HOUSE OF COMMONS

Justice Committee

Oral evidence: Mental Health in Prisons, HC 72

Tuesday 22 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; Maria Eagle; Laura Farris; Dr Kieran Mullan; Andy Slaughter.

Questions 82 - 172

Witnesses

I: Dame Anne Owers, Chair, Independent Monitoring Boards; Juliet Lyon, Chair, Independent Advisory Panel on Deaths in Custody; and Martin Jones, CEO, Parole Board.

II: Alex Chalk, Parliamentary Under-Secretary of State for Prisons; Kate Davies CBE, Director of Health and Justice, NHS England/Improvement; and Phil Copple, Director General for Prisons, HM Prison and Probation Service.

Examination of Witnesses

Witnesses: Dame Anne Owers, Juliet Lyon and Martin Jones.

Chair: Good afternoon and welcome to the Justice Committee of the House of Commons for the final session of evidence in our inquiry into mental health in prisons. Welcome to all our witnesses, whom I will come to shortly, but, first of all, as usual, we have to make our declarations of interest. I am a non-practising barrister.

Rob Butler: Prior to my election, I was a non-executive director of HM Prison and Probation Service, a magistrate member of the Sentencing Council and, perhaps relevant to this meeting, many years ago I was a member of the independent monitoring board of HMP YOI Feltham.

Laura Farris: I am a practising barrister, but not in the field of criminal law.

Paula Barker: There is nothing from me.

Maria Eagle: I am a non-practising solicitor.

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

Chair: Janet, I think there is nothing from you. Those are all the relevant interests to declare.

Can I welcome our first panel of witnesses: Dame Anne Owers, Juliet Lyon and Martin Jones? Perhaps you would each like to introduce yourselves for the record.

Mr Slaughter, do you have a declaration of interest to make?

Andy Slaughter: Indeed, Chair. I am a non-practising barrister.

Q82 **Chair:** Okay—in the nick of time.

If each of our witnesses could introduce themselves and their organisations for the record, we will then get straight into the questions.

Dame Anne Owers: I am Anne Owers, national chair of the Independent Monitoring Boards of England and Wales.

Juliet Lyon: I am Juliet Lyon, chair of the Independent Advisory Panel on Deaths in Custody. It is a non-departmental body sponsored by the Ministry of Justice, Home Office and Department of Health and Social Care.

Martin Jones: I am chief executive of the Parole Board for England and Wales.

Q83 **Chair:** Thank you very much. You have all given evidence to us before. It is nice to see you all again. Thank you also for some of the written

evidence that has been submitted from your organisations.

Dame Anne, from your perspective, given the role of independent monitoring boards, what is your assessment of just how much understanding there is of mental health needs within the prison population? Is there a good understanding? Is there a complete one or not?

Dame Anne Owers: I would never say that there is a complete understanding of mental health need. If you divide the world into pre-Covid and post Covid, there was a considerable input of mental health services into prison, mental health in-reach teams and so on.

Certainly, boards found that what they were describing was an extremely high level of need. In some cases up to 70% of prisoners in a prison had some sort of mental health need—complex and challenging needs. That went across the estate. In a young offender institution like Feltham, 44% of outpatient appointments were for mental health reasons. In women's prisons—this is well known—70% in one prison have mental health issues, but it is also across the male estate. Wandsworth has 300 to 380 mental health referrals a month. So they were establishing a high level of need. They were also establishing, of course, that the provision was not sufficient to meet the need, and that has been a constant issue.

Post Covid, there has been a real concern about unmet and unrecognised mental health need, because for quite a considerable time in the past year or so there has only been crisis intervention and acute mental health care. It would be very surprising if 23 hours of lockdown over a year and a half had not had a significant effect on prisoners' wellbeing to the extent that, in one open prison at Spring Hill, whereas normally 2.7% of prisoners coming from the closed estate would need mental health assessments, during autumn last year those proportions were 27%, 20% and 17% respectively. There is quite a high level of undiagnosed need right now.

Q84 **Chair:** The Ministry of Justice gave evidence to us and said, "We do not have a complete understanding of the overall prevalence of mental health needs of prisoners due to the cessation of NHS Health and Justice indicators of performance." Does that make sense to you? Is that something that is a consequence of Covid, or is it deeper seated?

Dame Anne Owers: No, I think that preceded Covid. I am not an expert on the exact ways in which this is recorded, but I know that the Prison Service has expressed concern about it not getting the right indicators from the NHS. We get indicators in individual prisons, but that is not a very effective way of establishing the overall level of need.

Q85 **Chair:** I understand that.

Mr Jones, from your point of view, when you have to deal with prisoners being considered for parole, from your insights, do you get the impression that there is adequate data and an adequate understanding

from the files that are submitted to your organisation?

Martin Jones: Our experience is that a significant proportion of those who appear before the Parole Board to be considered for release have mental health difficulties to some degree. Of course, there is a huge range within that of the different issues that may be faced, ranging from people with learning disabilities through to depression and anxiety, risk of suicide and self-harm, personality disorders and, finally, at the most extreme end, people with severe mental illness who may need to be transferred to hospital for treatment.

Certainly, our members report very real difficulties getting the correct diagnosis for those people to inform our assessment of risk, because, of course, that is key for us in making a decision as to whether somebody is manageable in the community or not and what support they need in the community.

The other thing that we and the Committee are very concerned about is, for example, IPPs. We get problematic behaviour. Quite often, that is symptomatic of mental health difficulties with people who are stuck in the system with deteriorating behaviour, and, quite often, that is linked to mental health difficulties and a loss of hope.

Q86 **Chair:** Understood. Dame Anne, is there anything more that could be done to measure mental health needs more accurately?

Dame Anne Owers: I am not an expert on that, Chair. I think it is often a question of resource. It is also a question of where you would want to measure it. For my part, I would want it to be looked at earlier than when people arrive in prison, in court diversion schemes and so on. That is a crucial place where you can make a really important intervention, and there is not nearly enough of that. It is about identification, but it is also about meeting need—and meeting need outside the prison system as well as inside it.

Q87 **Chair:** Juliet, anecdotally, people often refer to self-harm and suicide. They are often used as indicators of mental health in prisons. How useful from your experience are these as measures of need?

Juliet Lyon: I think they are useful and fairly dreadful indicators of mental health need. We know that people in the prison population, compared with the general population, are much more vulnerable and much more likely to be at risk.

I will give you a couple of sets of figures. We know that 21% of men and 46% of women have attempted suicide at some point in their lives prior to custody. That compares to a figure of 6% in the general population. We know that people are more likely to take their own lives in prison. Men are four times more likely to do that than men in the community, and women are 20 times more likely. So the risk is huge.

I agree with Anne Owers on the point about whether we should measure. A psychiatric morbidity study was conducted some years ago, so it is considerably out of date. It showed a very high degree of need indeed. Since then, there have been inquiries by the Health Select Committee and the National Audit Office more recently.

If one were thinking about scarce resources, money should be spent on preventive work. We have just heard mention of community sentence treatment requirements, particularly the mental health treatment requirement. There should be proper use of pre-sentence reports and mental health reports, a really decent assessment at the point of entering custody, and then at a point of any kind of proposed transfer. There are a lot of things that could be done to measure and assess individual need. Whether the expense of another psychiatric morbidity study can be justified, I am not sure.

Chair: There are some other suggestions there. Thank you very much.

Q88 **Laura Farris:** From the reading I have done before this session, it looks as if there is a high degree of uncertainty with a lot of prisoners as to what, if at all, the mental health condition is. Dame Anne, do you know this? Am I right in thinking that, for the prison staff, the prompt that a prisoner might have a mental health problem would be because of their behaviour? To put it in context, it would be more likely that there was something in the way they behaved rather than information arriving at the time the prisoner entered custody that would prompt the prison response. Is that a correct statement?

Dame Anne Owers: It is "both and". It could be information that arrives with the prisoner either on the prisoner escort record or the healthcare information that is passed on. That is far from perfect. Of course, many of the people whom we are talking about, sadly, will have been in prison before. They are exactly the kind of revolving door prisoner whom we talk about, who is in and out of prison because they cannot cope elsewhere.

But you are also right that, quite often, what would trigger something happening is behaviour. There are both, as Juliet has said, in terms of self-harm, but particularly in male prisons it presents as bad behaviour or as what are called "dirty protests", which is a phrase I don't much like because they are very rarely protests. They are usually an indicator of extreme mental and psychological disturbance. They are not transactional in that sense; they are behavioural. There are many things that would present and might then trigger assessments, but there should be an assessment of everyone on entry anyway.

Q89 **Laura Farris:** For what proportion of the prisoners who enter do you have adequate knowledge of their mental health? Anyone can come in on this, just to give the Select Committee a picture. Is it 10% or 30%?

Dame Anne Owers: It is really difficult to give an answer on that, I am afraid. What we know is what is picked up within prisons, and that varies

considerably from prison to prison. As I said earlier, you can be looking at up to 380 monthly mental health referrals from Wandsworth, which is a large, inner-city prison with 1,450 people in it, but that is still quite a significant proportion. There are 40% of those in another male prison with complex and challenging needs. That can get picked up on entry or it can get picked up later.

I am with Juliet on this one. I am not sure what the point would be of doing another very big survey, because we know there is a huge problem, and we know that at the moment prisons are not really the best places in which to tackle it, or not for anybody whose problem is essentially a mental health problem. All you can say is that it is a high level of need.

Q90 **Laura Farris:** We talk about mental health, but that expression is obviously quite vague. There is a significant difference between a serious psychiatric disorder like schizophrenia or personality disorder and depression or even milder spectrum disorders. Do you think prison staff are adequately trained to differentiate, and is there a mechanism that they would use or apply in undertaking that differentiation exercise in how they would refer, the urgency of the referral and whom they would refer to—all those sorts of considerations?

Dame Anne Owers: First of all, it would not be the prison staff who were doing those assessments. It certainly should not be. There is, as I said, specialist mental health provision in prisons—not enough but it is there. It is they who would be making an assessment of the kind of mental disorder that is there.

I think your point is well made, because it is prison staff who then often have to look after those people, whether they are looking after them in the general population or, more often, sadly, in segregation units. I do not think there is nearly enough training and support for prison officers who are doing that day-to-day job of dealing with people who are often extremely poorly.

The other thing, as one of your other witnesses just said, is that we are talking about a variety of different conditions. We are talking about what is mental health illness dealt with under the Mental Health Act, which means that you can transfer to secure mental health facilities. We are talking about personality disorder, which is often a catch-all explanation for, "We don't know what is going on here," which is the most difficult thing and where there is the least specialist resource.

We also have things like acquired brain injury. The sad thing in prisons is that the more ill you are, the more severe your confinement is likely to be and for longer, because you are likely to find yourself in a segregation unit either waiting a long time for a mental health transfer or else not being able to be transferred and passed around from one segregation unit to another. We gave evidence to the Committee of a woman with acquired brain injury who has been in segregation for over 1,000 days.

Also, in the high security estate, we know of at least one man with severe personality disorder who, again, has been segregated for over 1,000 days. They are not going to get any better.

Q91 **Laura Farris:** There can be a degree of a punitive element to somebody who exhibits more severe mental health problems?

Dame Anne Owers: It is not meant to be punitive, but in a prison it is often the only safe place to hold somebody who is a danger to others as well as a danger to themselves and who can manifest violent behaviour.

The other thing is that segregation units are too full of people who are on suicide and self-harm watch. It ends up being punitive, and it ends up being solitary confinement for a very long period, but that is a reflection of the fact that there are not appropriate alternatives. Some of those people, frankly, should not be within the prison system—they should be within the healthcare system—but the prison system ends up dealing with people in those extreme circumstances.

Q92 **Paula Barker:** You talk about solitary confinement and segregation. Would that not exacerbate mental health problems?

Dame Anne Owers: There is a very short answer to that, which is yes, in the great majority of cases, which is the point really. We need more alternative provision. For example, in Newcastle, there is something called the Oswin Unit, which is jointly run by the NHS and the Prison Service, and which provides both assessment and treatment for people with fairly severe personality disorders. But they are few and far between. There just aren't enough.

I worry when we are talking about creating more prison spaces. I was in a meeting very recently and learned that there are going to be 500 more prison spaces in the women's estate. If you wanted to invest, would you not want to invest in things outside prison that deal with some of the underlying problems that bring women to prison, which are largely mental health and substance abuse problems? Where you invest is critical in dealing with mental health issues.

Q93 **Maria Eagle:** Dame Anne, you already said in your introductory remarks that mental ill health and its incidence is much higher in the prison estate than it is outside prison. What impact has Covid had on mental health needs in prison, and what should the Prison Service's priorities be post Covid? Is there a distinction between the male estate and the female estate in that respect?

Dame Anne Owers: As I think I said earlier, there are a lot of undiagnosed mental health issues now sitting in prisons that will not have been picked up because prisoners have been behind doors for 22 or 23 hours a days, and because mental health services, which are now getting back, were for a time only crisis intervention. Essentially, prisoners have been in what is close to segregation for quite a long time, so it is not

going to make you any better. There will be a need for more resource to be put in to look at that.

Is there a difference between men and women? Certainly, the levels of self-harm in women's prisons have spiked more. There has been a 32% increase in self-harm in women's prisons over the past three months, and it has spiked again. It very much mirrors lockdown. Self-harm in women is often around the lack of contact with other people, families and so on, and less about a response to violence, which it sometimes is in male prisons.

Resource will be needed. You also need to look at the whole environment. When I was chief inspector of prisons, we did a thematic in mental health. We asked prisoners, who were suffering, as someone just said, a whole variety of mental health conditions from anxiety to depression upwards, what they really wanted. The big answers that came back were "someone to talk to" and "something to do." Those things have been notably absent from our prisons over the past year and a half.

Juliet Lyon: I feel particularly strongly about the impact of Covid, and particularly strongly that that has not yet been fully taken account of. There have been some very important missed opportunities that I wanted to draw to the Committee's attention.

The Scientific Advisory Group on Emergencies—SAGE, the Government's own scientific advisers—reported on 25 March in a publication on Covid-19 transmission in prison settings. That followed on from Public Heath England advice and advice from my panel, which had been to go in the last few months, certainly since Christmas, for universal vaccination of prisoners to allow for a safer environment in which some of the services that Anne has described could return, particularly in relation to mental healthcare, but also in relation to basically running a prison rather than having it as a holding pen. That was published on 23 April.

SAGE was very clear. It said that the current severe restrictions are having a highly negative effect on the mental health of prisoners and their families. It also said that, if you import a single case, you risk a large outbreak and that prisons could become reservoirs of infection—its words—including for variants of concern.

Nothing has happened in relation to those universal vaccinations, although, thankfully, we are reaching a point, because of parity with the community, that most people in prison—and I know you have a session with the director general, so he will be able to give you the figures—have at least the prospect of vaccination in sight. During this period when people's mental health was neglected, we ran a couple of consultations with prisoners. One man said, "I am sure there are a lot of prisoners suffering from severe anxiety, isolating in their cells, not knowing when they are going to be unlocked." That was the kind of feedback we were getting from people in prison.

When I talk to women in prison and talk to staff who have worked with them, that terrific spike in self-harm, which was really awful, corresponded with an almost total withdrawal of support and contact very suddenly. It was done in a very disciplined manner to try to keep people safe from the virus, but it actually had a profoundly negative effect on people in prison.

The other thing to say in relation to Covid, and it is important, is that we know that since August last year over 17,000 people have contracted Covid in prison and 13,000 staff have also contracted the virus. What is not known at all is how many are suffering from long Covid, and, of course, that will bring with it the kind of mental health difficulties that many of us will have heard described: the brain fog, the failure to concentrate any longer, feelings of depression, anxiety, sleeplessness and so forth.

It is hugely important now that we look to the Ministry of Justice and the Department of Health and Social Care together to institute some mental and physical health checks, literally individual by individual, so that people are aware of the extent of the problem. Here, I really would advocate measuring and assessing so that action can be taken both to respond to people with long Covid and to respond to the rising tide of mental health problems that we have already spoken about. Probably, long Covid clinics or something of that kind could be established. At the moment, the not knowing is very troubling.

Martin Jones: For me, it is about ensuring that people are properly identified and that the Parole Board makes a fair decision based on the evidence provided to us by report writers. The Parole Board has managed to keep progressing cases despite the pandemic, but I am worried about what will happen in maybe a year's time with people who have been stuck in custody awaiting psychological and psychiatric assessments, and the potential delays that there may be in the long term. We have been working with the Prison and Probation Service to ensure it is minimised in the long term and that some of the most vulnerable people are not kept in custody longer than they should be because of difficulties in doing those assessments.

Q94 **Maria Eagle:** There is a fair sense that the impact of Covid is that it will have worsened mental health issues, one way or another, across the estate.

Juliet Lyon, do you think the current mental health commissioning arrangements meet the needs of the prison population anyway, and do you think they are capable of meeting the extra needs that Covid has given rise to?

Juliet Lyon: The system is too complex, even though efforts have been made to try to simplify it a little bit. Talking to panel colleagues who work in prisons themselves, both really favour local commissioning and

working with local mental health trusts, even if it is more expensive, simply because the local trusts have the contact.

We briefly talked earlier about transfers. That is so variable across the country. There is a suggested limit—a target of 14 days from assessment to transfer. That has not been met on a number of occasions. In some cases, it appears to happen fairly easily and in others it is incredibly difficult. You need a commissioner who has a close working relationship with the prison. The complexities of having so many different commissioning arrangements seem to make it very difficult to communicate and pass on information.

From the IAPDC perspective, we know that is one of the main risks. If clear information is not passed on, that is when you can have somebody failing to pick up on suicide risk. It is really important that we get this right.

Regarding your point that it is worse now, we need to ask for extra resources. The Prison Service is not very good at asking for things, it seems. It seems prepared to be disciplined and do what is asked of it, and to cope come what may, but really not to ask. Actually, to ask now is very important. Schools and students have been given extra money for pupils to get some support for mental health. We should be looking for mental health support and additional resources in the community, probably through the local mental health trusts, to mitigate some of the worst impact of the Covid pandemic.

Q95 **Maria Eagle:** Mr Jones, perhaps you are the other person who would come into direct contact with commissioning situations. Do you think the current arrangements meet the needs of the prison population from where you sit?

Martin Jones: I think they need to improve. My observation would be that it can be incredibly patchy. Quite often, a parole board will be assessing somebody, they understand what their mental health needs are and how they might be supported in the community with the right support, but getting those arrangements in place can be incredibly difficult in some places. Sometimes, it requires my personal intervention with a senior person to ensure the right support packages are in place to support people who can be safely managed in the community.

The other difficulty is that, unless those support packages are in place, it inevitably results in somebody losing control in the community and being recalled to custody. Again, it is incredibly damaging to their mental health in the long term to be released, spending a couple of months in the community and then being recalled. There should be a much more universal view of what the system needs to ensure that the right support is in place much earlier, and that people's needs are identified much earlier in the process. It is not at all uncommon for a prisoner's mental health needs to be identified during the parole process, even though they may have been in prison for three to five years, and clearly that is highly

undesirable. They really should be arriving with us with a very clear idea of what their mental health needs are and how they are going to be safeguarded in the future.

Q96 **Maria Eagle:** Dame Anne, from the point of view of the IMBs, do you have any insight in respect of whether or not mental health commissioning arrangements meet the needs of the population?

Dame Anne Owers: We come across it most in terms of transfers, which Juliet and Martin have already mentioned, and that disconnect between people who clearly need provision. That is partly about the extent of provision and whether there is enough. Juliet mentioned the 14-day transfer window from second assessment. At Bronzefield, our biggest women's prison, only 14 out of 39 assessed women were transferred within that period. So you have that problem. In the youth estate it is, if anything, even worse in both provision and trying to move—well, certainly, in terms of provision.

Our view, which we have expressed in the current consultation on the Mental Health Act, is that you need somebody in the system with both the authority and the ability to ensure that transfers take place and that there is continuity of care—whether that is continuity of care after prison or continuity of care on transfer. I know people are looking at a model for that, whether that is a model within the existing healthcare system, which runs the risk of not understanding prisons enough, or whether it is from outside the healthcare system, in which case you may have a lack of authority to do anything. Something that can have both authority and ability to make those transfers within the commissioning arrangements is very necessary.

Q97 **Rob Butler:** I remember back in 2006, when I was contributing to my first ever IMB report at Feltham, we talked about there being too many young people with mental health needs who should not be there and should not be in the prison estate. It has been going on for at least 15 years to my knowledge, and probably well before that.

From all the annual reports you see from all your member IMBs, has anything improved over the last 10, 15 or 20 years, have things stayed the same or have things got worse?

Dame Anne Owers: That is an interesting question. You cannot deny that there have been improvements. Since the time when I was chief inspector of prisons and we did a thematic report on mental health, and when my predecessor, David Ramsbotham, did his first report on mental health, there certainly has been a much greater injection of resource, and of specialist resource—of actual healthcare resource—from those who understand mental health and how to manage mental health. But at no point since then have I observed anyone saying we have enough resource.

A lot of boards—Wetherby young offenders institute, for example—report a lot of vacancies in their mental health teams, use of agency staff and so

on and so forth. There have definitely been improvements, but in some areas, and particularly for those who fall outside a diagnosis under the Mental Health Act, particularly in the long-term high security estate, you have what is referred to as the merry-go-round. You move people from one segregation unit to another, and the last person to take someone takes the person no one else wants. You have these very disturbed and very challenging men in long-term segregation. But you cannot deny that there are improvements and a greater understanding of the issues and the needs.

Q98 **Rob Butler:** Who should be taking responsibility for people with the mental health needs that we are talking about, whether they are men, women or under-18s? Should it be the courts and the Prison Service, or should it be the national health service?

Dame Anne Owers: It is both, isn't it? What comes over very clearly from our independent monitoring boards, from the work that others, including Juliet's team and the inspectorate, do, is that there is not enough provision outside prisons. If you are a woman or a young person, that provision may be a long way away from where you are and where your family is.

My view now is that we need to invest more but not in prison, both before and after, dealing with mental health issues early, as Martin said, in terms of community provision, and often dealing with the associated substance abuse because they often run together, and also as a viable alternative to prison. As I say, there are some examples of that being done. Some of the units are now run jointly by the NHS and the Prison Service, which is sometimes appropriate because you need to look at security as well as healthcare. Some of those are jointly run provisions. It needs an injection of resource from the Department of Health and Social Care, as well as an injection of skills and experience.

Q99 **Rob Butler:** Juliet Lyon, what is your perspective, based both on your current role and your previous roles, on that split in responsibility between the Prison Service and the NHS?

Juliet Lyon: One of the major achievements, which obviously you and the Committee know about, is the reduction in the number of children in custody. We have, however, seen a rise in self-harm among children, particularly those in the secure training centres.

To answer the question, it is not a straight choice. Again, far more emphasis could be placed on preventive work. We were looking to work with the Magistrates Association on a survey looking at the use of community sentences with treatment requirements. We did this because the mental health treatment requirement handed down by magistrates and also by Crown courts features in just under 1% of all community sentences handed down by the courts, which is extraordinary given that it has been on the statute book for almost 20 years.

These particular sentences have to be made available and money has to be found so that, if the court decides that mental health is the driver for the offending and that treatment is largely the solution, they can make that choice. The magistrates made it plain that they were really interested in making that choice, but it is only available in a certain number of pilot areas. It is really important, particularly in relation to the spending review, to make sure that is rolled out uniformly across the country because that would make a significant difference.

The liaison and diversion services and the assessments in courts and police stations are working well, but they need this additional piece of legislation to be available to everyone. It is a very odd situation when you have something that is technically available but is not in reality in many areas of the country. That is one part of the answer, I guess.

You will know that I was at the Prison Reform Trust for a number of years and have worked a lot with children and young people. The vast majority of these children and young people come from a background of being in care. It was partly local authorities stepping up to the plate that enabled that reduction in numbers. There is still far more that could be done on that front to offer the support that young people need. That would be a mixture of local authority support and NHS care.

The criminal justice element actually could be very small indeed if things worked as they should. Now we have a sufficiently small number in custody to pay particular attention to individuals, which for years and years was not the case. I can still remember a study about self-harm where the academics involved simply could not find a control group because there wasn't a single young person they interviewed who could be part of a control group who had not harmed themselves, experienced self-harm, seen a cell mate or heard the screams in the corridor. There was just nobody who could say, "No, I am oblivious to all of that." It is so prevalent among very distressed, disturbed young people.

Prison obviously is not going to be the right environment, even if you support and train staff, because the staffing levels and ratios are pitifully small compared to any other environment where you might want to care for those young people.

Q100 **Rob Butler:** Martin Jones, do you have a view on whether if people had had more of a healthcare-focused environment, which can still be secure but perhaps run by healthcare professionals rather than a custodial one, run by those working day to day in prisons, they would have a better chance on release of living the life that they would deserve to live and that would enable them to be rehabilitated and not commit further offences?

Martin Jones: I wholeheartedly agree that, for most of the people you see in the parole system, the roots of their offending lie in their childhood, drugs, alcohol and mental health. Earlier intervention to try to get control of those issues is much less likely to result in long periods of

imprisonment and also get them in the place they need to be in the long term and prevent future victims. Certainly, a health-focused approach on what those needs are would be a much better way of ensuring that the public are safer in the long term, ensuring people are not kept in custody unnecessarily long and that it is reserved for those who remain a significant risk to the public.

Q101 **Rob Butler:** Do you think the NHS takes that responsibility seriously enough? Prisons, after all, do the best they possibly can, they would argue, with the people who are sent to prison, but should the NHS be stepping up a bit more here?

Martin Jones: If you look at the children who are at risk of coming into contact with the criminal justice system, many of them will have these needs, and, certainly, earlier intervention will have a much better long-term effect. All the numbers in relation to the drop in youth crime as we reduce the number of young people in custody would support that argument.

Q102 **Rob Butler:** Would it apply to the adult estate as well?

Martin Jones: Yes, I am sure it would. If you had the earlier intervention, a significant number of the people we see will have committed crime as a result of mental health and other underlying difficulties.

[Maria Eagle took the Chair.]

Chair: I am briefly going to be in the Chair while Sir Bob is otherwise engaged, but he will be back.

Q103 **Angela Crawley:** On the point that was made earlier, what consideration does the Parole Board give to prisoners' mental health when considering release? Are there particular cohorts of prisoners whose mental health prevents their release such as, as was alluded to earlier, prisoners serving indefinite sentences for public protection?

Martin Jones: It is absolutely a critical point for us. The heart of a Parole Board decision is understanding why somebody has committed a serious offence. Quite often, that is the key to understanding how the risk could then be judged to be manageable in the community and how you would support that person if they are released. We will often receive hundreds of pages of evidence about a prisoner's mental health—psychiatric and psychological assessments of that individual. We need to assess what their needs are. Leaving aside aberrant behaviour, because sometimes you get poor behaviour linked to mental health, you need to be able to work out what lies behind that into a workable risk management plan, what support would that person need in the community to be safely managed.

My concern is certainly that some of those cases take too long to get the information and the packages together to make that release in a timely

fashion, particularly with young men and young women who spend a significant part of their early adult years in prison, which in itself may not be good for their mental health. You get people whose mental health may have deteriorated significantly while in custody and it requires quite a lot of effort to get them to the point where that risk can be managed.

Our training to Parole Board members encourages members to have an honest assessment of the case. Ultimately, our focus is on risk of serious harm to the public in the future. You need not to get confused by a prisoner who, as was described earlier, does a dirty protest. What does that mean in relation to real risk in the community in the future? We are looking for risk of serious harm. We have, currently, 37 psychiatrists on the Parole Board who are really important for making decisions in these complex cases. They are critical for us to make the right decisions.

Angela Crawley: Juliet or Dame Anne, is there anything you would like to add?

Dame Anne Owers: Not from me.

Juliet Lyon: I want to say something about the deteriorating mental health of people serving indeterminate sentences. We did a brief report on that group and want to return to that group. We took a lot of submissions from family members and from people serving IPPs themselves. As Martin said, there is the lack of hope and the endlessness of it. People say, "Having Covid must be like being in prison, being restricted." No, it is not, because for those in prison it is like being in prison within a prison. For these people who are serving indeterminate sentences, I guess it is the very worst because there is no end at all. It is extraordinarily difficult. I have met staff working with these people, trying to inject some sort of sense of hope, some planning for the future. It is a really difficult situation, and it is clearly just not tenable.

This sentence was abolished a very long time ago, and I think it behoves Government to return to it and complete the task that Ken Clarke began with the abolition. We have absolutely no doubt in the IAPDC and the work we have done that it is continuing to damage their mental health and adds huge stress and anxiety to ageing family members who want to try, in many instances, to offer some kind of care.

Dame Anne Owers: It becomes a catch-22, does it not, because the longer people are there, the more they despair, the more their mental health becomes an issue and the more their frustration becomes an issue, the more difficult it is for Martin's colleagues in the Parole Board to be sure that they can be safely released? We have created this monster, essentially.

Q104 **Janet Daby:** Under the Bail Act 1976, the courts can remand an adult to prison for their own protection or, in a child's case, for their own welfare without that person being convicted or sentenced, even in cases where the charge they could face cannot result in a prison sentence. With that

Act in mind, what is your view on the use of prison as a place of safety or for the protection of a person who has a mental health illness or disorder?

Juliet Lyon: It is a contradiction in terms. That has become apparent from this conversation. It is not to denigrate the staff, who work very hard to try to keep people safe. It is not an appropriate place of safety. It is very interesting that the police, in quite an interesting alliance between the former Home Secretary and the head of the Police Federation, worked very hard to make sure that police custody is not seen as a place of safety, and deaths in police custody have dropped subsequently in the custody suites. We are very pleased to see that.

It is quite clear that you cannot have a situation where prison is considered a place of safety above all others. To give you a very quick anecdote, I received a phone call from a prison governor who was working absolutely 24/7 from the minute a homeless young man had arrived with some learning disabilities and substance misuse in a very severe state and was remanded in custody because there was no bed available in the area. The governor was determined to call everyone he knew to make certain that everybody put in the work that was needed. Of course, he did succeed in managing to find an appropriate place for that young man by the end of the following day.

To be in that position is very difficult, where you are responsible for someone's life overnight with very minimal staffing, knowing how very ill he is, knowing that the court has actually placed him there. This was a civil case, in fact. Amendments to the Bail Act are required.

There has been some interesting research recently in the Prison Service about warrants of concern and looking at how many people with mental health needs have ended up in custody, particularly in the women's estate, because the courts have deemed they need some form of protection. I do not think it is a question of scotching a myth. It is a question of not allowing it to happen, not allowing that place of safety, and setting up something else that would be health-led, which would provide that place of safety and care at a very tricky time in someone's life. To require that of the Prison Service is far too much to ask and could result in a disaster.

Q105 **Janet Daby:** Thank you so much. That is a very comprehensive response.

Dame Anne, I know you have already said that there is not enough provision outside the Prison Service. Do you want to add any more to that?

Dame Anne Owers: I just want to reinforce what Juliet said. For example, at Eastwood Park women's prison there have been—I cannot remember the exact period of time—five women who were so-called civil prisoners, not convicted of any criminal offence, simply sent there because it was considered to be a place of safety. It is simply not an appropriate place. In my previous role at the Independent Police

Complaints Commission, we argued very strongly, as Juliet said, for police stations not to be a place of safety. The only way you can stop it is by stopping them being such because they are not designed for that purpose at all, and it is part of the alternative provision that I would very much like to see.

Martin Jones: I completely agree with what the other witnesses have said. It is very outdated compared with what we know about the risks of people going to prison, the risk of suicide and self-harm. It does not make any sense to use prisons as a place of safety for these very vulnerable people.

Juliet Lyon: I should have mentioned that the Mental Health Act White Paper is calling for the end of the use of prison as a place of safety. That really needs to be pursued with vigour and energy, because that would do what we are saying needs to happen.

Q106 **Janet Daby:** That is really helpful information. Thank you.

In the process of transferring acutely ill prisoners from prison to hospital, is this sufficient in the transfer? If not, why not?

Martin Jones: The question I would have is about early identification of those people who have such acute needs to ensure that they are transferred at the earliest possible opportunity. We often see people where perhaps there is a question at the point of trial and sentence in relation to their mental health, and pretty quickly after they go to custody it becomes apparent that they are seriously unwell, and moving them to a hospital would be the best thing for their long-term needs and health. At the other extreme of this, people who are transferred to a hospital will then be discharged back to the Parole Board many years later. In essence, we are looking at somebody who may be well and ready to be released, and they have to go through the lengthy parole process with us. We are currently trying to undertake some pilots to speed up that process so that we can make a much swifter decision to release people in those cases, where it is appropriate to do so, rather than keep them unnecessarily in an expensive hospital bed. Early identification is really key for me.

Q107 **Janet Daby:** During 2020, 1,312 acutely ill prisoners were transferred to a secure hospital in England and Wales under the Mental Health Act. You are probably very aware of that. That is a huge number of people who were obviously in the wrong place to receive help.

Juliet Lyon: Recently I was talking to the daughter of a prisoner who had succeeded in getting her dad transferred during the first of the Covid lockdowns—a massive effort on her part. This was a man who suffered from severe psychotic illness. He was in such a bad condition when he arrived that his clothes had to be cut off him, she was saying, because his skin condition was so bad. He had been in a position and held in a prison where people could not attend to him or were not able to. I do not know the reason. I intend to look into it further. It was such a dreadful

story. It was great that she had succeeded, and she felt very proud of having done that, but for someone to arrive in a physically deteriorated state was very troubling.

As I have said, we know there are very variable times for transfers. Some take a very long time; some are done very promptly. Again, it is something the panel may want to look at. What are the ones that are done promptly doing right? It should be possible if it is picked up early enough to get somebody into the right place.

The mental health team at Wormwood Scrubs, when I went there with the NAO just before the lockdown, made it very plain that their work was taken up almost entirely with people who were awaiting transfer because their needs were so acute, whereas they wanted to attend to the lower-level mental health needs on the wings and also to work alongside staff and help them gain mental health awareness. Those kinds of things had to be put on the back burner because the needs of people who were acutely ill had to be met.

It is a problem that has to be gripped. The idea of setting targets has helped a little, but people can game targets and they can set the clock ticking when they make the assessment. If the assessment is delayed, it does not affect the end of target numerically. It is a question of diving in to find out the best practice, but also being more demanding of health. That seems to be a recurring theme. I do think health has to step up to the plate.

Dame Anne Owers: As I said earlier, one of our responses to the Mental Health Act consultation was having somebody in the system who has the authority and the ability to make these transfers happen when they should. There is an issue, as you said, about whether these people should be in prison in the first place. In some cases, the mental illness has developed, and developed really acutely, while they have been there, and to get those transfers done at the right time is really important. I agree with Juliet that you have to be very careful about targets because we have certainly had examples of assessments being delayed until a bed is available so that you can meet the target. You are hitting the target and missing the point if you do that.

The other issue that we are concerned about is re-transfers. Prisoners are sent to a mental health facility where, because you can compulsorily medicate and because you have a different level of care, they are stabilised and they are on medication, so they are switched back into prison where they immediately get worse again. Indeed, there are mental health provisions that refuse to take people because they are too violent or because they have autism as well as a mental health condition. People fall through those gaps. It really is important that we have a range of appropriate provision that is healthcare-centred for people whose problem at present is a mental health problem.

[Sir Robert Neill resumed the Chair.]

Chair: Thank you, Maria, for taking the Chair.

Q108 **Andy Slaughter:** We have spent a fair amount of time on this, and you may have dealt with this issue already. I was going to raise the effect of segregation on mentally ill and suicidal prisoners. What are your suggestions for improving the care? It seems to me from what you have said so far that things are pretty bleak. We know about the backlog in maintenance, staff shortages and the pressures of Covid. The only additional resources seem to be going into new prisons. Can you think of any ways, from your experience, that conditions could be improved immediately for particular prisoners who are segregated for those reasons?

Dame Anne Owers: I am not sure that there is an immediate solution to it. As you say, prison staff struggle and, day to day, try to develop some extremely good care for very challenging prisoners where the environment and the staffing is not the right place for them to be. I do not think there are any immediate answers. There has to be a range of approaches, it seems to me, such as more specialist units sometimes within prisons. There is a progression unit at Full Sutton, for example, which has done good work, although it has been very much knocked off by Covid.

We talked about other things, such as early diversion, joint provision for NHS and HMPPS, and specialist acute mental health care. There has to be a way of looking at the progression of people's long-term needs. Segregation is not the answer. It is the acceptance of the problem in many of these cases.

Q109 **Andy Slaughter:** It seems a slightly unusual question to ask, because there is a very fine measure of agreement and definition of the problem, and very little that seems to be on the horizon in terms of resolving it unless there is anything that any of the other witnesses know about.

Dame Anne Owers: The sad thing is that there are some examples of where you can do good work, but you need to put a lot of resource in and it needs to be a joint resource. As Juliet says, not in all cases but in quite a lot of cases it needs to be a healthcare resource. These are very difficult and challenging people. We are not saying anything is easy. If there were an easy solution, it would probably have been reached earlier. It demands resource that prisons simply do not have.

Q110 **Andy Slaughter:** I do not want to put words into your mouth. Drawing on what you have said already, you have a situation whereby very sick individuals are being put into segregation, which amounts to solitary confinement in many cases. That could be for long periods of time, up to months. That would worsen their conditions and will monopolise the time of staff because they are so challenging. They then cannot do work with other prisoners. That is a pretty vicious spiral downwards, is it not, in terms of service?

Dame Anne Owers: It is far from ideal. As Juliet says, the mental health staff cannot do it. The same is true if you look at prison in-patient units. Those prisons that have in-patient units, the IMBs say to us, are full of people who are acutely mentally ill. At various levels, there needs to be a much more fundamental look at how we deal with this.

Juliet Lyon: If you want to end on a remotely hopeful note, maybe Covid gives the chance for a reset. Actually, to some degree, most people have experienced solitary confinement, segregation and what it is like to quarantine. If the impact of that is unpicked carefully and taken very seriously, and if efforts were made to mitigate for that, it would cause a complete review of healthcare both in the community and within the prison setting itself. There is a need for a reset and a rebalancing, and that is completely clear from what has been said today. Covid could be used as a way of leveraging that much-needed change.

Q111 **James Daly:** I would just like to pick up on—I was going to say—a quick point, but I hesitate to say that, so I apologise. What I am interested in is the link between mental health and release from prison. Martin, what is the Parole Board's attitude to mental health issues and how they play into whether somebody is safe to be released into the community?

Martin Jones: Where we have real concerns about somebody's mental health—and it forms a significant proportion of the cases that we deal with, particularly those convicted of the most serious sexual and violent offending—we will try to use our specialist members to ensure they can bring their expertise to their decisions in those cases. Ultimately, it is whether that risk is manageable in the community. For us, the risk management plan and mental health support services are crucial for us in making that decision. It is an area that panels will focus on relentlessly to ensure that appropriate support is in place.

Certainly, our members will be taking the view that, if that risk is possibly manageable in the community with the right support, we will be pressing for the right support to be in place. Of course, we cannot compromise the safety of the public, and there is a balancing act to be struck as part of that. For many of the people whom we see with serious mental health difficulties, if you understand what the condition is that you are managing and you have the right support package, that risk can be managed in the community, and the job of the Parole Board is to hold the system to account.

One of the things that we are looking forward to over the next couple of years as part of the root and branch review of the parole system is an increase in the Parole Board's direction-making powers to require other agencies to put the right support packages in place so that we can ensure things are happening. At the moment, we are a bit timorous in asking those questions, whereas, if somebody is safe to be released with the right mental health support, we should require agencies to do that.

Q112 **James Daly:** How do you feel that the RECONNECT service is helping or

assisting, or not, as the case may be, with what you have just been talking about?

Martin Jones: I think it has potential. I am not entirely clear. I have not seen enough of the results of that so far to speak with confidence, but it certainly has potential to improve the system and could work in the long term.

Q113 **James Daly:** I have one final question for Dame Anne. It is really the same point, in that I suspect from my own experience in this area that the Parole Board is very reticent to release people with defined mental health conditions unless there is a very, very, very rigorous package of support available. Therefore, I have the awful idea in my head that, if you have a mental health condition that has not received the appropriate treatment, you will more than likely stay in prison because of that. Am I wrong?

Dame Anne Owers: No, I think you are probably right. I am no expert on parole. Martin is the parole expert on this panel. We have already referred to indeterminate sentence prisoners for whom this is absolutely the case, but it is the nature of the sentence as well, which adds to the mental health condition, which then gets worse. If there were more appropriate treatments for some of those people who are clearly mentally unwell in various ways, it would certainly assist in people being able to safely get parole.

Q114 **James Daly:** Do you have any experience of the RECONNECT service?

Dame Anne Owers: None at all, sorry.

Martin Jones: My only other comment and observation would be that it certainly is true to say that cases where the prisoner has mental health needs can be the most complex and take the most amount of time. It is not at all unusual for us to find that a case will take 18 months to two years to reach a conclusion, which seems to be exactly the opposite of what you would want to ensure. For very vulnerable people you should be trying to make a much faster decision, but the complexities you talk about feed into the opposite, and that is one of the things that worries me hugely.

Q115 **James Daly:** One of the things, therefore, about mental health treatment in prison is the link between the criminogenic need that is being assessed by the Parole Board and the treatment being received in the prison environment. Obviously, people with mental health issues are in prison for a wide variety of different offences. If you are in prison for a serious violent or sexual offence, the criminogenic need for that person is somewhat different from somebody for a different type of offence. It is exceedingly challenging, I would think, to have that level of bespoke support to every single person's individual needs within the estate. Is that a fair comment, Martin?

Martin Jones: Certainly. If you look at the numbers, we only focus on those who have committed the most serious offences; 90% of those released from prison each year are released without going through the Parole Board. We only look at the top percentage. We certainly see people, for example, recalled to custody because of chaotic behaviour and non-compliant behaviour in the community, and when you are looking at the case it is all about unmet need and how you support that. It becomes a real blancmange that requires a lot of unpicking to get to the right answer, and I am sure that more could be done.

Chair: Thanks very much indeed. I am very grateful to everyone. Thank you very much to our first panel for your time and your evidence today.

Examination of Witnesses

Witnesses: Alex Chalk, Kate Davies and Phil Copple.

Q116 **Chair:** Minister, it is very good to see you. Mr Copple, it is good to see you. Ms Davies, we have you remotely. You are not forgotten down the other end of the line.

Minister, thank you very much for coming to see us. With us we have Alex Chalk, the Under-Secretary of State for Prisons, Phil Copple, director general of prisons, and Kate Davies, director for Health and Justice at NHS England/Improvement.

Let me kick off, Minister. When we looked at some of the written evidence from the Department, you conceded that you do not have a complete understanding of the overall prevalence of mental health needs for prisoners. That is a frank admission, but why is that?

Alex Chalk: That is right, and we have been very frank about that. Evidence exists from the HMIP report, of which you will be aware, where they made assessments of the numbers of individuals, both in the male and female estate, who reported mental health issues. It is also right that a snap audit has taken place in the NHS this year, which will be reporting shortly, and there is an overall review of the provision in custody, which will provide some additional information.

I would like to make this point at the outset, if I may. The state's obligation to people in its care is a very solemn one, and it is one that the state takes seriously; that is point 1. Point 2: the state is indivisible; in other words, this is on all of us in the state. However, in terms of the architecture about how healthcare is provided, it is important that I do not inadvertently mislead the Committee as to how that happens. We accommodate the provision of that service—of course we do—but it is also right to point out that band 3, band 4 and band 5 prison officers are prison officers. They are not, as it were, mental healthcare workers. We can talk about the Act and various training that takes place. We accommodate that service. What we do not do is provide that critical primary mental health service.

We take extremely seriously the provision of mental healthcare within the custodial estate, but all that data does not necessarily specifically come to us. It will go via DHSC. We, of course, take a very close interest in it and we speak to our colleagues in DHSC, but it is right that the overall picture is not confused.

Q117 **Chair:** Does that data sharing and the fact that you are not ultimately the commissioner—you are not the person who can call the shots—create operational problems, Mr Copple?

Phil Copple: I would not say it creates operational problems, Chair. The reality is that, to get anything done effectively in a modern prison, you need to work well in a range of different disciplines. Certainly, from my point of view, there have been enormous strides involved in healthcare in prisons, in general, when you are talking about healthcare as a result of the NHS taking back responsibility in 2005. That has to be a better arrangement than a separate commissioning and provision arrangement being done outside the NHS within HMPPS itself. We have to work very closely with our health partners both on the ground, with the people who are providing the health, and strategically at a regional and national level with Kate and her team, who are doing the commissioning.

Q118 **Chair:** Do the data flows and accountability levels that the Minister referred to work in practice?

Phil Copple: In practice, data is shared. It is a normal part of working together. Some of the issues here are actually about what data is available to all of us.

Chair: It is the adequacy of the data.

Phil Copple: How easy it is to collect and so on, and for it to remain accurate over time.

Alex Chalk: It is also important to say that, while there are some things that have significantly improved—for example, the assessment when people first arrive in custody, in which I think we have seen significant improvements over recent years—it is also correct to say that sometimes an individual might not want to disclose that right at the beginning. Arrival in custody can be an extremely traumatic experience, and they may not want to disclose.

The second point and an area where I think there needs to be significant improvement is that, of course, people's mental health is not stable throughout their time in custody; it can deteriorate. The question is: how can band 3, or wing officers, necessarily identify that and refer them to health services within custody, so that the picture is a dynamic picture and is not assumed to be static and remaining unchanged from the moment of admission? Do you see the point I making?

Q119 **Chair:** I get your point. Ms Davies, can you help me on those two points? First of all, is there enough understanding? Do we have the data to fully

understand the need, and what about the Minister's point that it is dynamic and can change? How does the system from the NHS perspective actually operate to pick that up?

Kate Davies: Stressing the point that the Minister made, from 2018 onwards we put in the requirement for every single man and woman going into the adult estate, and also the children and young people's estate, to have first-day screening. That includes all elements of mental health and physical health, but most recently improves what it means for mental health and, I have to say, for women's screening as well.

Secondly, it is a requirement that they have a second follow-up screening within seven days. That is really important because, as the Minister identified, it is quite often when men and women go back to their cell, they are in custody for the first time or they may be in custody on repeated occasions, that their drug misuse may well decline or change or become more chaotic. Their own anxieties, their own needs around medication and psychosis then come to the fore, so those two elements are absolutely essential.

What certainly has improved since I was last in front of this Committee has been the data to support and assure that that screening takes place. We know that 92% of men and women in the adult estate receive their first-day screening. Of course, we want 100%. It decreases a little on their second screening appointment, but we monitor that very carefully, prisoner by prisoner and commissioner by commissioner.

On the other question that Phil Copple answered around working together, it is essential that we work closely together and we share information and data. We have what we call a prison pressures report, which is about quality monitoring of suicide, self-harm, deaths in custody, mental health and substance misuse. We look at the rating of prisons across the 110 adult prisons that may have different areas of need and risk, escalating that risk and concern before it gets to a point where we are all concerned about it in a way that is not good enough. That has been very successful in the last two years of implementation to work together to identify those prisons that are at risk or have concerns.

Q120 **Chair:** Ms Davies, both you and the Minister referred to screening assessment upon arrival. The Lammy review, you will remember, noted that BAME prisoners with mental health needs were less likely to be identified at reception than white prisoners. Is that still the case? What does the data tell you now?

Kate Davies: That was an incredibly important challenge from the Lammy review. As part of that, one of our requirements was to ensure that we monitor and support it. Black, minority and Asian prisoners are monitored as part of that screening, particularly across protected characteristics. At the moment the rate is one percentage point less than for white average counterparts for first, initial-day screening. It drops. There is a concern about second screening for our black, minority and

Asian men and women, which is less than for their counterparts within the white ethnicity group. We are monitoring that very carefully. It was a challenge that we took up in the Lammy review and one that has been very important to us.

Q121 **Chair:** How much less second screening than their white counterparts?

Kate Davies: For 2021, the data for second screening is 65% for black and minority men and women and 73% for our white patients.

Q122 **Chair:** What are the steps being taken to bring that gap down to get us to something like first—

Kate Davies: Moving back to the way we support all our commissioners, all our individual prisons, it is very important that we identify where those outliers are. Is that a situation that is common across some prisons? We know there may well be prisons that have a higher representation of black and minority men and women. It may well be a particularly acute issue across all ethnicities and race and gender. There may be issues within reception prisons where you have a higher churn of men and women going through and where, in some areas, there may well be a higher churn of black, minority and Asian men and women. It is really important that we identify where those outliers and needs are.

Q123 **Chair:** Minister, are you satisfied that we are making progress on the Lammy recommendation?

Alex Chalk: It is undeniable that we are definitely making progress, but we remain vigilant. The key to this will be ensuring that this document, which is the service specification that the NHS imposed for that initial assessment, thereafter continues to deliver what is expected. I am confident that we are moving in the right direction. We are absolutely committed to the central tenet of the Lammy review, which is "explain or change", so that if there is a divergence within custody either we can explain that for the reasons that Kate was starting to indicate or, indeed, we make adjustments. We are absolutely committed to that.

Q124 **Rob Butler:** Mr Copple, independent monitoring boards often say in their annual reports that there are many people with mental health needs who should not be in prison but are, to use the Minister's words, being accommodated there. My own experience having visited many prisons, although not as many as you, would seem to echo that.

Can you describe a little some of the challenges that are faced in prison, particularly by your staff, who, in my experience, do a tremendous job of trying to achieve the best service they can? Describe a little bit the challenges that they face dealing with people accommodated in custody rather than in a healthcare environment.

Phil Copple: It is right to say that there is quite a spectrum of mental health needs. There will be a range of people with whom we work in partnership with mental health providers to try to look after, but they do not meet the threshold to be sectioned under the Mental Health Act.

In respect of the cohort you refer to where it could be said they should not be in prison at all, and who perhaps do meet that threshold, we can have lengthy periods where we have to look after those people where they are undergoing a period of assessment and then they may be seen to meet the criteria but there can be waits before they actually move. During that period, and it will vary with the individual and their diagnosis, we can often have quite serious, sometimes very extreme, issues that they can present of harm to themselves and to other people. It is sometimes the case that staff have to deal with very traumatic incidents in relation to those individuals. I won't give graphic examples, but some of the self-harming behaviours that staff have to deal with can be absolutely appalling and extreme.

I heard some of the evidence from the earlier witnesses, and it is correct, as Dame Anne Owers said, that sometimes those individuals can end up being managed in segregation units, which is far from ideal but is necessary because of a lack of any other safe location to hold them during that time. Staff try to work very hard with nursing staff, mental health staff, who provide in-reach service into the prison to try to support people. Essentially, in that scenario, we are struggling with the fact that it is not the right place and we do not have the right range of skills, including in the mental health team because they are not there to deal with that group of people other than in the very short term.

The other thing to bear in mind is that it inevitably pulls resources away from everybody else, including a lot of other people with less acute mental health needs whom the services and the staff are also trying to support and could do a better job with if those individuals were not with us in such numbers and for such periods.

Q125 **Rob Butler:** Minister, as a result of that, assuming you accept the evidence given by the director general, do you think there is an argument that there should be some alternative provision, directly the responsibility of the NHS, rather than the accommodation being within the remit of the Prison Service?

Alex Chalk: The bottom line is that, very often, people who have acute mental health problems should not be in prison. The sentencing White Paper from 2020 made this very stark and used quite graphic language. I made a note of it in preparation for this. It said, "Prisons should be places where offenders are punished and rehabilitated, not a holding pen for people whose primary issue is related to mental health." If that is the issue, what is the answer?

There are two aspects to that. First, you have to make sure that people are not going into custody in the first place if they should not be. You cannot legislate for people developing a mental health problem, but you do know that position. How do you do that? First, by ramping up the community support in the first place such as, for example, having crisis mental health teams at A&E, having the crisis helplines, having the mental health ambulances and so on. You can hopefully try to address

some of these issues before someone gets involved in criminality: point 1. Point 2: if they get to the police station, you must ensure that the police have the resources they need to divert people.

Also, if people find themselves in custody and they develop an acute mental health issue, we have to get them out and into hospital as quickly as possible. One of my key priorities is the 28-day target, which, incidentally, derives from the NHS and is in their guidance document from June of this year: in other words, 14 days from presentation to diagnosis and a maximum of 14 days from diagnosis to transfer. Those are the critical things, but it all stems from the central position that, if people's primary issue is a mental health crisis, they should not be in prison.

Q126 **Rob Butler:** Kate Davies, should the NHS be doing more to accept that responsibility?

Kate Davies: I am very proud to be director of health and justice in the NHS, taking on board since the Health and Social Care Act 2013 the responsibility of commissioning for patients within the prison sector and the criminal justice system. It is absolutely essential that the NHS is central not only to clinical standards and NHS needs and requirements for men and women going in and out of criminal justice—sometimes, let's be honest about it, very serious offenders who are going to be in the prison system for many years. Often, as we know, in the prison system 60%, if not more, of men and women are going in and out in under six months. It is absolutely essential that the NHS is part of commissioning those services.

It has often been said by others—not me—that the commissioning of health and justice by the NHS in prison systems is world leading, but there is still much more to do. We are working in a prison system at the moment that has seen a massive increase in substance misuse. It has seen an increase in the number of men and women with vulnerabilities both in the community and coming into prison, and it is really important that we have the resources—obviously, it is a Government decision to look at that—to support that increased need and requirement.

Lastly, on the NHS, one of the things that the long-term plan was very clear on when it was published in January 2019 was increasing the pre and post-custody services and putting in additional investment for prison-leaver programmes, the RECONNECT programme, which unfortunately because of Covid has not yet got up to speed as we would have liked, and also embedding the liaison and diversion programme now 100%, and alternatives to custody. That has to be the answer across the whole of the system.

Q127 **Rob Butler:** As a very senior leader of the NHS, are you comfortable with the number of people who are accommodated in prisons who have mental health needs, as we have heard, who are not being cared for full time by healthcare professionals but are being cared for, to the best of

their ability, by prison officers? Do you feel that is right and okay?

Kate Davies: I am certainly not comfortable with the fact that our prison system—particularly in the last couple of years that has been exacerbated by the needs and requirements around Covid and social-distancing restrictions—is still full of very vulnerable patients who do and should receive individual care and support.

Am I comfortable that the NHS is committed to increasing, and has increased and is continuing to increase, our priority of mental health, substance misuse, integrated provision and physical healthcare conditions, which are often diagnosed for the first time alongside mental health conditions in the criminal justice system? Yes, I am. I think the NHS is very committed to patients with that vulnerability. A question was asked right at the beginning. An assessment of those needs in prisons and the criminal justice system has sadly shown that it has decreased and is disproportionately higher than in the community.

Q128 **Rob Butler:** Minister, are you satisfied that the NHS is doing absolutely everything it can to look after people who have been sentenced to custody but clearly have a mental health need?

Alex Chalk: We always need to do more. There is no question that we always need to do more. Let me give you one example of some of the things that the NHS is doing now. It is a document I alluded to before. This is from 10 June 2021, hot off the press. It is the transfer and remission of adult prisoners under the Mental Health Act 1983. This is the first time that it is doing what we called for in the prisons White Paper, which is, bluntly, to make a diagnosis and send them to hospital. That is now in the guidance, and we warmly welcome that.

The other point that has to be borne in mind, which is a point that Kate very fairly made, is that if somebody presents with paranoid schizophrenia in some ways it is almost an easy case. The difficult ones are where people have a combination of issues. It might be a neurodiversity issue—a brain injury, for example. Combine that with alcoholism. Combine it with the fact that there may be trigger events that lead to episodes of poor mental health. These are extremely difficult cases.

The direct answer to your question is that I think the NHS has made really important strides. We have been very clear about what we hope to see.

The final point I want to make—because this is full spectrum—is that it is critical at the time of sentence that we want to have sentencing judges who receive that PSR from the probation officer saying, "We think there is a mental health context," to be able to say either, "Right, we are going to send you for a section 37 hospital treatment order," for example, or, alternatively, "Do you know what? We are not going to do that. We are going to have a community order with a mental health treatment

requirement, potentially allied with some unpaid work so that you feel the debt has been repaid to society."

We want to roll those out and we are massively ramping it up so that the courts have those alternatives, which are credible, punish the offender, if that is what is required, but also secure that early rehabilitation. Whichever way you slice it, in any country in the world, dealing with significant mental health issues in custody is always going to be very difficult.

Q129 **Rob Butler:** As we heard from the previous panel, judges and magistrates are often very keen to impose those sentences but they are frequently not available in many areas because the NHS cannot make them available.

Alex Chalk: Which is why we are putting a huge amount of resource into this. As part of the £2.3 billion, which is the additional amount going into mental health, we have a target to increase the number of CSTRs with a mental health treatment requirement to cover 50% of England and Wales by 2023, and we want to go further still. These are difficult, intensive and expensive orders, but we are very clear that this is something we need to focus on. As I say, give the courts the alternatives so that they do not have to sit there thinking, "What on earth are we to do? We have to punish this offender in order to keep faith with the society that asks us to make these decisions." The British people expect punishment but also rehabilitation. When it comes to mental health, they rightly expect it to happen early, and that is what we want to deliver.

Q130 **James Daly:** Kate, what are the preliminary findings of the NHS England-commissioned mental health needs analysis?

Kate Davies: There are a number of pieces of work being done around the mental health needs analysis. The first, as the Minister has already alluded to, is that we undertake a yearly audit of mental health needs. That has been undertaken for the last four years. Unfortunately, we did not do it last year because of Covid and the restrictions of Covid. I am very happy to tell the Committee today that that mental health benchmarking audit took place on 16 June. It is important that we do that at a moment in time on a particular day where every single establishment is part of it. Of course, I cannot give you the findings because that has only just been done. I am sorry, but there was obviously a close on the one during the Covid pandemic outbreak.

We are just about to publish a report by the Centre for Mental Health, which we commissioned to look at the needs assessment of mental health in all our establishments and, particularly as I think you asking the panel before me and my clinical panel colleagues where the gaps and analyses are that we need to look at around long-term conditions. Also within the whole pathway of care, we need to be doing more as part of early interventions.

One of the findings in that needs assessment is more to do with prevention and early assessment, particularly now that we have the recommendations of the Mental Health Act review that Sir Simon Wessely chaired around prisons not being used as a place of safety, and very clear recommendations for us to monitor and support interventions in assessment as part of remand or bail hearings for mental health needs and conditions across the criminal justice system. That is just a selection. It will be published very soon.

Q131 **James Daly:** That is good news. Thank you. Can I ask one specific example related to prevention and early assessment? I was looking at some research from Professor Susan Young. Kate, I do not know whether you recognise these figures. It is estimated that 25% of prisoners have ADHD. If the appropriate screening and treatment programme is applied and entered into, the research suggests that the reduction in criminality after release from custody is 40%. There seems to be an issue with ADHD screening on entry into the estate. If I am wrong on that, please tell me. Could you comment on what seems to be quite a big issue within your remit within the prison system?

Kate Davies: I am familiar with some of those statistics, but I am not familiar in great detail with that particular report, so I do not want to comment on that. I am very happy to go back and have a look at it. It is important as part of ADHD and what it means around the whole complexity of needs in mental health, learning disability, autism, Asperger's; also what that means with issues that may be undiagnosed and quite often are diagnosed for the first time while in prison, ADHD being one of those. That early assessment is one of those reasons why it is absolutely essential.

One of the stark statistics that I am particularly aware of as part of what we are doing with our policies around learning disability, which, of course, is different from mental health, is where there are dual elements. A higher propensity of men and women with learning disabilities and learning needs are entering the prison system because of their mitigation at sentence and not being part of early interventions. The information and statistics around ADHD are absolutely key to that as well, so thank you.

Q132 **Maria Eagle:** Minister, we have been told in evidence that mental health commissioning in prisons is based on the split between a secondary forensic in-reach model, which is designed to deal with those people who have very severe mental ill health, and a more general primary care model that reflects the way in which these services are structured in the community. We know that in prisons the spectrum of mental ill health does not mirror what we see in the community.

Are you clear that that arrangement is suitable to meet the needs of the population in prison? What are you doing to address the needs of those whose diagnosis is not enough to enable them to get secondary care but is more severe than would be appropriate for the primary care end of

your commissioned services?

Alex Chalk: Respectfully, I think that is an extremely fair challenge because it is precisely the issue that is often faced in prisons. People are sufficiently ill that they need some specialist intervention, but it may be that they do not cross the threshold to be transferred. Obviously, that is a matter of clinical judgment. In the Prison Service, as I said right at the beginning, prison officers are not well placed to make those assessments, and, indeed, they can't make those assessments. Were they to do so, they could be doing an injustice to those individuals. It must be a matter for the primary care facilities in the prisons.

What Kate would say—and she can more than speak for herself—is that, where those assessments are made that an individual has, for example, severe psychosis and needs some additional care, the key is to ensure that that treatment is provided quickly, which is why the point about delay is so critically important. However, I am prepared to accept that there will be some cases where, because of the complexity that I indicated before as it is a combination of circumstances, finding the precise tailored treatment is difficult, and that is one of the great challenges that we face in custody. Ultimately, that must remain a clinical judgment. That must be a matter for those experts who are in the prison. The job of the prison officers has to be to identify those cases where somebody is presenting a concern to that officer to ensure that they get down to the facilities and those decisions are made there. It may be one that Kate can take further forward following those introductory remarks.

Q133 **Maria Eagle:** I will ask Ms Davies, but could I ask you, Minister, before I move on to her, if you know how many prisoners are in the position of falling between the two stools of your commissioning arrangements?

Alex Chalk: It is very difficult to make an assessment of that because it is episodic, as I indicated. That is the anecdotal evidence we get from prison officers or, indeed, from inspectors who go there. There are people who wax and wane. Sometimes, they have issues where their mental health deteriorates and sometimes they do not. What I can say is that, where it is necessary for those individuals to go and receive that treatment, it is what takes place.

Our responsibility is to make sure that prison officers through their POELT training are alive, potentially, to suicidal ideation through the ACT process, but also they are trained to identify where there may be the kinds of warning signs that mean, in simple terms, that this is an individual who is clearly experiencing some sort of crisis; we need to get them that kind of care. However, thereafter, it must be a clinical assessment. I want to make that clear. It is really not something that prison officers are well placed to opine on.

Q134 **Maria Eagle:** Do you intend to review these commissioning arrangements?

Alex Chalk: Act one, scene one is to get the assessment, which Kate has already indicated and that we expect later this year. It did not happen last year because of Covid, as we know. There are two aspects to it. There is the snapshot from the care that was provided earlier in the year, but also the overall audit from this year. We will be looking at that very carefully to assess what is the level of need at present, are the resources in place to make us comfortable that we are satisfied that this is an inadequate service, and, if not, I will need to speak to my ministerial colleagues to make sure we are in a place that we are comfortable with.

Q135 **Maria Eagle:** Perhaps you are already reviewing the commissioning arrangements, on the basis of what you are saying there.

Alex Chalk: No, we have to take it in stages. You cannot review the commissioning arrangements until you know what you need to commission for. That is why it is so important for these regular audits to take place, and that is why we will be looking forward with interest to see what the latest one uncovers.

Q136 **Maria Eagle:** Kate Davies, do you recognise the problem that I started out by putting to the Minister about the commissioning arrangements mirroring the community arrangements but the prison population itself does not, and there will be people who fall in between the two stools of your commissioning arrangements? Do you recognise that as a problem?

Kate Davies: I recognise it as a problem and an issue because we have already started to address that. We have reviewed the mental health specification, which is a national specification and the baseline for all our mental health services across prisons, alongside the substance misuse specification and the primary care specification, over the last three years, to make quite sure that we have a more trauma-informed and integrated mental health provision. As you identify, as in the community, it is absolutely essential that our mental health and primary care mental health services are there to assess and support early screening, but also to make rapid and sometimes acute referrals around secondary care or forensic needs and requirements. That could include neurodiversity and some other issues that may well be related to trauma or adjustment difficulties, alongside the work that we have been doing.

That has kept going through Covid, but it has slowed down, as the Minister said. It is an NHS-led piece of work. It means now that we are moving away from the previous models, where there are primary and secondary mental health services, and moving into an integrated mental health whole-systems approach.

In answer to that question, it is absolutely essential. We have done this within the women's prison estate around trauma-informed mental health provision. The children and young people's estate is the SECURE STAIRS model around the trauma-informed whole approach. Particularly for adult male prisons, we have to move into a position where there is an ability to

work with referrals at different times but also to look at where people fall between the gaps.

You asked what that number is. We know that 70% of our men and women at any one time will have a need around mental health, which might be exacerbated when they have been in prison for days, weeks or months. We are starting with a number and saying that the majority of men and women in prison have to be part of being able to be supported for a mental health-based integrated support system.

Maria Eagle: I cannot see Mr Copple, but I assume he is there.

Chair: He is still there.

Kate Davies: HMPPS have been supporting us within that modelling.

Q137 **Maria Eagle:** Mr Copple, do you have anything to add on those points?

Phil Copple: Not much, other than to say it is absolutely critical that in the first place it is a health-led responsibility, and, in the second place, we work very closely together to make sure that the services get delivered on the ground in the way that we intend them to.

Q138 **Maria Eagle:** Do you have more of a sense of how many people who are held in prison at the moment are not getting the support they need in this respect because they are falling between the stools of the different commissioning arrangements?

Phil Copple: I think it follows from what Kate has described. I do not think it is a simple matter that there is a gap with people falling between two stools in quite that way. It also follows from the data issues we have about prevalence and scale of the issues that it is therefore difficult to estimate particular cohorts within the overall need of mental health requirements across the population. Just as we only have estimates for the overall need, in turn we also only have estimates in respect of what it might mean for different cohorts within the total group.

Q139 **Maria Eagle:** It makes it quite difficult to commission that, does it not?

Phil Copple: But that takes us back to why there is a need for the mental health audit on a regular annual basis and why there is a need for the review of mental health needs across the whole population, so that Kate and her colleagues have a much stronger basis on which to plan for service provision.

Kate Davies: Can I come back on the very important question about need? One of the things that has been really important and essential in our model within the NHS is lived experience. We have been supporting various different service user bodies in and out of prisons—User Voice, Revolving Doors Agency, Clinks, to name a few—to identify the needs and concerns, particularly through the Covid period. One of your last panellists said that this was an opportunity through Covid to reset, in many respects, that needs assessment and that dial. I would not

underestimate, as well as the data and the numbers, which are absolutely essential, that it is the voice of the men and women in the prisons whom we are also supporting as part of that input and that quality intervention.

Q140 **Dr Mullan:** I want to follow up on some of those questions with Ms Davies. The line of questioning you have heard is based on the idea that you are either acutely psychotic and need to be taken out of hospital or you are getting some kind of primary care in hospital. That is obviously not an accurate reflection of what happens in the rest of the health system. Lots of people are in secondary care and tertiary care who are not acutely psychotic. I am not sure it is put forward as an accurate proviso. Could you clarify this for us? I assume there are intermediate secondary care consultations and psychiatrists involved in people's care outside of acute psychotic illnesses and severe episodes, or there are not.

Kate Davies: Absolutely. I am sorry if I have misled the panel on that.

Dr Mullan: No, not you. You haven't.

Kate Davies: It is about primary care. It is about secondary care, as you say, across the board. You have the equivalent of IAPT services, the equivalent of brief interventions, as well as long-term complex mental health pathways. We also have an indicator on what that means to make sure that it is not just about brief interventions but longer-term mental health provision as well. You have the OPD pathway, which is much more around the forensic elements.

It is not as simplistic as that. I know a lot of my clinical colleagues have identified that. Next to things like substance misuse, bereavement, sexual abuse, trauma and other elements, it is absolutely essential that it is across many areas and interventions and referrals. Thank you for the question. I am sorry if I misled the panel.

Q141 **Dr Mullan:** I wonder if the question is more about the proportion of work that might take place outside the prison population and how often primary care will be able to deal with the proportion of people with a similar problem. I assume the complexity range or distribution of the prison population is very different. Do you feel there is enough of that intermediate secondary care provision to reflect the more complex population in prison versus the community? That is what I would be more interested in. Do you think at the moment you have that broader range of spread for those intermediate situations?

Kate Davies: We are stepping that up all the time. Certainly, since we started to reset the services within prisons alongside our prison colleagues and HMPPS, we are commissioning constantly and have been waiting because of the Covid situation for additional secondary mental health services. There are different ways of intervention and support. One of those services that we originally commissioned in a cluster of prisons is called wing walkers, which is about supporting from a health and wellbeing start point, but it has interventions around some of those needs and concerns that may have been hidden as part of the Covid pandemic.

There is absolutely no doubt that we need to increase those interventions and preventions. It is a long-term plan. We completely said that was our priority. Alongside the rest of the mental health provision in NHS England, it is certainly a priority to increase that at pace.

Q142 **Dr Mullan:** A key element of any service provision will be around staffing. I do not know who is best placed to answer this between Ms Davies and Mr Copple. Could you give us an overview of the mental health service staffing that is available in the prison estate?

Phil Copple: That would be Kate.

Kate Davies: Alongside the quality reports, we have been monitoring our staffing numbers and what it means for vacancies in different disciplines, whether that is psychiatric, mental health, primary care or substance misuse. A very important intervention within staffing is increasing peer support and more general co-ordination of care and case management. One of the biggest increases is in some of the paramedic services to support crisis intervention. As Mr Copple said earlier, we want to have staff working and not necessarily take people away from other longer-term therapeutic interventions. We are monitoring all those numbers of staff in our prisons and our services but, also very importantly, where we feel there are some risks and concerns.

I identified before that we also have to get clearance for our staff when they are recruited. They are NHS staff. They are working seven days a week. They have worked seven days a week all the way through the pandemic. I want to thank my NHS staff massively for the work they have been doing. Sometimes, we have a delay in clearance and we work with the Prison Service to make quite sure that is speeded up.

Q143 **Dr Mullan:** Could you give us some sense of the picture, if you are monitoring it, in terms of the number of psychiatrists and therapists?

Kate Davies: We recently did some monitoring. Again, please bear with us on some of the information because some of the data that stopped during Covid has only just begun to come back in again. We have about a 10% vacancy rate in some of our areas, particularly around mental health psychiatrists and some of our more acute services. They are different between different prisons and different establishments. Some of those vacancy rates at the moment are also because we are putting in increased service provision and they have yet to recruit.

Q144 **Dr Mullan:** If someone wanted to transparently review the staffing at an individual prison, would they be able to do that? Is that published and available for people to look at?

Kate Davies: We commission, I am sure everyone is aware, through seven regional commissioning teams in NHS England, who then commission across all their adult prison estate and pre-imposed custody services. All those contracts with the individual prisons and establishments have the monitoring of those staffing needs and numbers.

It is a fairly new requirement as part of the allocation of funding. Also, I have to say, it is very helpful at the moment when the Prison Service, as the Minister was saying, is looking at increasing the number of prisons and the estate's capacity. We are also using that work to look at the capacity of additional prison healthcare services and staff needed in any new establishments.

Q145 **Dr Mullan:** It is broken down at the moment into seven commissioning areas. I am not sure the Committee was able to get hold of clear and transparent information on the staffing levels in prisons. It would be helpful to have that.

Kate Davies: I am certainly happy, as with previous Committees, to follow through with any details or numbers if people would like them.

Q146 **Dr Mullan:** I think you mentioned that the vacancy rate is 10%, but that it varies.

Kate Davies: That is an average. We look at it by different regions and different prisons. In some it is zero and in some it is 2% or 3%. In one establishment—we were looking across the whole of the establishments recently—it was something like 37%, which is obviously a concern and too high. We do a deep dive, and the regional commissioners and local commissioners will do that. As I say, sometimes, that is because of new services coming in and recruitment, or maybe we are waiting for clearance.

Q147 **Dr Mullan:** What about the use of agency or locum staff rather than substantive postholders? Do you have some overview of that? I am sure it has enormous cost implications.

Kate Davies: It is absolutely clear. Obviously, we need to be really honest that workforce is one of our biggest priorities across the NHS. It is a big priority within the Prison Service. We are working very closely with the Royal College of Nursing and the Royal College of Psychiatrists to look at all the recruitment strategies for the career, which is amazing. Within the criminal justice sector and the prison sector, we have amazing staff and amazing job and career pathways. It is not necessarily the one that everybody knows when they are looking at applying for jobs. There is work that has been done to support that. Obviously, we have agency staff. We have staff on shorter-term contracts to make quite sure that we do not have the vacancies. That is something we have to address. As I said, Chair, I am very happy to go back and get those figures.

Q148 **Chair:** Can you send those to us, please?

Kate Davies: I could give you figures now that would be for individual establishments, which would not be appropriate commercially.

Dr Mullan: I understand.

Kate Davies: But, also, you would probably prefer to see them across the board.

Chair: Yes, please.

Q149 **Dr Mullan:** I am curious that, by contrast, your evidence, while not suggesting everything is fine, perhaps does not reflect, for example, evidence we had from the Royal College of General Practitioners in which they described staffing levels as critically low and under-resourced. Why do you think they—

Kate Davies: I heard Dr Jake Hard and others give some of that evidence. I completely understand why my clinical colleagues would say that staffing levels are at a level they are unhappy about, because no service would be happy to have any vacancies when we know how acute the need is for our patients within prisons. There are certainly some establishments that are faring worse than others as part of those levels and that recruitment. It is a priority. We are getting good support from the Royal College of Nursing. I can give an example. I think 60 nurses were recently part of placements across our establishments. I am working very closely with the RCGP on that as well.

Q150 **Dr Mullan:** The vacancy rate compared to the NHS average does not sound too bad. Is that a perception of what the staffing levels should be? You might be filling the vacancies, but they feel there should be more people providing the service.

Kate Davies: I think there is a little bit of that within the answer, if I am honest with you. We have vacancy rates, but we also have a lot of staff and a lot of people who are very committed to this career and this area of work. There is an understanding that we would like to see more staff and more resource to support the need as we go forward. Of course, that is alongside resource and investment issues.

Q151 **Dr Mullan:** In terms of retention and recruitment, my final question is about the care and support of those staff, and the mental health support for staff working in what I am sure is a very challenging environment at times. How do you approach that, and what tangible work have you done in relation to it?

Kate Davies: That is a really important question. As have many staff during the Covid pandemic period, people have been working seven days a week. We are obviously committed to rolling out the Covid vaccine with all our incumbent and roving teams across the prison establishment, and I am pleased to say that is going very well.

It is really important to recognise that staff obviously need their time out. They need to get some really important supervision and training processes when they are working with such complex patients. The training and development, and the accreditation of training and careers, is a massive priority to support those staff and to maintain them. It is not just about new staff. It is not just about vacancy numbers or agency staff. It is actually about maintaining some real skills. We have an amazing group of clinical cells at our health and justice clinical governance groups, which are really good at supporting and developing

policies. Those are requirements for this patient group in that set of settings.

Q152 **Dr Mullan:** Do your staff take part in the general NHS staffing survey?

Kate Davies: Yes.

Q153 **Dr Mullan:** How does their wellbeing compare to the averages?

Kate Davies: I would have to go back and ask that question. I could not give you an answer and say I am happy that it is the full picture. But they certainly do take part in it.

Chair: Thank you very much. There are two things you will come back on.

Q154 **Paula Barker:** This is for Mr Copple and Ms Davies. Beyond suicide and self-harm training, is there any other training that prison officers and other support staff receive to support them in identifying and responding to the needs of those inside?

Phil Copple: In terms of the suicide and self-harm training, it comprises six different modules, one of which is instruction in mental health awareness. All new prison officers do that training, and other staff who are prisoner-facing in different grades, including staff we do not employ like teachers and so on, do that training. The other modules are much more around making the system work well for people with identified needs and trying to support them.

Over recent years we have invested a lot in the other main element of training in meeting needs in a general sense, which is the key worker initiative for prison officers. All prison officers in the male estate who work on residential wings are trained to become key workers to have a case load of around six prisoners. They develop a particular relationship, follow their sentence plan, try to challenge them where necessary, but also try to support them, engage with them and encourage them to follow their sentence plan and make progress. That training covers a wide range of not just mental health issues but being alert to prisoners' needs and issues and how prison officers can support them on a day-to-day basis, particularly referring and signposting them to other services, including mental health services in a prison.

Q155 **Paula Barker:** Do those caseloads ever go beyond six?

Phil Copple: They vary a little between establishments, depending on the size of residential units and the precise size of the staffing group, but we have broadly tried to have that guide in the numbers. When I say case load, I do not want to give the impression of a clinical case load approach. This is a prison officer role within the sentence management process. It is about establishing really effective professional relationships and getting to know the prisoners very well, and taking time to talk to them, which is fundamental to everything we try to do, including good mental health and supporting people with mental health problems.

We try to resource it on the basis that, on average, a prison officer would be able to see each of those prisoners for 45 minutes every week, but we allow them flexibility so that for some prisoners it might be 15 minutes and for another it might be an hour, depending on the scale of need and so on. It is also fair to say that it is something that has been severely disrupted during the pandemic, but we try to maintain wellbeing checks for higher-risk prisoners as a minimum even within our exceptional delivery models during outbreaks in the pandemic.

We are hoping to renew our efforts to take the key worker initiative forward, and we are also aiming to take it further into the women's estate now, having done the closed men's estate.

Q156 **Paula Barker:** What are the big differences between the men's estate and the women's estate in respect of this?

Phil Copple: The obvious one in mental health issues and presenting behaviours and challenges is the significant difference in self-harm rates between men and women. That presents huge challenges in the women's estate. We have a small number, but a significant minority, of very prolific self-harmers in the women's estate.

Often the issues behind self-harm link to mental health issues, and we try to take a multidisciplinary approach to address those issues. Prisons will typically involve healthcare teams alongside prison officers and managers in that, and if there are women who are engaging in certain aspects of the regime, such as particular work or education, it will involve the staff in those areas as well.

We try to take similar approaches with men who self-harm. We can have prolific self-harmers in the men's estate, but it is much more pronounced in the women's estate. During the pandemic, we have seen quite different patterns in relation to self-harming. It needs to be borne in mind that women are only 4% to 5% of the population, which is a very small proportion. In terms of self-harming, we saw a significant spike in the summer, but then we have made good progress in the months since, and the self-harming rate by the turn of the calendar year came down to where it was before the pandemic. In the men's estate, self-harm rates reduced during 2020 throughout the pandemic, despite all the restrictions.

Q157 **Paula Barker:** Dr Mullan touched on this in his question about the support that is available for operational staff dealing with mental health issues, and Ms Davies was talking about regular supervision sessions. Is there a formal structured programme of supervision for the operational staff?

Phil Copple: No is the short answer, although the Minister may want to say something more. This is something that, from a policy perspective, we and Ministers are keen to consider. We are acutely aware going into a

spending review of what the costs might involve in trying to resource a supervision model for all prison officers.

We have produced a lot of guidance for line managers in the service to try to encourage wellbeing conversations to be an ordinary part of day-to-day line management of frontline staff. We have augmented what we do in terms of occupational health. Frontline staff have access to counselling as well as to a general helpline. We have gone further with how we have developed some of those counselling inputs and put more into that in recent times. We also have a network of 1,600 mental health allies as an initiative over the past 18 months or so across the estate to support the mental health of their peers across the staff group as well, recognising some of the challenges and traumas that people have to deal with.

Q158 **Paula Barker:** Has that been drawn up in conjunction with the trade unions?

Phil Copple: Yes. We have had extensive discussions with the trade unions and they support all those initiatives. We have had some debate about the precise delivery models and whether more can be done, as you might expect. Certainly, in terms of the effort being made and some of the investment being put into that, unions are fully supportive of that effort.

Q159 **Paula Barker:** Minister, is there anything you would like to add?

Alex Chalk: Just very brief points. On the issue of self-harming, the pandemic has been so instructive. In very simple terms, the rates of self-harm in the male estate went down 13% and in the women's estate up 13%. That is so instructive. When we talk about investing in the women's estate and a trauma-informed approach, what that actually means is trying to create an environment where it is not going to trigger that kind of behaviour.

The only other thing I wanted to indicate is that it is absolutely right that we as Ministers, exactly as Phil indicated, look at the extent to which we can train up our officers with evermore sophisticated training. That is important. That is what we will look at. But we should never lose sight of the most important thing, in my view. If you want to run a safe, humane, compassionate, rehabilitative prison, what is really important is trying to hold on to those prison officers.

One of the most effective tools at your disposal is someone providing a bit of common sense and experience when it comes to addressing somebody who might be verging on crisis, but, in fact, it may just be that they are despondent and deeply unhappy about their circumstances. It is being able to spot those warning signals, having the judgment to know when they need to refer someone to treatment, when, in fact, it just requires that sensitive and humane conversation.

We will look at all these things, but it is really important not to lose the wood for the trees, which is why I see holding on to prison officers, allowing them to develop that experience—that jailcraft, if you like—is so important in providing some of that immediate interface with people who are very often extremely complex, sometimes very damaged and potentially in need of mental health support.

Q160 **Paula Barker:** Ms Davies, is there anything else you would like to add to that?

Kate Davies: One of the things that has been really important through the last two years in the pandemic is the integrated work with the prison officers and the healthcare teams. They have worked very closely together to support the needs of the residents and patients. I know our healthcare teams have advocated strongly for prison officers in relation to their care and their needs within the Covid period, as well as some of those challenges on behaviour and how that has been understood. Maybe healthcare staff have helped some of the prison officers understand that as part of, for example, social distancing or what else has gone in.

It is not to be underestimated that, in order to run a good healthcare service and a good prison, and for residents and patients to feel as safe as possible with a number of conditions, it has to work collectively and it has to work together. One of the things that is a real opportunity is the new NHS whole-systems requirement around the integrated care systems. We know there is a new Health and Care Bill going through Parliament. That really needs to identify how the populations within the prisons but also the populations in the communities are commissioning and supporting men and women in that, and see the advantages of working very closely together to support the needs around mental health, physical health and early interventions.

I would identify that for all men and women. For the women's establishment—you asked Mr Copple a question about women and men—you have a higher representation of women who identify with domestic violence and sexual violence. Maybe there are also issues around their families and childcare, which of course there are with men as well. There are often many women on shorter sentences—a lot of substance misuse-related sentences. We really need to challenge and address whether those men and women should be in custody in the first place, and when they leave how we pick up their continuity of care, hence the priority of the prison leavers programme, RECONNECT, and how the integrated care systems and the population-based systems are already looking at how that can improve the understanding of that patient group.

Chair: Thank you very much. We are running short of time and there are a number of issues still to get through. Could both questions and answers be as concise as possible, please?

Q161 **Andy Slaughter:** I was going to ask about mental health treatment requirements, but you dealt with that earlier.

You talked about the extra resources that are available for mental health. We heard from Dame Anne earlier that these are used in less than 1% of eligible cases, despite having been around for many years. Have you any idea what sort of increasing usage you envisage?

Alex Chalk: The short answer is that we accept the challenge that there needs to be more of them. The last data I had was that about 500 orders were made in the last year. If I am wrong about that, I apologise, but it is something of that order. As I say, our target is to reach 50% of England and Wales by 2023 and to significantly increase in that way.

The bottom line is that, in terms of community orders, the general direction of travel is to consolidate around some seriously expert and specialist orders. The difficulty has been that the poor old sentencing judge is very often faced with a very complex sentencing landscape. We want to consolidate around a smaller number of orders, and for one of those particular orders to be these mental health treatment requirements because we think there is demand for it and we think the courts will welcome it.

Q162 **Andy Slaughter:** You hope to reach 50% in England and Wales by when?

Alex Chalk: By 2023.

Q163 **Andy Slaughter:** What do you mean by hoping to reach 50%?

Alex Chalk: This is coverage, to ensure that there is the availability to impose those orders across that proportion of the country.

Kate Davies: It is NHS England that commissions the mental health treatment requirement orders. You are quite right, they are not new. They were not used at the level we all would have liked back in 2018-19 when we increased the investment through the long-term plan for mental health treatment requirement orders. We are working very closely with our sentencers and our HMPPS partners, particularly the National Probation Service, to have a target to increase and get people to understand, as sentencers and services, that not only are mental health treatment requirement orders available, but they can also be delivered in a combined fashion with drug and alcohol orders, too.

It is a really important distinction. It is not a new policy area but one that has perhaps been forgotten or slightly misunderstood, and maybe does need—

Q164 **Andy Slaughter:** I see. You are saying it is just not used at all in a lot of areas at the moment.

Kate Davies: We have 14 new sites that have come on board since we took on the challenge to reignite the policy around community treatment requirement orders. I believe the Government have just put some additional investment into the alcohol and drug treatment requirement orders. We would really welcome the investment to reach 100% on

mental health treatment requirement orders. As you say, it should not be different in Liverpool—the Sefton programme is an excellent programme, which has demonstrated a benefit—from somewhere else in a different part of the country.

Q165 **Andy Slaughter:** My other question is about the physical state of existing prisons. You are spending quite a lot of money on new prisons. Assuming—tell me if I am wrong—that they will incorporate an NHS facility, and we were hearing about specialist units for mental health earlier, what can you do, given the huge backlog in maintenance and the lack of capital money that exists in prisons, to ensure that they are a better fit for mental health?

Alex Chalk: I will say two things. There is a massive investment in prisons. To put it in some sort of context, it is the second biggest state project after HS2, with £4 billion going in. That is good because it means those prisons themselves are new, they have less maintenance demands and so on. That is point 1.

Point 2 is that the maintenance budget for prisons overall has been dramatically increased to over £315 million. It is right to say, in the interests of complete frankness, that there is a backlog. I absolutely accept that. It is not going to be cleared overnight, but, none the less, this is a dramatic ramping up. We think clean, modern prisons are more rehabilitative prisons and better able to address mental health needs.

Kate Davies: Investment into the building of new prisons is also investment into the health and wellbeing services and the mental health services that are in all those prisons. That is also essential. You cannot open a prison without the investment of health services within that prison, as the Minister has already identified.

Andy Slaughter: I won't take time, as we are very short of it, but if there is anything else you can send us that looks at how the money you are going to spend on existing prisons will sit with the work that is going on with mental health, that is what we are trying to get at. I am happy to leave it there.

Q166 **Laura Farris:** My question is to Phil on the transfer of prisoners to secure psychiatric units. In your experience, when you look at the prisoners who are transferred, do the majority of them have a psychiatric condition that you were unaware of because it was not diagnosed or because it was not picked up at the initial screening, or have they developed the condition since they have been in prison, or do you not know or not have that information?

Phil Copple: It is probably best if I answer at a slightly anecdotal level. I can refer to a study that we have done recently, which might throw some light on that as well. It is typical that people who are assessed as having met the threshold for transfer under the Mental Health Act were not necessarily people who were seen immediately when they came into custody as being that ill. They would often be seen as people who had

some mental health issues and history, but not seen as being that ill. Something has happened during the time they are with us, which can be a lot later into the sentence. Sometimes, it can be years later for somebody who has a long sentence.

We did a piece of work recently looking at nine prisons that served the courts, trying to identify people, from the warrants or on supplementary information that the court sent with the warrant, where there was a vulnerability of mental health or self-harm identified for them. What was interesting is that the vast majority of those people who were identified with that kind of concern on the warrant did not, in the end, get sectioned under the Mental Health Act. In turn, nearly 90% of the people over the 12-month period that the project ran across those nine prisons who did get sectioned under the Mental Health Act had not been identified on their warrant at the time they were first sent to custody. It does indicate that a lot of the issues tend to develop later.

One other interesting thing in the study I want to quickly share, because it reinforces a point we made earlier, is about people waiting for transfer.

Q167 **Laura Farris:** I will come on to that. I have a couple of very quick questions. If it is the case that, generally, the prisoner's mental health has deteriorated during the period of their sentence, is it possible for prison—we have not heard much about sharing best practice. There must be some prisons that manage it better than others. Do you share best practice between the prison estates?

Phil Copple: Yes, we do, and with health colleagues. I refer the work of health colleagues to, for example, the inspectorate. We would often identify some establishments where there is good practice and share it within that partnership forum.

Q168 **Laura Farris:** Could you give us an example?

Phil Copple: One example would be Durham prison. We have extremely effective integrated services there. That is shared very widely among both prison and NHS managers.

Alex Chalk: In respect of autism, the National Autism Society specifically indicated that Wakefield, Whatton and Parc had autism accreditation because of the work they are doing. That is something we roll out.

We should never forget that, before an individual is sentenced to custody, before it is "down you go", as it were, to the defendant, there is a PSR that will be provided. That is before the court. The judge can say, "No, hospital order. I am not sending you to prison. You are going to have a hospital order, potentially even with a section 41 restriction as well." In other words, if somebody has serious mental illness, the court may well decide that they are not going to send someone to custody anyway. It is not entirely surprising that these issues very often are ones that emerge after the point of their first arrival in custody.

Q169 **Laura Farris:** We heard in our first panel that the long delays can have a punitive effect, even if that is not the intention. We have also basically heard from both of you that it is worse among women than men, and maybe that self-harm is more intensified when there are isolated periods. I suppose, consistent with other obligations that you might have to make reasonable adjustments for disabled inmates and so on, is there a creative solution, beyond a bold ambition to bring transfer times down, to improve the holding experience of those prisoners?

Alex Chalk: Absolutely. This goes to the heart of our approach in respect of the women's estate. It is easy to speak glibly, "Oh, we want to build a trauma-informed estate." I went to HMP Drake Hall, and there are physical differences that make a difference to people's experience. For example, when a woman gets off the van and arrives at HMP Drake Hall, or wherever it is, the physical built environment is not depressing, debilitating, invoking a sense of total despair. You have secure areas but not necessarily bars on every window. You have wider corridors. You have smaller groups—bubbles, if you like—with more breakout space where people can speak. You have decent areas where people can cook. It is that sense of feeling of hope, so this is an environment that does not engender that kind of activity.

Yes, there is a real problem of self-harm. What I found very instructive when I went to that prison is that it particularly ticks up at the time when they are close to release, at the time when people are thinking they are going to have to go into a different environment altogether. Of course, people do not want to lose their liberty, but it is basically a humane and decent environment.

Phil Copple: In the study of nine prisons serving the courts, of all the prisoners over a 12-month period who had been sectioned under the Mental Health Act, 40% of them had been what we might call a gate section. They went at the point when their time in prison was finished. They did not find a bed until the day the custodial part of the sentence was served or the remand period ended. It suggests that staff had been struggling to look after them within the prison setting for a period of time, diverting resources away from other people who we need to look after, as well as creating enormous uncertainty for the individuals about what is going to happen to them on their release date or at the end of the remand period. All that had been managed through, and then at the point when they were due to leave prison they were sectioned under the Mental Health Act and went to a secure psychiatric facility.

It demonstrates the importance, it seems to me, of what the Minister and Kate were talking about earlier, of having time limits that the system can achieve so that we do not find ourselves in that situation.

Q170 **James Daly:** You talked about this earlier, Kate, and I know there have been some problems related to Covid, but can you set out how the RECONNECT service works in practice?

Kate Davies: Thanks for the question. It was really clear that all men and women who leave different prisons and different establishments, depending on their length of sentence, will get picked up and supported through the NHS. There are two key ways that you improve that, and I realise I need to keep my answers short.

One is to support the digital transfer of patient records, needs and assessment. The second is to have a more care co-ordinated model, particularly immediately on release as well as for the higher-risk offenders. We are very pleased that the long-term plan, as I said in my earlier answer, took up the real challenge to say how we can continue. It is similar to the success of the liaison and diversion service that is now embedded across all the commissioners in NHS England and local commissioners. We look at the priority of how we continue the safer prescriptions that maybe people have picked up in prisons, their first substance misuse appointment, their long-term mental health care, particularly if they have had a number of sessions or are part of a cognitive therapy or a different programme. Also, for our higher-risk offenders, it is working very closely with the Parole Board and the National Probation Service on how that is integrated with community mental health trusts and the management of the more complex patients.

We have only nine pathfinders at the moment. When I knew I was coming to the Committee, I was able to update; there are 11. We are now rolling out to have the coverage of RECONNECT services across the board by 2024. It is not necessarily all prisoners; it is about identifying the highest level of risk and need. Also, people are particularly going from reception prisons very quickly where there will be a real benefit, with short-term interventions, picking them up with immediate medication or substance abuse, mental health and physical health problems. I really need to include physical health, because often you have a lump in your groin or in your breast and it is the first time that maybe you have had an assessment; it is how you continue with that continuity of care.

Q171 **Paula Barker:** Her Majesty's Inspectorate of Prisons expressed serious concerns about the pre-existing shortfall in mental health services and about the deterioration in prisoners' mental health due to the pandemic. In fact, it said, "The cumulative effect of such prolonged and severe restrictions on prisoners' mental health and well-being is profound." What resources are currently available, and what will be made available to meet the needs as they currently exist?

Alex Chalk: I will make one point at the beginning. I have read that, of course, and it is sobering and very serious. To put it in wider context, which I think is important, at the beginning of this pandemic, PHE predicted as their worst-case scenario that the number of prisoners who would die in the estate would be 2,700. In the event, and although every single one is an enormous loss to the friends and family concerned, the figure is about 121 at the moment. The only reason I say that is because

I want to pay tribute to the staff at HMPPS, who have genuinely saved lives with their robust and decisive action. There are literally thousands of people alive today who have been in the prison estate who would not have been alive if they had not taken those steps.

There are a couple of things that we need to do: trying to ensure that people have access to phone credit so they can speak to people on the outside, which is particularly relevant to the female estate but men's estate as well; so-called purple visits so you can have video calls; and distraction packs.

One other thing is the use of technology. What we are trying to roll out is the use, for example, of technology so that people can get some of their mental health treatment not just from the people inside the four walls of the prison estate but beyond, having that remotely and digitally. That is important. Why? First, because it might be the best source of care, but, secondly, when that person leaves custody they can stay on the same pathway, if that makes sense. It is something that we have accelerated because of Covid but it is going to have long-term benefits for the healthcare of the next generation of prisoners.

Q172 **Paula Barker:** When will all of that be available right across the prison estate?

Alex Chalk: For example, the purple visits and the digital has happened already. That has already been accelerated. The additional credit was a one-off emergency measure, as were the distraction packs. As for things like the technology to roll out out-of-prison healthcare, that is a rolling process developing over time as we roll out the digital infrastructure. Those are some of the aspects.

Phil Copple: The mitigations the Minister outlines have been very important all the way through the pandemic.

The other thing I would recognise over that period is just a lot of care and compassion and very strong leadership shown in our prisons by lots of people on the frontline to make sure that the very real risks in terms of mental health, suicide and self-harm were mitigated as far as we could.

It is right to acknowledge the fact that the restrictions that we have had to put in place have inevitably had serious detrimental effects on people's wellbeing, just as the measures in the whole country have for the whole population. This has been much more severe in prisons, and I recognise that. It has had detrimental effects on people's rehabilitative prospects and opportunities as well, inevitably. Sometimes, the discussion around this can almost give the impression that there was something fundamentally wrong with what we did. There was not. There was something fundamentally right with what we did, for the reasons that the Minister said, and I am not apologetic about it. I am not dismissive of the detriments it has caused either.

As to the achievement in that period, a lot of people would have feared certain terrible outcomes for us with Covid-related deaths but also in terms of order and control, and self-harm and self-inflicted deaths. People might have reasonably expected that to have happened in the prison population. By and large it has not. The self-inflicted death rate actually reduced during much of 2020 compared with the year before and is at similar levels to where it was in recent years. The self-harm rate has reduced overall. We had a spike in the women's estate, and that came down. In the estate as a whole, it has come down during that period.

Those are incredible achievements, it seems to me, if you think about the living conditions of people during that period.

Alex Chalk: The levels of prison violence are down by over 30%. One of the great drivers, you might think, of poor mental health, basically, is, "What is going to happen to me? Am I going to be attacked in prison?" There is a massive reduction, and also a massive reduction in the amount of violence on staff. Extraordinarily, this was a period when people might have assumed, "Hang on, if you lock down a prison, it'll be a powder keg. It's just going to blow up." That is not in fact what happened. Some of the key metrics that you might think make up the overall temperature of the prison came down.

Although it is absolutely right to look at the sobering and serious consequences, the overall picture has been, I think I can fairly say, one of success, which really is a tribute to those staff. A lot of people could have died and did not. A lot of violence could have taken place that so far has not. While we remain very vigilant and we have to be mindful of what happens as you cascade through the regimes and as you unlock, what could have happened—that apocalyptic scenario—did not come to pass.

Phil Copple: I acknowledge there are risks going forward. We are in recovery. The NHS is in recovery. We are trying to do everything we can to work with Kate and her team and deliverers of services on the ground to do what we can to support prisoners now as we, hopefully, continue recovery. We have a mental health collaboration between our staff and NHS England staff to devise innovative ways in which we can do that during the recovery period.

We are seeking to do all we can in light of what will inevitably be risks of people getting used to the idea, hopefully, that we come out of that level of restriction, however gradually and however carefully, and start to have more opportunity to engage in more normal activities in prison as well.

Kate Davies: There have been some really important programmes, and we need to think about how we can continue those. Some of those are about accommodation and release, around housing and homelessness, which was stood up particularly for vulnerably housed people in the Covid element, and that is something that I think is really important about people's mental health, wellbeing and ability to continue and, hopefully, reduce reoffending. We are also here with healthcare around reduction of

reoffending. I have signed off 2,000 new licences around the way that digital systems can work, from primary care to secondary care, from prison into hospital settings. We had waited years to get those signed off. It took us three months to get them signed off within the pandemic.

It is still an ongoing operational procedure, but with some real benefits. Nothing will change the fact that those digital systems need to remain, but the most important thing is about the face-to-face work, the capacity, the quality and the integrated mental healthcare services.

We have been questioned before in this Committee about our partnership agreement with the adult prison service and youth custody service. That is a really important element so that we hold each other to account, and we hold each other to account for the benefit of the patients. When there has been an increase in mental health and anxiety, it is anxiety and people being scared in the prison system around their mental health. We are working together to look at how our future partnership agreements can be much more robust on the pre and post-custody element. That has come through the pandemic experience and learning, come through the work we have done with over 100 outbreaks at one time, and that is essential in continuing to hold ourselves to account as we go forward.

Chair: Thank you very much, everyone. Thank you to our three witnesses, Minister, Ms Davies, Mr Copple. Thanks to members of the Committee. The session is concluded.