hopkins, Senior Public Affairs Officer
T: 020 7383 6287 | E ghopkins@bma.org.uk

---

20 Prison Reform Trust, Inquest (2012) Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?