HOUSE OF COMMONS

Justice Committee

Oral evidence: Mental Health in Prison, HC 72

Tuesday 8 June 2021

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Watch the meeting

Members present: Sir Robert Neill (Chair); Paula Barker; Rob Butler; Angela Crawley; Janet Daby; James Daly; Miss Sarah Dines; Maria Eagle.

Questions 1 -81

Witnesses

I: Dr Sarah Allen, Consultant Clinical Psychologist and Lead Psychologist for Health and Justice and OPD Services at Central and North West London NHS Foundation Trust; Dr Sarah Hewitt, Consultant Forensic Psychiatrist, Central and North West London NHS Foundation Trust; and Dr Russell Green, Medical Director Mental Health and Substance Misuse, Practice Plus Group.

II: Dr Jake Hard, Chair, Secure Environments Group, Royal College of General Practitioners; Dr Josanne Holloway, Chair of the Faculty of Forensic Psychiatry, Royal College of Psychiatrists; and Simon Newman RN, Head of Healthcare, HMP Berwyn, Betsi Cadwaladr University Health Board.

HOUSE OF COMMONS

Examination of witnesses

Witnesses: Dr Allen, Dr Hewitt and Dr Green.

[The meeting was not on air at this point.]

Chair: Welcome, everyone, to this meeting of the Justice Committee, and in particular to our witnesses, whom I will come to very shortly. I will deal with some formal business at the very beginning.

In due course I hope we will be joined by Angela Crawley, who is a new member of the Committee and who will make any declarations of interest, as necessary. We need to make our declarations of interest as relevant. I am a non-practising barrister. Are there any other declarations people ought to make?

James Daly: I am a practising solicitor and a partner in a firm of solicitors.

Rob Butler: Prior to my election, I was on the board of HMPPS, a magistrate member of the Sentencing Council, and relevant to today's hearing, prior to that, between about 2013 and 2017, a board member of the Youth Justice Board.

Maria Eagle: I am a non-practising solicitor.

Miss Dines: I am a barrister, but I have not taken any cases since my election.

Q1 **Chair:** Thank you very much, everybody.

Turning to our first panel of witnesses, Sarah Allen, Sarah Hewitt and Russell Green, welcome, all of you, and thank you for coming. Could you very quickly say who you are and what your organisation is for the record and for those who are watching and do not have our briefing papers?

Dr Allen: Thank you for having us today. My name is Sarah Allen. I am a consultant clinical psychologist working for Central and North West London NHS Foundation Trust. We provide services in a number of prisons and secure settings.

Dr Hewitt: My name is Dr Sarah Hewitt. I am a consultant forensic psychiatrist. I work within a women's prison. I am also a medical lead for health and justice services for CNWL Mental Health Trust.

Dr Green: I am a general adult consultant psychiatrist and also medical director for mental health for Practice Plus Group. We are commissioned by the NHS and provide services in about 50 prisons in England.

Q2 **Chair:** Thank you very much, all of you. This is the first evidence session in our inquiry into mental health in prisons. Thank you for coming to bring your expertise to bear for us.

I am told that we are not on air yet, so I will do the countdown now.

[The meeting was on air from this point]

That has got us going again with our panel of witnesses for the mental health inquiry. Let us get straight into the questioning. The witnesses have introduced themselves for the record. It is great to see you all.

Can I start with all three members of the panel? What is your assessment of mental health needs among the prison population? We have had a good deal of background evidence, including from the organisations you represent, who have helped us with it. How accurate and how complete is the understanding that practitioners, the Prison Service and others have of what the mental health needs are, their extent and levels of complexity? Who wants to start?

Dr Hewitt: I am happy to start. I think there is enormous mental health need within the prison population, but it is important to think about what actual mental health need means. There is a broad range of disorders, personality issues and substance misuse issues, which go from very basic issues to really significant mental health difficulties where people are psychotic and out of touch with reality. Some quite old papers talk about 80% of the prison population having some form of mental disorder. These are old and it is very difficult to do complete research within the prison environment for a range of reasons. More information could be obtained from the patients for us to deliver appropriate care, but, certainly, on a day-to-day level, there is a huge need within the prison.

Q3 **Chair:** I saw your written submission from Central and North West London Trust saying: "We do not have high-quality accurate data which details the incidence of different types of mental health problems or describes conclusively the right interventions." Would you like to pick up and explain what could be done in that context to measure more accurately the need?

Dr Allen: What my colleague was saying about the breadth of need is really important because the studies that have been done look at specific diagnostic criteria. There is relatively consistent evidence on things like severe mental illness—the incidence of something like psychosis in the population. However, in the services that we offer, very frequently we see people who have a huge spectrum of comorbidities, people who have substance misuse histories with a range of different potential diagnoses, but also really significant trauma histories—having experienced significant adversity throughout their lives, often starting in childhood and continuing through adulthood, exacerbated by going in and out of prison and by substance misuse. The complexity of their need is very great.

In terms of the understanding of that, Chair, all sorts of things are done. We look at our needs frequently in the provision that we make, but also the commissioners look at completing treatment needs analysis prior to commissioning work. There are some areas of evidence out there, but the

idea of a complete picture that tells us exactly how many people there are with what sort of need is difficult partly because of the complexity of that need.

Q4 **Chair:** Is there more that could be done structurally by the Prison Service or the Department in the way that reporting and data collection works that could improve that?

Dr Allen: That is an interesting question. I find it difficult because I think the diagnostic uncertainty is complicated in trying to give an exact picture. You might see any given person and say they might reach a criteria for this, this or this diagnosis, or many of them. Being able to say exactly what is the picture for that person, let alone for the whole population, is complex. I do not know if the others would like to add to that.

Q5 **Chair:** I was going to bring in Dr Green and perhaps you could also deal with this point. The Ministry of Justice themselves seem to say that they do not have a complete understanding of the overall prevalence of mental health needs of prisoners for various reasons. What is your take on that issue?

Dr Green: I would echo the other two witnesses in that there is a huge mental health need. It is perhaps not helpful to see the people coming into prison as either mentally ill or not mentally ill. The reality, certainly in my clinical experience, is that almost everyone who comes into prison, as has already been mentioned, has had generally pretty horrific life experiences. While as psychiatrists and psychologists we might debate the exact diagnosis, the reality for that person is that they are struggling and they are suffering. That is probably where you see some uncertainty.

On a practical day-to-day basis—for instance, in the remand prisons I have worked in—almost everyone who arrives will be referred to the mental health team because they themselves find that they are struggling. We could do better with data, and that would be helpful, but the reality is that the vast majority of people who come into prison have a level of mental health need, and, generally, that is pretty complex. We see very few simple mental health conditions, if I can put it that way. People coming into prison are not generally okay and only six months before have developed a relatively mild mental health condition. They have generally experienced trauma and difficulties since childhood, which makes those problems complex.

Q6 **Chair:** We have been told that, quite often, self-harm and suicide are used as indicators of mental health need in prison, but, equally, evidence from a number of witnesses suggests that that is not as reliable an indicator. It is picked up very often in public and in reports that this is an indicator. To what extent is it reliably an indicator or not, or is that misleading us to some degree?

Dr Hewitt: Self-harm and suicide attempts are really a marker of emotional distress. Some people, we know, self-harm when they are not

in prison; some people self-harm when they are just in prison. Although it is a proxy marker for levels of distress, you cannot really say that that is due to mental disorder. It is a good way of showing how patients are being managed within the prison population, but there are also lots of people who are very mentally unwell who would not self-harm and who might be aggressive or irritable instead, or neglect their self-care. It is one marker, but it is more a marker of emotional wellbeing to which mental health issues contribute.

Chair: Thanks. Everybody seems to agree with that. That is helpful.

Q7 **Maria Eagle:** The National Audit Office said in its 2017 report—and I am going to quote this as it is quite stark—"Government does not know how many people in prison have a mental illness, how much it is spending on mental health in prisons or whether it is achieving its objectives."

Given that gap in understanding of mental health need in prison, what effect does that have on the commissioning of services? The commissioners are there trying to provide services in this vacuum of understanding. Do you get a sense—as those who are on the frontline providing the services that are commissioned—that there is a gap there, and what impact does it have on the commissioning of services?

Dr Green: As I mentioned earlier, because it is easier to record more severe mental illness, commissioning of services in some ways is skewed by that. Perhaps it is much harder to quantify the number of people who are coming in who, while they may not have been diagnosed with a formal mental health problem in the past, still have significant need to support their mental health.

My experience is that our services are structured relatively well—there are still challenges—around caring for people with very severe psychotic illnesses, and we know the pathway that those people should take. The challenge I face in the prison setting is providing a service to the other 95% of people in prison who have need and are often struggling, and often, tragically, are the people who take their own lives. That is where there is a challenge for commissioning. There are signs that that is changing—there is a great focus on talking therapies—but that probably reflects historically how commissioning was done.

Dr Allen: There is something about the reality of how service providers try to respond to the commissioning environment and landscape. My experience has been generally that, when commissioners ask for a service, they know broadly what they want. There is a financial envelope attached to that, and we, as providers, work out what we can provide within that envelope. It almost comes a little bit backwards in some ways. We are trying to run a service and we do the very best that we can.

As your other witness said, there is a very useful focus on those with severe mental health difficulties. Probably, some of the remainder of the

money gets used to highlight and to work with the rest of the need. It is about trying to do the best that we can within the envelope that we have.

Q8 **Maria Eagle:** Dr Hewitt?

Dr Hewitt: We also need to consider how hospital beds are commissioned when people leave prison to go to hospital. They can go to secure forensic services—if they pose a significant risk of harm to others, they will go to a low secure unit or a medium secure unit, commissioned directly by NHS England—whereas people who pose a lesser risk of harm to others go to psychiatric intensive care units commissioned by CCGs, locally. Very often, we find it quite difficult to get people into hospital at the lower end in terms of risk but still with psychotic illnesses, because the thresholds for people to be admitted to hospital under the Mental Health Act are so great within general adult services. PICU is part of the general adult service. So, the hospital beds and where the prisoners go to when they need to be transferred out needs to be thought about.

Q9 **Maria Eagle:** I was, in the dim and distant past, the Prisons Minister. I do not think it has changed sufficiently from my time for this question not to be important. There is a distinction between the mental health needs of women in the women's estate and men. I am not saying there is not some overlap, because there is. Is the commissioning of services sufficient and adequate to deal with those very different needs? Obviously, the women's prison estate is very small. The number of women prisoners is much smaller. It is easy to overlook a small percentage of the population. Is there an issue that women's mental health needs for the women's estate are not being met as well as perhaps the mental health needs of men in the overall estate, or not?

Dr Green: I think you make a good point. The same issues apply both for men and women in prison, but probably to a greater extent for women in prison. When we talk about people having experienced trauma, for women coming into prison that is often more severe and more sustained. In a sense, women arrive at the point of prison often with far more difficult, horrific experiences than sometimes you see in men's prisons. It is the same issues but they are more severe.

There is currently an increased focus on improving care for women in prison. Again, that is about improving the care for the large majority of women who come into prison who do not meet the criteria for transfer out to hospital or specialist units but nevertheless have a significant mental health need. Certainly, for me, that would be primarily around improved access to talking therapies that historically have perhaps only been available to a relatively small minority. We need to be able to offer that, in effect, to every woman who comes into prison because they do all need it.

Dr Allen: I think the commissioning is not so very different between the male and the female estate, although in the majority of our prison

services there have traditionally been more advanced talking therapies programmes in the female estate in which we work.

The other big and probably quite important difference is the development of a trauma-informed practice across the whole of the prison estate—that has been more advanced in the female estate, although there are moves now within the high secure men's estate as well—to try to get that cultural change within the wider prison, not just in terms of specific mental health treatments for an individual. That has been quite important work—of course interrupted to some extent by Covid, which I am aware we will come on to. I think that cultural change is also very important.

Q10 **Maria Eagle:** Prisoners tend to be assessed on reception in respect of their mental health needs. Are you able to access sufficient available information at that point to determine the mental health needs of the prisoner—of the patient—and to develop a treatment plan for them? What can you do beyond that point of assessment at reception to make sure that the mental health needs of prisoners are being catered for?

Dr Hewitt: In the CNWL prisons, some have a dual reception screening. Some just have reception screening with a primary care nurse who will review physical and mental health. In some of our prisons, we also have a 72-hour thing called an early days in custody screening where a mental health professional will go and see every prisoner who comes in and do an assessment purely of their mental health. We find in those prisons that it is easier to identify people who are unwell. It is easier to spend the time getting their background history and to think about managing them in a safe way. Those prisons where they have a specific screen with a mental health professional for mental health problems tend to manage better than those just with the primary screening.

We also have an issue with access to notes. If the prison is run by a different organisation from one that provides community psychiatric care, it is very difficult to get hold of notes in a timely fashion, to identify who care co-ordinators are and sometimes what medications are. We also sometimes get barriers, in that organisations need written patient authorisation for us to access their notes. Sometimes there are notes available, but we cannot get access to them because the patient will not allow it. It can be quite a frustrating activity getting hold of people's history.

Q11 **Maria Eagle:** Do either Dr Green or Dr Allen have anything to add? Otherwise, I will pass back to you, Chair.

Dr Green: No.

Dr Allen: The issue of notes and access can be complicated just by the numbers coming in. When we think about being able to do a full mental health assessment, when you are in a smallish prison that contains mostly people who are on sentences, there might be five receptions a week and that becomes much more possible. When you are in a busy

remand prison, there can be 60 receptions a day, so you are never going to be able to perform that level of depth of assessment; you are relying often on what people tell you, and they may not be in a state to give an accurate history themselves.

Chair: I understand. I think Dr Green agrees with that.

Dr Green: Yes.

Q12 **Rob Butler:** We have talked a little about both the adult male and the adult female estates. Can we look at the youth estate in its various incarnations? Dr Allen, you sent a very helpful letter as part of the written evidence. Can you just talk us through what you perceive are some of the specific aspects of mental health in the youth secure estate, perhaps explain what SECURE STAIRS is for colleagues who may not be familiar with it, and mention transition as well either from the youth estate to the adult estate or the youth estate back into the community? Apologies for hurling a lot of questions at once, but I am just inviting you to talk more generally. Finally, are there any significant differences between provision in YOIs, STCs and SCHs? So, over to you to talk us through what you think are the most important aspects of youth provision.

Dr Allen: I think the issues are different from those in the adult estate. As I mentioned in the written evidence, we know a little more on numbers and facts and figures at the moment because of some very useful studies that NHS England has led on. That has helped to facilitate the provision of the SECURE STAIRS framework, which I will go on and talk about.

One thing that we have noticed in the time that we have worked in the youth estate over the past six years is a real change in the population. Overall, the youth estate numbers have gone down dramatically—it is a good thing generally not having children locked up—but the severity of the crimes and the length of the sentences have very significantly increased. In terms of mental health need, we see a different type of person with a different type of offence. We have a very significantly increased number of people coming in at the ages of 15, 16 and 17 with life sentences. That, of course, is a very difficult thing for them to come to terms with, and shapes our thinking about the care that they will receive during the course of their custodial stay.

In the youth estate, there is a useful process called the CHAT, which is a system where everybody who comes in gets a very comprehensive assessment. As Dr Hewitt said, it is similar to the early days in custody, but with greater depth. They look at mental health, primary care needs and also neurodevelopmental needs. That provides us with a useful opportunity to really know what the difficulties are for each individual as they come in.

We are also in the position now with the advent of SECURE STAIRS commissioning to try to work with everybody who is resident in the young

offenders institution. "SECURE STAIRS" is an acronym. I cannot tell you what everything stands for at the moment, but it is an integrated care framework. It is commissioned both with Prison Service staff and health staff, and aims to try to bring everybody together to think about each young person, and, in fact, the system more widely, from an attachment-based and a developmental perspective. Everybody who comes in will have a psychologically informed formulation that helps us to understand how they have come into prison, what it is that has gone on in their life that has shaped their pathway towards their positioning at the moment, and also helps the staff to understand them and their behaviours.

Further to that, it looks at providing supervision and reflective practice—things that we are quite familiar with as clinicians—to the officer staff as well. The idea is that the whole environment becomes much more aware of and able to work in a psychologically informed way because staff are also supported in the work that they are doing. You can probably gather from the way we have been talking that staff can be exposed to a very significant level of trauma. Particularly for non-trained custodial staff, it can be a very huge drain on their resources. We think the importance of being able to reflect on and understand those aspects of their work cannot be underestimated.

I was just checking what else you had asked about. You also asked about transition particularly.

Q13 **Rob Butler:** Yes, transitions either to the adult estate or, indeed, if somebody is released, from the youth estate into the community and therefore trying to access CAMHS, which can be difficult at the best of times.

Dr Allen: Yes; it is a very significant problem. Anybody who has tried to do that in the community, or had contact perhaps from people who have, will know that CAMH services are very hard-pushed now, and we have great difficulty often being able to pass somebody on to CAMH services if they are released into the community. Often, that is complicated by the fact that they might be quite close to 18. CAMH services work up to that point and mostly then discharge to an adult service, which has higher levels of criteria.

There is a very significant gap for us on release, complicated by the fact that we often do not know when release will be, given there are issues about remand and sentencing when people are moved out without us having adequate ideas about that. Addresses are often not known until perhaps the day of release, which means that knowing where somebody has been released to and therefore which CAMHS teams to contact is very difficult. Often, we have a very intensive period of work about release trying to contact people. Expensive clinicians' time is spent tracing phone calls and trying to find people who will take on the young boys who are being discharged.

The transition to the adult estate is interesting. It will be particularly interesting to see what happens as SECURE STAIRS is very firmly embedded in the youth estate and they move into an adult estate that does not work in such a way. That will expose some of the gaps that we see in the adult estate. It will be interesting to see in the longer term whether it would also be possible to work in such a psychologically informed way in the adult estate.

There are times when we have really good relationships and links with adult estates or if they are moving on to one of the specific YOIs—moving from Feltham into the other side of Feltham or up to Aylesbury. Sometimes they are moving into main adult prisons, and contacting and being able to provide handovers can be complicated in those situations.

Q14 **James Daly:** Can I ask the witnesses about their view on the use of prison as a place of safety or for a person’s own protection? When I was practising in the courts, that happened very infrequently and tended to be a remand provision. Things may have changed since I appeared before the courts. I would be very grateful if you could give us a flavour of how often that is happening. Dr Allen made a very important point that the amount of time that somebody has in the prison environment is obviously crucial in terms of the impact that mental health treatment can have on that person.

Dr Allen: As you are referring to, we think that prisons are really inappropriate places to be used as a place of safety. They are not set up for that. The staff are not trained to deal with people in that situation and that should not be the way things happen.

I could not talk too much about frequency, but perhaps my colleagues can tell you a little more about that. You are right: the amount of time they have is absolutely crucial, and us knowing about them at the right time when they first come in is the other aspect of that. It links to what we were saying about assessment of need at reception. It can be that somebody crops up quite late in their sentence and we are told they are going in a week, but what can you do? How can you link them up with those services? Those kinds of issues are really complicated.

Q15 **James Daly:** Dr Allen, can I just ask a quick point related to that? It is important. If somebody is coming into a custodial environment, when would the professional, the clinician or the prison have sufficient details about a person’s background to be able to start treatment or to be able to put a programme in place?

Dr Allen: I would say that completely depends. It depends on how the person presents and what they tell you, and then it depends on what other kind of information you can get in being able to provide a multimodal assessment. Sometimes, you will have huge amounts of information and liaison with your offender management colleagues, with probation, who will be able to tell you all about the background, the offence and their sentencing dates. Other times, it is very difficult to find

out that information. You might have some background information on what their schooling was like and what previous psychiatric treatment they have had, or you might know nothing at all.

Dr Hewitt: I look after a healthcare unit in a female remand prison. Over the past 12 months, we have had four, maybe five, women who have had medical recommendations for detention into a psychiatric hospital, for whom a bed could not be found and they come into prison instead, one of whom was pregnant and manic. It is absolutely outrageous, really risky, and an affront to dignity. It is about courts and liaison diversion services not being able to access beds in a timely fashion. I can understand why people end up in prison if there are no beds available, they are very unwell and you cannot let them out into the community. None the less, prison is not an appropriate place.

The other thing to bear in mind is that we see a number of people who pass through police custody in the courts where there are concerns about their mental state but they might not talk to professionals. So the information is handed over to us in the prison that they are concerned about their mental state. When we go and see them, we find out that they are floridly psychotic—so very unwell. They had opportunities to be diverted, but because they have not had the opportunity to have such an in-depth assessment of their mental state or they do not have the background history, they have not been diverted and they have ended up in prison, which again is inappropriate. This is something that I feel very passionately about and desperately needs to be addressed because it is unsafe and undignified.

Dr Green: To echo Dr Hewitt, we cover a number of remand sites, and, not infrequently, again, people will have been partway through the process of being detained to go to a hospital but a bed could not be found and they arrive in prison. That happens both in the female and male estate. As Dr Hewitt says, it is tragic to see someone arriving in prison who should have been in hospital. It then has multiple impacts. Obviously, for the person, it delays their treatment. Once they are remanded to custody, we are in the process of having to refer out to our forensic colleagues, which usually results in a delay of a number of weeks to get that person into hospital, when, had they been diverted before coming to prison, they could have been in hospital straightaway.

Another really important thing is that, because that person is in prison, they are then often deemed to require a secure bed, which is in very short supply. Had it been arranged for them to go to hospital before coming to prison, they may well have been manageable on a general ward, where there are more beds. That failure within the system actually puts huge pressure on secure beds. It is a real issue because it is tragic for the person; they do not get treated, and that is most important. Actually, it puts an unnecessary pressure then on secure beds.

Q16 **James Daly:** That was incredibly helpful evidence. I have one brief

further question, Chair, if that is okay, and I apologise to the witnesses for what I think will be a naive comment. The vast majority of people I represented had mental health issues one way or another. That was essentially the reason why they were in the custodial environment. I just wonder about the challenge of the different criminogenic needs. Clearly, we are concerned about somebody's mental health, but we are also concerned about the relationship between their mental health, the nature of the offending and the risk to the public. Obviously, people are in prison for different offences and have different criminogenic needs. Could I have a few comments regarding how the management of the risk to the public is managed at the same time as the mental health challenges that somebody presents?

Dr Green: That is a really complex question. There is probably a number of aspects. At the risk of reiteration, there are a group of people whom I see coming into remand who are arrested for what are fairly low-level offences that are often very clearly to do with their psychotic illness. Certainly, my experience as a psychiatrist is that 15 or 20 years ago they would not have come anywhere near a prison—I think they would have been diverted. The process seems to allow them to proceed to prison, where in the past it perhaps did not. There should be some real focus on that area because it creates such issues. I do not know if Dr Hewitt wants to comment more widely.

Dr Hewitt: I think this is a really interesting and extraordinarily complex question. People's mental health issues contribute to violence and crime in a number of different ways. Some people are very psychotic; they are hearing voices and have lost touch with reality, and they may offend because of their psychotic illness. They are very unusual, but it is very clear that if you treat them with medication and the right support, they will not pose a risk of harm to others.

There are then those people who are psychotic and, as the previous witness said, just a bit chaotic in the community, who might harass their neighbours because they think their neighbours are talking to them. The risk they pose is not significant, and it is just about distress and managing their mental health appropriately, which community services find difficult.

There is a broad group of people in the middle for whom personality aspects, substance misuse aspects and a range of mental health issues all contribute together to pose an individual risk of harm to others of reoffending. For that group of people, I think it is right that some of them are in prison and have good psychiatric care in prison, but there are not the talking therapies or effective substance misuse services available to look at the trauma that will reduce the risk. It is that middle group of people whom I worry about the most and who have the most complex needs, because they need lots of agencies to be involved to reduce their risks. They are perhaps the ones that do not get as good care. I do not know if other witnesses want to add anything else.

Chair: That seems to be pretty well covered.

Q17 **Miss Dines:** Can we turn to those with lower-level mental health issues? What sort of support and services do they receive? It is obvious that people who are very seriously unwell will get a lot of attention quite quickly, but what about those who have low-level mental health issues? How are they treated?

Dr Hewitt: That, again, is a very interesting question. What is important, as we have said previously, is that women and men who come into prison have complex needs. If they were seen by a psychiatrist in the community or mental health service in the community, they might be seen as just being a bit depressed, but within prison you have to consider substance misuse, anxiety and depression, a history of trauma and how they respond to the environment within prison.

I will be completely honest. I think most of the people within prison could do with a good psychologist. It is fairly universally accepted that if you have a good psychologist and good talking therapies everyone would benefit from that.

Within our services, we often have what is known as primary mental healthcare teams, who provide lower-level, stepped care interventions. Sarah Allen is probably the best person to talk about that. They range from psychoeducational groups to looking at treatment for anxiety, depression and trauma, to one-to-one psychological therapies. They are picked up. Covid has had a big impact on the availability of face-to-face psychology, but a lot more could be done.

Q18 **Miss Dines:** Sarah, can you add your experience on that, please?

Dr Allen: For me, one really important thing to highlight is that there is a single point of access into mental health services. One issue that can get complicated with commissioning is that, if different people are trying to pick up and assess people, they end up going through multiple different assessments and getting passed around between different services. For me, if there is a single point of access that everybody can refer into, ideally, with self-referral as well, that gets screened by mental health professionals, who can then allocate the most appropriate person to assess.

If it looks like low-level mental health needs, it will come to something like, as Sarah was saying, a primary therapies team, who could then complete a triage assessment and try to understand what the needs might be. We think about trying to offer a stepped care model of treatment. The people with lower-level needs might be able to start with something like self-help guides. There is specific self-help information available for people in prison. Some of it is co-produced with people from prison, which I think is really helpful. There are then psychoeducational groups: come along and learn a bit about this situation and, hopefully,

experience it as being normalised, and learn from your peers about coping mechanisms.

There are then more intense therapeutic groups led by professionals where the focus is on something specific like low mood, managing anxiety or a trauma pathway, which, as we have all been saying a lot, is a very common need. For lots of people, they might think they are going crazy, but being able to understand that their experiences reflect the trauma that they have suffered can be very helpful as a first intervention.

For those who have both the time on their sentence and who want and need it, there should be the availability of individual, focused psychological therapies. That would be whatever the evidence base is for that population in the community transposed into a prison environment, paying particular attention to the context and, as your colleague said, to the criminogenic factors as well.

We then look at people's specific vulnerabilities and we shape our treatments around them. That would be an ideal. The absolute ideal would be that we are able to offer that to everybody.

Q19 **Miss Dines:** Dr Green, do you have any addition to that? As a supplementary, what is being done, and is it enough?

Dr Green: Although I think I have already used the phrase "lower-level needs", sometimes that is probably not a good way to look at it. What I have experienced working in prisons is that we get a huge number of people who present saying that they have depression or anxiety, and, as has already been mentioned, once you spend some time with that person, what you discover is that they have very complex mental health needs. That complexity is different in a way from someone presenting as psychotic, but it remains complex.

From my point of view, the way our organisation works is that we have an integrated mental health team. We do not split it between primary and secondary, although that is a model that is used. That is on the basis that, for many of these people, on Monday you are step 2, but on Friday, because something really difficult has happened, you are step 4 and things have changed. What I think we have is a group of people with fairly overt psychotic illnesses, and, as I say, in some ways we are kind of set up to manage those.

We then have a huge number of people not with low-level problems. The model is set up in prisons a bit like the community as if you have a large group of people who, in general, are functioning pretty well in life but then face a mental health illness. The reality in prison is that that is not what we see. We see people who have experienced trauma throughout their lives, who come to us and say, "I am struggling with low mood." We need a system that can address some of the problems behind that, as both witnesses have said, and that is around talking therapies. Generally, medication is overprescribed for that group of people.

Is enough being done? I think we do the best we can with the resource we have, but, yes, we need more talking therapies.

I think Dr Hewitt made a really good point also about working with our prison colleagues and other people within the prison. Caring for mental health in prison is not just about the mental health team. Most people's experience of prison day to day is interacting with officers at education. If we could do more to help everyone who works in prison understand the impact of people's really difficult trauma and how that causes them to self-harm or present as challenging or "behavioural", which is something you hear commonly in prison, that would benefit prisoners a lot and probably make working in prison easier as well.

Chair: Thanks. I see there is agreement and general nodding there. That is very helpful.

Q20 **Paula Barker:** Good afternoon to our witnesses. I would like to look at the overall prison environment, if I may. We have strayed slightly onto this in questions from Ms Dines and Mr Daly. I was interested because evidence suggests that the prison environment exacerbates or can exacerbate mental health conditions, and prisoners frequently cite prison as a reason for mental health deterioration.

I would like to understand better what you believe can be done to improve this. I know we have heard a lot about talking therapies. Dr Allen, you talked earlier about the trauma-informed practice. Dr Green, you have just talked about working more holistically with the officers and education unit, not just the mental health team. How do we actually address those issues and bring about that change? I would be keen to understand your views on that.

Dr Green: There is a fundamental challenge for helping people with mental health problems in prison. At a certain level, prison is designed to not be very nice, I suppose, and, therefore, by definition, it is going to make people's mental health worse. If prison is designed as punishment, that will inevitably be the case.

A huge amount of work equally goes into doing rehabilitation. Some of it is simple. Interestingly, at the start of Covid, we were all really worried, rightly, about people's mental health. We saw some interesting things happen. As the regime became more restricted, the inadvertent consequence of that was that prison in some ways became safer. One of the big things for people in prison is often that they do not feel safe, and that is generally speaking to do with drugs and bullying. In the early stages of Covid, because that made people feel safer, quite a lot of people actually reported feeling better. That, unfortunately, has not been sustained.

To come back to the point, if we want to improve mental health in prisons, we need to look at the whole institution and at the things we can do to make people feel safer, with meaningful activity and education,

which in reality is exactly the same things in the community for you or me. When I look at improving the mental health of someone who lives in the community, it is not just about seeing the mental health team; it is about having exercise, having stuff to do and a reason to get up in the morning. We need to see it a lot more holistically if we are going to have an impact on generally improving mental health in prisons.

Q21 **Paula Barker:** Thank you. Do the other two witnesses want to contribute anything further on that?

Dr Allen: I think we would echo much of what our colleague said. It was very comprehensive. One of the other important things to remember is that, for any of us when we are coping with stress or difficulties, if you imagine what you do to manage, you think about exercise; you think about hanging out with your friends, calling someone, maybe having a glass of wine, exercise, or whatever it is. Many of those strategies are not available for people in prison, particularly at the time when they would want them. Regardless of all the things we have talked about such as trauma and mental health diagnostics, the ability to adequately cope with stress is really complicated in that environment.

I think one of the most useful things is the training of staff, but also supporting them and, as we were talking about in the youth estate, to be able to reflect on their practice. Losing experienced staff both on the prison side and from mental health is devastating in terms of the loss of knowledge and experience you have in working with these complex individuals. Supporting and retaining staff is a really important part of this work.

Q22 **Paula Barker:** When individuals come into the prison system with mental health issues, they are often segregated, as I understand. Is that something that could possibly be looked at? Would that help you to ensure that that segregation does not happen? If they are integrated with other prisoners and the officers, and exercise is more readily available, would that assist?

Dr Hewitt: I do not think that segregation is something that I recognise. There is a segregation unit for people who are very behaviourally disturbed. Generally, those people do not tend to have psychotic illnesses—it is to do with personality and the way they deal with stress. Some prisons have healthcare units where people who are very unwell can stay while they are waiting for transfer to hospital, but the majority of people with mental health issues are on the house blocks or the wings, and are integrated. That is my experience. Actually, sometimes, it is difficult for people around them if they are banging and noisy. They can have quite a significant impact on the environment, but they do not tend to be segregated; they tend to be part of the population.

Q23 **Paula Barker:** We know that some individuals are convicted of committing extremely serious crimes, and some of those individuals will have severe mental illness. What is your view on how prisons balance the

punishment/rehabilitation side of that alongside the treatment of those prisoners? I know that we have touched on that slightly, but is there anything that you could expand on?

Dr Hewitt: I am a forensic psychiatrist. I think those people with very severe mental illness are identified pre-trial, and very often they are sent to secure hospitals rather than to prison. That is absolutely the right environment for them. It is best for society because they get the care that they require. They can live meaningful lives and it reduces the risk of harm to others.

There are more people who have significant mental health issues who remain in prison. Often, they are offending because it is related to their history of trauma. If we increase access to talking therapies, if we increase meaningful activity, and if we increase contact with families, that will all be beneficial to these people. It is difficult, as my colleagues said. Prison is supposed to be a punishment. It is supposed to be unpleasant. There is a balancing act to be had here.

Dr Green: My experience of working in prison is that, for the vast majority of people who work for the Prison Service, their day-to-day focus is on keeping a safe environment and rehabilitation. In general, I have been really impressed by prison officers and their commitment to supporting people who perhaps should be being nursed by qualified nurses; often officers are having to step into that and manage it. On a day-to-day basis, the Prison Service works really hard at keeping us safe in a rehabilitative environment, but that cannot take away from the fact that you have been separated from society, and various privileges that we all take for granted have been removed.

Q24 **Paula Barker:** Dr Allen, I would like to come back on a point that you made earlier about the trauma-informed practice, which sounds fascinating, to be honest. You may not have the data, but is there any data available about the impact of trauma-informed practice and reoffending rates in the future? Does it diminish those reoffending rates?

Dr Allen: That is an excellent question. I would like to be able to tell you that, yes, I definitely know both the data and that it does what I think it would do. There is some data from the Clinks prisons where some of these ideas have been implemented more readily, and there have been some studies ongoing. There is an organisation called One Small Thing leading some of the training initiatives in the female estate, and they have also commissioned some research into that, I think, at the University of Portsmouth. I can get you that and send it on separately if that would be helpful.

Paula Barker: That would be great. Please, if you do not mind, that would be really helpful. Thank you.

Chair: That is really helpful. Thanks very much.

Q25 **Janet Daby:** I thank the witnesses for your contribution so far. My

question is on something you have already touched on. It is about people who are acutely unwell, maybe psychotic. You have spoken about the fact that they need to be in a secure hospital and they need to be diverted or away from prison. Dr Green, you mentioned that there was a failure in the system. What do you think that failure is and what is the remedy? How should that situation be put right?

Dr Green: The process, as I think everyone within the system would want it to work, is that when someone is detained by the police and it is identified that they are mentally unwell, they get a full assessment by a psychiatrist or other appropriately qualified person. If, at that point, it is recognised that they need to be in hospital, the process, if necessary, of detaining them under the Mental Health Act should happen and they should go to hospital. What seems to happen is that it does not happen quickly enough. The clock, in a sense, is running and they find themselves before a judge or magistrate before the process of completing the Mental Health Act assessment is done or often before a bed can be found. At that point—and I have every sympathy with the court—they are left in the position of saying, "What else can we do?" Therefore, the person ends up in prison.

My experience is that everyone within that process is trying to do their best, but I suspect one of the big challenges is the availability of a bed on the local mental health ward, which means there just is not time to source a bed somewhere else. That certainly seems to be an issue.

Dr Hewitt alluded to having really effective liaison and diversion teams. Not everyone who is severely unwell obviously presents as unwell. I am sure many of you have experienced working with clients in the courts system. Sometimes, it needs someone else to say, "I think this person isn't well. We need to get them seen." There then needs to be an effective response to that, otherwise, again, as Dr Hewitt said, you see someone arrive at prison who really should have been spotted earlier. I think we need a more effective way of diverting people before they get to prison.

At a purely resource level, it makes absolute sense because, otherwise, they still end up in hospital, but it is six weeks later, not having been treated for six weeks and in a bed that they probably never really needed. They will be in one of Dr Hewitt's medium secure beds, which is far more resource intensive than one of my general adult beds. From every sense, it is a system we need to make work, and I suspect it is investing in that diversion.

Q26 **Janet Daby:** Thank you. Are you saying then that we should be investing in more secure psychiatric hospitals to make more beds available?

Dr Green: Our experience currently with secure beds is that there are significant delays caused by there not being bed availability. That may also be the case with general beds. Ironically, people are ending up in

secure beds because we cannot get them a bed at the local, non-secure unit when they need it. There seem to be issues at both levels.

Q27 **Janet Daby:** Dr Hewitt, would you like to add to that?

Dr Hewitt: I think that is right. Generally, I find that the delays in taking people from prison to hospital are too great. It can be easier to access secure beds if it is a very straightforward case. If the offence is very serious and someone is very unwell, it is quite straightforward to get them into secure beds. The issue that I find difficult is those people who may have committed low-level assaults or criminal damage, who require a psychiatric intensive care unit within the general adult estate—it is separate from the forensic estate. The secure units are forensic psychiatry. PICUs are general adult psychiatry. There is a reluctance to take people on forensic sections in PICU beds because they tend to stay in hospital a lot longer. It is a lot more complex. You are involving the courts and they perhaps do not have the expertise, but the level of security in terms of the risk the patient poses is appropriate. You do not need the secure unit to manage them safely.

It is about where we send people from prison. We cannot send them to general adult wards because they are prisoners. The very minimum level they can go to is PICU. There are not enough PICU beds. It is difficult to get access to those beds. Would we be able to send people to general adult beds if they are appropriate for them? I have several patients who have ended up in PICU whom I would be very happy to have managed in a general adult ward, including a pregnant woman who went to a low secure unit because a PICU was too unsettling for her, but she could have managed in a general adult ward if we had been able to send her there.

Q28 **Janet Daby:** Would you say this is really about service provision and the lack of it?

Dr Hewitt: It is, but it is also about the fact that, once you dealing with a remand prisoner or a convicted prisoner, you have to apply to the Ministry of Justice for a warrant to transfer them to hospital. The Ministry of Justice has minimum levels of security required for people in prison. If you are in prison, you need to have at least a PICU—you need to have a tall fence and an airlock entrance. Generally, the Ministry of Justice will not allow prisoners to go into a general adult ward because of the levels of security required. As my previous colleague was saying, if someone has committed a relatively low-level offence and ended up in prison when they should not be in prison, it means they need to go to a PICU bed, which is not clinically appropriate for them, but that is the only legal available action. Does that make sense?

Q29 **Janet Daby:** Yes, it does. What happens to that person during the time when they are in prison and acutely unwell and waiting to be hospitalised in a PICU setting? Are they given medication? For somebody who is already in the system, what happens and how long, on average, does it take for them to be transferred?

Dr Hewitt: Those are fantastic questions. We can offer people within prison prescribed medication that they would receive in hospital, but, if they say no—if they do not consent to it—we cannot give them medication. They are there, they are waiting and becoming more unwell as time goes on.

Very often, if they are acutely unwell, they might be very agitated, they might have paranoia about what is going on around them, and it is really difficult to manage them in a dignified manner. Prison staff absolutely do the best they can. They are absolutely fantastic, but they are not trained mental health professionals, and it is very difficult for them and it is very difficult for the patient.

Some prisons will have healthcare units where there will be some sort of clinical input. Other prisons will not have healthcare units, and people who are acutely unwell will be managed on the wings. They might have a cell where it is easier to observe people, but, out of hours, they are observed by a prison officer without any training. That wait is not pleasant for anybody. It is not safe. I think everybody who works in the prison would like it to be much easier to get people out into hospital quicker.

Q30 **Janet Daby:** Anybody else can respond as well. What is that wait? You have not given me an idea of what that is.

Dr Hewitt: A couple of weeks would be relatively quick, but I have waited months for people to go to high secure beds.

Q31 **Janet Daby:** When you say months, how long was that?

Dr Hewitt: Three or four months.

Q32 **Janet Daby:** That person has been extremely unwell during that period.

Dr Hewitt: Yes.

Q33 **Janet Daby:** Dr Sarah Allen, would you like to add anything to any of those questions?

Chair: Do you have anything to add, or do you agree essentially, Sarah?

Dr Allen: No, I am fine.

Chair: Thanks very much, Janet. That is very helpful. That is great.

Q34 **Rob Butler:** I have a couple of fairly small points that follow on from that. The Ministry of Justice, as I understand it, has to impose that higher threshold because, once somebody is on remand or convicted, there is then a security consideration linked to the justice system. The question really is: should the NHS be taking more responsibility or being held accountable for not providing the right care before it gets to that stage? One thing that has made me nervous when I visit prisons is that they seem to get all the blame. It is essentially that people, for want of a better phrase, have been dumped on them.

Dr Green: Yes. In some ways, that is certainly how clinicians feel and how I felt in prison. It is really upsetting when you are there on a Friday afternoon and someone who is really unwell arrives and they should be in hospital. Had they got any other illness apart from a mental illness, they would be in hospital. While I get angry and upset about that, I would not necessarily say it is because people cannot be bothered or anything like that. It is just a difficult system. If there isn't a bed, they have to go out of area. It is very hard to find beds.

Your point is right. We end up trying to care for someone in prison who by any measure requires to be in hospital, and, of course, we are held accountable for that care we give. People do their absolute best. Also, it has an impact on everyone else's care in the prison, because, obviously, a lot of resource is directed to someone that unwell; therefore, that resource cannot be applied to caring for the people who reasonably are in prison.

Q35 **Rob Butler:** I want to go to Dr Hewitt with the first question, but you have just led me into my follow-up question. Something else that I have often encountered in prisons is in the psychiatric care wards or units, which may be of very different standards and levels of clinical intervention depending on the establishment. Quite often people will say that hospitals will not take them, and forgive my lack of health service expertise, but, in layman's terms, because they cannot be cured or treated appropriately, and consequently they will not accept them, again, they are essentially just pushed back to the prison and the prison just has to deal with it.

Is that something you have experienced, and what is the answer to that? It seems like prisons who have them dumped on them are held accountable. Perhaps it should actually sit with the health service to do something about it.

Dr Green: You do find these really challenging situations where everyone agrees they have a mental illness and the view of the hospital may be that they are not going to benefit from hospital treatment. From my experience of working in the prison, I feel that they need a much greater level of care than I can provide in the prison. There is sometimes a gap there. That is a really tricky one to solve because some of that is clinicians discussing the minutiae. In fairness, in general, it is not them blasély saying, "We cannot cure them." It is them making a judgment about the suitability of hospital and, to some degree, their limited resources.

You are absolutely right: it is then another scenario where, as a prison mental health service, we are having to try to support and care for someone with very high needs. The answer to that may be that we need more specialist resource in prison, or it may be that there needs to be a different resource outside prison.

Q36 **Rob Butler:** I am aware of time running out, so, Dr Hewitt, can you

answer those two points very briefly?

Chair: We need to be brief with both the questions and the answers, because we have a second panel to get through yet.

Rob Butler: Absolutely. Dr Hewitt, could you be very brief?

Dr Hewitt: I think this is a very complex question. PICUs—psychiatric intensive care units—are designed to manage people for a short period of time who are acutely unwell and acutely behaviourally disturbed. I do not think they are set up to do the slightly longer-term bit of work with the prison population who need transfer. I think there is a service gap. It is about longer-term psychiatric rehabilitation, and there are not very many psychiatric rehabilitation beds any more.

Dr Allen: The other aspect that we have not spoken about yet is the offender personality disorder commissioned pathways, which might have a bearing there, particularly when there are issues of people being thought to be untreatable. We have all said we do not like the distinction between illness and behaviour, but there is a specifically commissioned pathway, the offender personality disorder pathway, which works with many of the complex individuals whom we have been talking about who might not easily fit into hospital beds. There is specific work both in the secure hospital estate and in prison and probation related to that population.

Chair: That is very helpful.

Q37 **Maria Eagle:** Can you tell us what your view is on the commissioning of services based on this primary and secondary care split, whether or not it is appropriate, and what the advantages and disadvantages are?

Dr Hewitt: At CNWL, and the organisation that my colleague works for, we think that integrated services are best. I think the more services are involved, the more gaps there are to fall between, and one service running everything makes sense. I do not see any real benefit from having lots of services catering for the same sort of patient. I do not know if other people agree with me.

Q38 **Maria Eagle:** Basically, we have gaps created by importing the arrangements outside the institution. Would that be a fair assessment?

Dr Green: Yes. The community in prison is not a cross-section of the community that that system was designed for. It should absolutely be an integrated system.

Q39 **Maria Eagle:** If the current arrangements are not meeting the needs of the prison population, what is the answer? How should they be arranged instead?

Dr Green: At a practical level, I think many prisons do run an integrated mental health service. It may be that it was originally commissioned as primary and secondary, but, as Dr Allen described, there is flexibility

within that envelope of funding. That is where most services in prison are going, and hopefully commissioning will follow that as those services get recommissioned.

Maria Eagle: The theory is that it is supposed to be the other way round. That is quite interesting to hear from you all. Thank you, Chair.

Chair: Thank you very much, everyone. Thank you very much to our three witnesses. You have been extremely helpful and we have had some very useful evidence from you. I am very grateful to you for your time and your trouble.

Examination of witnesses

Witnesses: Dr Hard, Dr Holloway and Simon Newman.

Q40 **Chair:** We now move immediately to our second panel: Dr Holloway, Dr Hard and Mr Newman. Welcome to all of you. Thank you for your patience. I know some of you have listened in to some of the earlier conversation. Could you quickly introduce yourselves and your organisation for the record?

Dr Holloway: I am Josanne Holloway. I am a consultant forensic psychiatrist. I work with Greater Manchester West Mental Health Foundation Trust. I am the associate medical director for specialist services, which includes our prison service and our forensic service, but I am here as chair of the forensic faculty, and I represent the Royal College of Psychiatrists.

Q41 **Chair:** Thanks very much. Dr Hard?

Dr Hard: Good afternoon, everybody. I am a GP by trade and I am here representing the Royal College of GPs. I chair the Royal College of GPs Secure Environments Group. I am also the clinical lead for the NHS England and NHS Improvement Health and Justice Information Service, which is the IT system used in the English prison estate.

Q42 **Chair:** Thank you very much. Mr Newman?

Simon Newman: Good afternoon, everybody. I am Simon Newman. I am the head of healthcare at HMP Berwyn in north Wales, but I am representing the Royal College of Nursing this afternoon as a member of the justice and forensic healthcare forum.

Q43 **Chair:** Could I ask for an overall take from the three of you to start with about the impact of the prison environment on prisoners with poor mental health? We have heard a lot about the statistics—the figures—and the prevalence of mental health within the prison population. Are there any specifics about the environment of prison itself as an institution that have particular impacts that need to be addressed, and are they being addressed?

Dr Holloway: There is a lot about being in prison that I suppose adds to people's morbidity, and, as the earlier witnesses said, most of it just exacerbates things that would happen to anybody outside prison anyway. However, I think you can mitigate against them. Even though they are inevitable, there are also things that you can do to mitigate against them.

The sorts of things that you think about when people are in prison that might cause stress or make the disorder worse are overcrowding, lack of privacy, solitude, lack of meaningful activity, isolation from social contacts, your loss of identity and sometimes inadequate healthcare. You can mitigate against all those things. I am sure we will talk about them a bit later, but you can improve healthcare, improve occupation, and improve contact with family and friends. One good thing that has happened in the prisons because of Covid was the £5 extra for telephone calls and the monthly videoconference calls with family, which have been a really useful, helpful addition that we need to make sure continues even after Covid. There are lots of things about being in prison that do not help.

Q44 **Chair:** Understood. Thank you very much. Dr Hard and Mr Newman, what do you think?

Dr Hard: If I could just jump in there, what has quite clearly not been mentioned in the evidence given before is that what happens in prison is temporary and that people need to go back out at some stage. Even if there is, as we have heard before, a double-edged sword—some people improve in prison and some people deteriorate in prison—you then have an additional barrier on the exit point and the disruption that follows through from that. Even for that small minority of people who improve and stabilise while in prison, we need better systems to dovetail their care when they leave prison.

Q45 **Chair:** Thanks very much. Mr Newman?

Simon Newman: Without a doubt, the environment impacts on mental health. What we must remember is that, even with very effective mental health services, we still need to ensure that prisoners live in an environment that is conducive to wellbeing, paying particular attention to that health triad of being able to sleep, eat a healthy diet and exercise. A tablet or talking therapies will not be an answer to everything. It is really critical to make sure we have that foundation of sleep, diet and exercise.

Q46 **Rob Butler:** I would like to ask essentially the same question but with a specific focus on young people, the under-18s, in various parts of the youth estate. What impact does the custodial environment have on their mental health? Do you have any other comments about young people specifically?

Dr Holloway: It is very similar to adults but worse, I would say. They are in a state of transition themselves. There is the added thing that education is very important for young people. That might be disrupted and that can, I suppose, affect their sense of identity. Family social

contact is very important. Who they make contact with and who their peers are, again, may have an impact on their mental health.

The other issue is that they are also in a transition. Even if they had mental health problems when they went in when they were youths under CAMHS, on the way out, if they are lucky enough to get the follow-up services that they need, it is going to be a completely different set of mental health support. It is more complex with young people than it is with adults, although it is still very traumatic for adult people.

Q47 **Rob Butler:** We heard from Dr Allen in a previous evidence session that the SECURE STAIRS model and also the CHAT very detailed analysis when young people come into custody is helpful and beneficial, and perhaps makes it a less severe environment than adult prisons. You seem to be suggesting the opposite.

Dr Holloway: I am not suggesting the opposite. I am suggesting you need to do more for young people in order to reduce the disability that comes from being in custody. All these things mitigate against that. That is why it is more important.

The other thing is that, because not very many youths go into custody and not very many women go into custody, they tend to have more needs, more issues, are more unwell than the male population. There is also a concentration of individuals with more severe needs in the youth and female estate than you might have in the male estate.

Q48 **Rob Butler:** Dr Hard, what is your perspective?

Dr Hard: It has been some years since I have looked after juveniles in YOIs, but my experience then was that they were essentially being housed in prisons designed for adult males and not for children. That has to be considered inappropriate for somebody at that age. There are complexities that juveniles face. The sad thing is the inevitability that I feel, or felt, having looked after those young men and women, that they would go on to be seen again within the adult estate. To me, it seems like a failure at the juvenile end, if you like, to have diverted them away or put services in place to prevent them from transitioning to the adult estate.

Q49 **Rob Butler:** Mr Newman, I know that HMP Berwyn is an adult establishment, but do you have any perspective from the RCN point of view?

Simon Newman: Absolutely. I have personal experience from working in the secure children’s estate as well as the young offenders and female and male estates. While my colleagues have already referred to the fact that their numbers are far fewer from a child and female perspective, the need is significantly more.

A particularly interesting point, to which my colleague referred, is housing children in an environment that was built for adults. Having worked in a

secure children's home, I can comment on the benefit of the support that is given to children within that setting that we cannot give to younger people or females within a prison. Without a doubt, having those bespoke environments for those particular high needs is absolutely beneficial.

Rob Butler: That is very useful. Thank you very much indeed. It is important to draw that distinction between YOIs, STCs and SCHs. Thank you, Chair.

Q50 **Angela Crawley:** My question is specifically to Dr Hard and Simon Newman. We have already covered some of the unavoidable consequences of imprisonment. Are there any examples of prisons or prison health services that have successfully supported prisoners' mental health, and could you outline what it is about those prisons and services that have effectively supported those and improved their mental health?

Dr Hard: That is a really complex question and one that I do not have an immediate answer to, because I think it is fair to say that the different types of provision across the estate vary from provider to provider. We have heard from the previous witnesses that an integrated model works well. The sad fact is that there is no real detail as to how that integrated model should work and how we could map that and ensure that it was being delivered in the same way across the estate. We then have to take into account the fact that almost every prison I have ever worked in has been very different in population needs. Again, we are missing data about how we design the services, how we create the pathways and how we integrate those services both inside the prison and how they dovetail with the community.

Q51 **Angela Crawley:** How does improved mental health look, in your opinion, and how does it contribute to the rehabilitation of individuals?

Dr Hard: I would start with the community. This is a point that was touched on with the previous witnesses. If we had more resources in the community, and we could divert more of the complex-needs patients away from prison and have them appropriately treated in the community, that would improve the experience of people with mental health problems in prison.

While in prison, we already have very good systems for screening at reception and the second stage screen in line with NICE guidance, but what do we do with that information that we have gathered and how well resourced are the teams that we have heard about, whether they be the primary or secondary mental health team? I would argue that, again, the services are just not adequately resourced to deal with the depth and the level of need and the variety of needs that we have heard so much about already. At the moment, there is not, in my experience, a perfect solution.

Q52 **Angela Crawley:** Okay, thank you for that, Dr Hard. Simon Newman, could I bring you in to answer those same questions? I am happy to

repeat them if you require.

Simon Newman: No, that is fine; thank you. No doubt, as my colleague and the witnesses on the first session alluded to, the integrated approach is quite clearly the best approach to take.

In terms of whole-system review and whole-system changes, again, as my colleague just alluded to, we need to ensure that community services are effective and accessible, because a number of members have reported across the estate men and women who arrive in court or arrive in custody who are unwell and who, in an ideal world, should have accessed community services. Rather than solely beefing up mental health services in prisons, let us look at community services to ensure that the population can access care before crime is committed, before entering police stations, courts and prisons.

Certainly, in terms of resources, there is a nursing skill shortage. In England at the moment, there are 35,000 registered nurse vacancies. That is just in the NHS; it is not including the private sector. That is just reported vacancies; that is not vacancies matched to need. As to where improvement is needed from a registered nurse perspective, it is an increase in student nurses to increase and improve the workforce.

Q53 **Angela Crawley:** That is a really helpful suggestion. Thank you for that. Josanne, I know that you want to come in. Can I ask you first of all a question, and hopefully you can answer both the question and the point you would like to make at the same time, if that is okay?

Dr Holloway: The point I was going to make is that we are talking about what the best service would look like. We do not know that yet, but there is a structure that we could use. The Royal College of Psychiatrists has something called the quality network for prison mental health services. It is a group of prisons that join voluntarily and do a self-assessment and share good practice. I have a whole list that I can send you of good practices that different prisons have introduced and that they share with colleagues. The quality network could be a route of trying to identify what might be working or what seems to work in improving mental health of prisoners. That is why I put my hand up.

Q54 **Angela Crawley:** Thank you very much. That answers part of my question. Specifically, what is your view of the use of prisons as a place of safety or for a person’s own protection?

Dr Holloway: My view is that it is completely inappropriate as a place of safety, but it can be an opportunity if the resources are there to divert people into mental health, because, sadly, for a number of people, the route into mental health is through the criminal justice system. One of the quite worrying statistics I know is that, if you are a BAME individual, you have 40% more chance than a white individual of accessing your mental health through the criminal justice system. We really need to make sure that our mental healthcare in prison is adequate and good enough because it might be the chance for an individual to get

appropriate care. Although it is not a good place of safety, we need to be able to lift people out of the criminal justice system into mental health when we can.

Q55 **Angela Crawley:** Thank you very much for that answer. Dr Hard, would you like to add anything to that question?

Dr Hard: Yes, certainly; thank you. I think prison as a place of safety represents a failure in the system. People should have been dealt with much sooner, as we have heard from the previous witnesses, whether that be in the community or when they are in contact with police custody and then diverted into liaison and diversion. Certainly, once they hit prison, we have also heard—and I cannot emphasise this enough—that the impact that somebody has with a severe mental illness once they are in prison is pretty catastrophic, not only for the individual but for the team, both health and custodial staff, who are trying to look after that person.

Q56 **Janet Daby:** Thank you, witnesses, for your contributions so far. My question is to Dr Holloway first. You have mentioned that the route for many people with mental health issues from the BAME community is through the criminal justice system. What needs to change? What is being done to make that change and to stop that from happening?

Dr Holloway: One of the other sad things, just to add to that, is that there is some evidence also that they are less likely to be identified at reception if they have mental health or a learning disability. It is about making sure that community services are accessible to all the population. That is important, because one of the reasons why it might be through the criminal justice system is that they do not find it as easy to access services in the community.

The second thing, as we said, is to make sure that they are identified and diverted once you identify them. It is about education, about how mental health, mental ill health, mental disability or distress is expressed by different people in different ways, and recognising that as a form of distress as opposed to labelling it as disruptive behaviour or whatever it might be.

To bring it all together, I think it is about education across the whole piece, making mental health more accessible to all our individuals, all our citizens, even in the community, and helping people to recognise that it can present in very different ways in different people and not to label it as "disturbance", if you like.

Q57 **Janet Daby:** Dr Hard, would you like to add to any of that?

Dr Hard: Whereas screening, as I have touched on before, is relatively good, bringing in Dr Holloway's point about accessibility, what we do not have is a very clear understanding of how we might configure services differently from one prison to another. If you are in a cat B local remand prison and you have a high population of foreign national offenders or

BAME, or whatever particular nuances you might need to consider within your prison environment, and how that differs from one prison to another in another part of the country, you might need different mental health services configured in that way to help support those people.

Q58 **Janet Daby:** In the last panel, one of the responses was that for people who are acutely unwell, whether they are psychotic or otherwise, it could take between two weeks to three months for them to be transferred to the hospital setting that they need and not a prison setting. To me, that sounds totally unacceptable, and you have already mentioned that as well, Dr Hard. I am interested in what effects you think that has on the patient themselves.

Dr Holloway: I have some numbers, if you want them, as to how long it takes to transfer prisoners. The average for a prisoner being transferred to a high secure unit is 160 days, to a medium secure unit 59 days, to a low secure unit around 55 days, and to a PICU about 16 days. The higher the level of security, the longer it takes to get transferred into prison.

As to what effect that has, it has been mentioned before in this panel. It is about increased distress, worsening of the symptoms, worsening of the disorder, and it will take longer to improve—if people have been unwell for longer, they might take longer to get better.

As has also been mentioned before, it adds stress to the staff who need to take care of them, which means that they have less time to take care of other prisoners. It impacts on everybody in the prison when you have an individual with high mental health needs who is still in the prison and not transferred out.

The other thing is that it is even wider in a sense because the prisoner's family and social contacts are also very distressed about their relative or their friend being in an inappropriate place and not getting the help they need. It is ripples, is it not, in the pool?

Q59 **Janet Daby:** Dr Hard, would you like to come in?

Dr Hard: I have just a couple of things to say. We have to remember that the services that commission health and justice inside prisons—and I am talking about England specifically here—are separate from those that commission the medium and high secure beds we have heard about before. There is, if you like, a boundary. There is no easy solution to say, "I have somebody in prison. I am just going to bounce them into a specialised commissioning bed," because a process needs to be gone through and there is the delay that we have heard about.

I have looked after some catastrophic cases in prisons who are struggling to get out to a secure bed. Watching the horrific nature of their deterioration, whether they are lying in a pool of their own urine or faeces, is utterly degrading to them. We cannot get away from the fact that that is inhuman and degrading, and they need to be in hospital. If you think about it, if you are working in that environment, whether in

healthcare or as a custodial member of staff, if you are exposed to that on a regular basis, you will start to think that that is normal and acceptable, and it is not. Those are the two things I wanted to bring up at that point.

Q60 **Janet Daby:** Thank you for being very clear about that. Simon Newman?

Simon Newman: I just want to echo the views of my colleagues. It is extremely distressing for the men and women in prison who are waiting for secure beds, and the conditions in which they are living is exactly as my colleague has just described. It is also the impact that it has on the wider prison and the impact on staff as well. It is not right. Even when we have modern facilities, the facilities are not suitable to care for men or women who are so mentally unwell that they are in distress.

Q61 **Janet Daby:** It sounds very distressing even to hear about it, to be honest, but thank you very much.

In terms of coronavirus and the restrictions it has had on prisoners, I am interested to know how it has affected prisoners who have severe mental health. How has it affected their health? I know in the last panel they talked about some positives as well as negatives. It has meant, in some cases, people only being allowed out of their cells for one or two hours a day and people having their toilets in the same room they are eating in. This is a common thing. How has it affected the mental health of prisoners? Have extra resources been needed to be able to manage those situations?

Dr Holloway: Covid has exacerbated difficulties that were already present. I am not going to repeat what the previous witnesses said, but I will add that, although Covid may have reduced things like aggression or violence in the short term, it is a very short-term thing to be a bit positive about, because I think it will come back to bite us once things open up. The one thing that has been good is that prisoners have been relatively safe in the sense that fewer prisoners, as a proportion, have caught Covid than prison officers. That would have had an impact on the prisoners themselves.

It has been alluded to a little before about the different ways of commissioning health for prisoners. So many services are involved in buying a piece of the service that is going to be provided for them. The impact of that has been, for example, that some of our prisons have different guidance about PPE, resuscitation and social distancing. That means that the interventions with the prisoners are more complicated or more confused, and it just adds to the distress.

Although there is good IT and that has been pushed through, the hardware and the resources often have not been there. Even though, for example, telephone conferencing has improved—and that is a good thing, because some prisoners can get quicker access to GPs or their psychiatrist—there is a lot that we still need to do to make the best of that. The one good thing that has happened is that, because of

information technology, if the resources and the willingness are there, it has been easier to liaise with community services and for community services to maintain contact with their patient while they are in custody. That has been good. Joining in on CPA meetings in the prison, by prisoners who have been transferred to hospital and the other way round by prisoners who have come back from hospital into prison, has been a little bit easier. It will be good if that continues to be maintained. I will stop there.

Q62 **Janet Daby:** Anyone else? Dr Hard, before I hand back to the Chair?

Dr Hard: What we have seen throughout Covid over the last 15 months is a disruption in all of the services, including the ability to provide mental health services to our patients. Undoubtedly, just as we are seeing in the wider community, there will essentially be a surge or backlog of cases that need to be dealt with. In order to meet that demand, we need extra resources to deliver those for those patients.

Q63 **Chair:** That is very helpful, everyone. Can I just step back a bit? We have seen a comment from the National Audit Office observing that, as far as it can see, the Government do not actually know how many people in prison have a mental illness. They do not know what the actual spend on mental illness is or whether that spend on mental health is achieving their objectives. On the back of that, what is your assessment of how well the nature of mental ill health in prisons is understood by the authorities, by people on the ground, or elsewhere? That posits quite a serious problem. I do not know the extent of the problem. Is it just numbers, or is it something deeper than that—they just do not understand what it is?

Dr Holloway: There has been a recent review of quite a worldwide series of articles. In numbers, it seems like the prevalence rate, for example, of psychosis is five times in prison what it is in the community, just to give you an idea, and depression is about three or four times what it is in the community. The prevalence rate is definitely higher in prisons. Those are the easy numbers, as was mentioned by the previous witnesses.

The emotional distress and the less clear diagnostic categories of mental health problems are much less easy to identify. The way to do that is through good assessment at reception. The quality network has looked at that. For example, only about 60% of services in its group had assessment by an appropriately qualified mental health professional at reception. It is not everywhere where the assessment of mental health difficulties is as good as in the places in which Dr Hard works. There are still quite a few places that need—

Q64 **Chair:** As well as better, more consistent assessment at reception, is there also a need, particularly with longer sentences, for some form of ongoing appraisal or review of the assessments, and does that tend to happen effectively in practice?

Dr Holloway: Yes, but I suppose they have to identify them first. If they have not identified them—

Q65 **Chair:** Once they have, do they get reviewed? Maybe Dr Hard can help us on that. What is your take on both those points?

Dr Hard: There are a couple of interesting points here. One is that some screening is done around learning difficulties within education, and that data is not shared with health, and, equally, the issues that you may have in relation to health are not shared with education. There are pockets of data there.

If we look at the ability to interrogate the SystmOne data, for example, as you would, let us say, primary care data in the community, we are years behind; we are probably a couple of decades behind the wider community at understanding prevalence-based illness and procedures around that just managing blood pressure. We do not have that depth of knowledge around mental health in prisons by a long chalk. Although screening is good at capturing significant diagnoses, it does not capture yet the complexity of mental health problems, as touched on by witnesses in the previous panel. As I have said in the written evidence that I have provided you with, we do not have a method for routine analysis and research based on the level of need of mental health of people in prison at all at this stage, and we need it.

Q66 **Chair:** Is that inability to share the data between education and health an issue because of protocols or because the systems are not interoperable? What is the actual obstacle?

Dr Hard: It is a little bit of both. It is something that I have been working on. There is a GP colleague of mine who lives not far away from me who is looking at how you screen for learning disabilities and difficulties, and it is something that we have come up against in just having our conversation. You know something about this individual, about their reading age, for example, or the fact that they have dyslexia, but in health I know nothing about it, and therefore I cannot orientate my services to meet the needs of that individual.

Touching on a point that I alluded to earlier, even if I did know that and I configured my services differently, what do I do about it when the person leaves? How do I transfer that information to the community so that they can pick it up, whether that is the mental health team, the GP or the education or housing local authority, et cetera? Do you see?

Q67 **Chair:** I understand that. That is a real issue, is it not, of transfer going forward? Mr Newman, what is your assessment? How poor is the understanding, and what can we do to improve it?

Simon Newman: Without a doubt, the health assessment when prisoners arrive in prison is effective. As my colleague has just alluded to, the electronic IT system is only 10 to 12 years old in the prisons and the data quality is patchy.

As to your original question, Chair, regarding the extent of mental health problems within the prison, at no point have we established at a specific

point in time what the need is. I think it is important to make the note that the population is forever changing. Prisoners are continually leaving and arriving. The need is fluctuating all the time. The need in each of those establishments is going to be very different. Until we get to the point where the data is of high quality and we have a wider view of the whole system and the need, we will not be in a position where we know what the need is, how much is being spent, and what health outcomes we are achieving as a consequence of the spend.

Q68 **Rob Butler:** Flowing on from that, I would be interested to have your views about workforce and particularly prison officer and operational staff. What do you think about the mental health awareness training? How regular and how appropriate is it, given a lot of the constraints that you have already described?

Simon Newman: What I have seen in isolated pockets that has been extremely effective is the roll-out of the mental health first aid training for custodial staff, but it needs to be extensive. My colleagues have already referred to the need for staff who work in prisons—not just health staff—to have mental health training. The feedback regarding the mental health first aid has been hugely positive, but it needs to be rolled out extensively.

The other group that would benefit from better mental health training and also greater awareness around what health is delivered and how mental health is assessed within prisons is magistrates. I think they need a greater understanding of mental health. We spoke about whether prison is an appropriate place of safety. We need to be clear with magistrates what sending an individual to prison to access mental healthcare really means.

Q69 **Rob Butler:** Dr Hard?

Dr Hard: Training that involves both prison staff and healthcare staff is essential because it brings together those two teams who have a dual duty of care for that person while they are in prison. It builds relationships between those staff members so that if they have questions they can raise them—there is a general level of understanding in the whole-prison approach. The issues that we face, however, are that there is a quite a significant amount of turnover within the staff. The training would need to keep up with that.

Although we are talking about mental health, one word that is really key and we also think about is vulnerability. A lot of people whom we are speaking about may not have a severe mental illness; they may be particularly vulnerable. There is a level of understanding around how, as a member of staff, whether you are a prison officer or healthcare staff, you deal with those vulnerabilities and how you pick them up as safeguarding issues. I do not think those systems are robust enough currently in order to meet the needs particularly of the vulnerable people. That goes back to the training issue that we touched on at the beginning.

Q70 **Rob Butler:** Absolutely. Dr Holloway?

Dr Holloway: I agree. I think training is important. The quality network found that that only happens with the mental health service provider in about 40% of the prisons that are part of the quality network. So there is a long way to go.

I was also picking up what Simon Newman said about training beforehand. There is something called—I am sure you know about it—the mental health treatment requirement, which is the community treatment order with a mental health treatment requirement, which is used abysmally poorly. I think it is 0.3% of all community treatment orders.

The college did a survey and found that about 10% of the current prison population would have benefited from or could have been managed with a community treatment order with a mental health treatment requirement. I suppose we could do something upstream, as it were, to prevent some people with mental health difficulties getting into prison. That requires education and a bit of resources as well for people to think about mental health treatment requirements. The position statement of the college has been launched today. In a pilot that cost around £75,000 to set up, they had 30 mental health treatment requirement orders. If they looked at how much time those individuals would have spent in prison, that would have been half a million pounds. It is a really cost-effective way of reducing the risk of somebody with a mental health condition being sent to prison because of safety concerns.

Q71 **Rob Butler:** On whom is the onus to make that provision? I recall, from being a magistrate and being aware of the mental health treatment requirement, that all too often you would be told it is not available and the local health trust couldn't do it. As a magistrate, you might well sit there thinking, "The person in front of me is an ideal candidate, but I cannot sentence them to it because it is not available in the area." That was not necessarily a fault of the Prison Service or indeed the justice system; that sat more with the NHS, did it not?

Dr Holloway: Correct. I think that is where it is. The resources are not there to do that. What I am saying is that the resources are not that big, and with a small resource you can have an impact on a lot of people. The college has put forward some ideas as to how much it would cost to roll them out. If we talk upstream, that is another way of reducing the morbidity or people with mental health problems getting into custody. But you are right: it is a resource problem with the NHS, which also does not know enough about it.

Q72 **Rob Butler:** I am sorry for cutting you short. I am aware that we are running very close to the end of our time. Very quickly, and I think I know the answer to this question, could you each say a brief word about what you think about mental health staffing levels in the custodial environment and how appropriate they are? Mr Newman mentioned right at the beginning the shortage of nurses more generally.

Simon Newman: Just reflecting back on the numbers of vacancies across registered nurses, across the NHS independent sector, et cetera, if we look at mental health provision in the communities, there are not adequate staff. Subsequently, there will not be adequate mental health staff available within prisons.

Q73 **Rob Butler:** That is because?

Simon Newman: There are 35,000 registered nurse vacancies in England because not enough registered nurses are being trained.

Q74 **Rob Butler:** Does that fall down to provision rather than a lack of people wanting to do the training, or lack of seeing it as a fulfilling and satisfying career or well-enough-paid career?

Simon Newman: I do not know whether you are aware, but there was a removal of bursaries for student nurses, which significantly impacted on attracting students into registered nurse training.

Q75 **Rob Butler:** That, of course, is across nursing generally. Is there a specific barrier or obstacles in terms of mental health nurses working in a custodial setting?

Simon Newman: It then moves on to issues around retention. If there is an abundance of posts available to clinicians, clinicians will work where they feel most valued and potentially in environments in which they are able to flourish. We have spoken this afternoon about a number of challenges working within the prison setting. It is critical to have effective leadership within the clinical setting and most importantly within the prison setting. As to being able to recruit and retain, every clinical area is difficult, but the prison environment in particular with this challenge is more so.

Q76 **Rob Butler:** Dr Holloway, from the perspective of psychiatrists?

Dr Holloway: We are down on psychiatrists. Another issue is that, even if you might have the right number of psychiatrists, some of them, or a big chunk of them, are locums, and they do not have the commitment or, I suppose, the need to be involved in clinical leadership. That is where commissioning counts. It is really important that, as part of the commissioning process, things like education and clinical leadership are really part and parcel of what is commissioned, and it is not just providing clinics, because I do not think that helps in the long run.

Q77 **Rob Butler:** Dr Hard, from the GP perspective?

Dr Hard: I think we would always benefit from increased resource around mental health in prisons. This was touched on by the previous witnesses. There is a big gap between the severe end of mental illness and the lower end that is managed by primary care. In between that, there is a huge volume of patients who cannot get their needs addressed currently because they do not really fit in either category neatly.

Q78 **Rob Butler:** Is it because they do not fit into either category neatly that there is the fundamental problem, or is it because there are not enough clinicians of whatever type in the custodial setting to care for them?

Dr Hard: It is both. Arguably, the volume is huge. You cannot meet all of those needs immediately either from a primary or secondary care element even if it is an integrated solution, as we talked about before. You may feel that, as a GP, "I can deal with some of this person's problems, but I can't deal with all of them." However, they do not meet the needs threshold for a secondary care consultant psychiatrist, who is visiting less frequently. There is that large volume of people in the middle who fall between those two stools. Of course, they may benefit from some of the things we heard about before, whether it be the talking therapies or Simon's point about having access to meaningful activities. It may be that we also need to support that with additional staff to work with those individuals to progress through their sentence or into the community settings where they go when they leave.

Q79 **Chair:** You talked about falling through the gap. That obviously happens within the prison system, as far as we can see. Is there also a risk of that falling through the gap upon release? How common is that? What could we be doing to prevent the falling through the gaps? You have touched upon the prison setting or integrated setting, but what about on release?

Dr Holloway: I think there is a big problem of getting people to have appropriate or any mental healthcare on their release. There are lots of reasons for that. One of them in particular is, for example, that half the individuals who leave prison have no fixed abode. Trying to work out which mental health service is best placed to meet their needs is a really difficult issue.

Secondly, because community services are so stretched, when individuals come into custody they are discharged from the community mental health team. Again, they need to be re-referred when they are discharged. This is something that we are certainly going to be picking up in the college on an interfaculty basis because it is not just forensic psychiatry; all psychiatrists need to have some principles around how to make this better. It is a big problem.

Q80 **Chair:** Are there any more comments on the release point?

Simon Newman: Without a doubt, the continuity of care on release is critical. It will be interesting to see the output from the accelerator project, which obviously includes the health elements to it, but it is also linking in to employment and housing as well, as my colleague has just mentioned. It is not going to be effective just to have a GP with whom to register and a prescription if the releasee does not have employment and housing.

Q81 **Chair:** That is fair enough. Dr Hard?

Dr Hard: The only other complexities I would add to my two colleagues' answers are the Friday releases, because, of course, nobody gets released on Saturday and Sunday, and the unexpected releases from court. Unfortunately, RECONNECT in England has not been able to get into full swing, which was the programme commissioned by NHS England, but I am very much looking forward over the coming years to see how that deals with some of the issues in terms of getting people into the community treatment areas.

Chair: That is very helpful. Thank you all very much, ladies and gentlemen, for your evidence this afternoon. It has been extremely informative to us and very useful. I appreciate you taking the time out to come and meet with us. If there are any further thoughts or information, as some of you said, do not hesitate to send that to us in addition to the very helpful written submissions we have had from you already. We are very much obliged to you. Thanks to colleagues. The evidence session is concluded.