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Justice Committee

Mental health in prison

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Report, together with formal minutes relating to the report

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Justice Committee

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Summary

Healthcare in prisons, including mental healthcare, has improved since April 2005, when the NHS took over responsibility for healthcare in prisons, however, much more still needs to be done. There are many longstanding problems that have existed for many years where insufficient progress has been made. Most urgently, action must be taken to prevent mentally ill people being sent to or kept in prison due to a shortage of mental health services in the community.

Those responsible across the health and justice systems are committed to continuing to improve mental healthcare for prisoners and there are some promising areas where some initial steps have been taken but these need to be seen through. These areas include improved flow of medical information, increased use of integrated models of care, and improving the continuity of mental healthcare from prison through to release.

The Ministry of Justice, HM Prisons and Probation Service, and NHS England, surprisingly, do not know the extent of the need for mental healthcare services in prisons, but it appears from the evidence for this inquiry that there is a significant unmet need. We welcome the work commissioned by the NHS to quantify this, but this analysis must be used to plan and resource prison mental healthcare services properly, if it is to have any worth.

The covid-19 restrictions saved lives but have had a severe impact in prisons and the deterioration on prisoners' mental health as a result is concerning. We recognise this reflects the experiences of the general population and that there now exists an unprecedented level of demand for mental health and wellbeing services across the country. There does not appear to be an action plan nor additional resources set aside to deal with the inevitable increased demand for prison mental healthcare services that will result.

We would like to thank all those who provided evidence to this inquiry. We would also like to thank all those working in prisons (operational, healthcare, and other staff) for their great efforts during the pandemic.

Introduction

1. This inquiry looks at mental illness in prisons in England and Wales. Her Majesty's Prisons and Probation Service (HMPPS) runs prisons and probation services across England and Wales as an agency of the Ministry of Justice. Responsibility for providing prison healthcare (including for those with mental illnesses) moved from the prison service to the NHS in 2005 following concerns raised by HM Inspector of Prisons about the general level of qualifications and experience of staff in prison medical services compared to the NHS (with which they had to compete for staff).[1]

2. Healthcare is a devolved matter; in Wales, the Welsh Government and NHS Wales are responsible for healthcare provision in prisons.[2] HMPPS works in partnership with NHS England and NHS Wales to commission prison healthcare from a variety of public bodies (including the NHS) and private and voluntary sector organisations. NHS England also commissions liaison and diversion services aimed at channelling vulnerable people away from the criminal justice system. National agreements set out the combined responsibilities of the various parties including the Department for Health and Social Care, Public Health England and Public Health Wales.[3]

3. The purpose of prison is not just to rehabilitate but to punish and deter offenders through incarceration, including separation from family and community. There are, nevertheless, legal and humanitarian reasons for ensuring that prisoners' healthcare needs (physical and mental) are met while they are in the custody of the state.[4] We are conscious that some sections of the public may fear that prisoners whose mental health needs require treatment get a 'soft option' and that some people may believe some prisoners will manipulate professionals into believing their mental health needs are greater than is the case. We are, however, aware of no qualitative or quantitative evidence that misdiagnosis of prisoners is widespread. The evidence received from our public call for evidence suggests, by contrast, that many prisoners keep their mental health problems to themselves owing to the stigma and shame attached and that those who do need help often have trouble getting it.

4. Mental illness is on a spectrum and prisoners' conditions (as with the general public) may range from less severe and undiagnosed issues such as mild depression to those who are severely unwell. Prisoners are more likely than the general public to have further conditions alongside mental illness (for example learning disabilities, autism, speech and language difficulties, ADHD, acquired brain injury and substance abuse) that may make treatment of their mental illness more challenging.[5]

5. The identification of mental illness in a prisoner can happen at different stages for different individuals before or during time in custody, including where:

1 HM Inspector of Prisons, *Annual report of HM Chief Inspector of Prisons 1995–1996*, pp 22–23 and HM Chief Inspector of Prisons, *Patient or Prisoner*, December 1996

2 The Welsh Parliament published its report *Health and social care provision in the adult prison estate in Wales* in March 2021, (there are no female prisoners held in Wales).

3 Public Health England and Public Health Wales are also partners in prison healthcare. See the National Partnership Agreement for Prison Healthcare in England 2018–2021 and the Partnership Agreement for Prison Health in Wales for details (accessed 13 July 2021)

4 Governments, according to the World Health Organisation, have "a special duty of care for those in places of detention which should cover safety, basic needs and recognition of human rights, including the right to health." World Health Organisation, *Prisons and Health*, 2014, p 1

5 Department of Health and Social Care (MHP0062)

- the police are called if a person in a mental health crisis behaves in a way that worries or affects others;
- an acutely mentally ill person in the process of being prosecuted is held on remand because no mental health bed is available in the community;
- a person is suitable for a community order that includes a requirement for mental health treatment but that treatment is not available and the sentencer decides on prison instead;
- a person arrives in prison with a mental illness recognised in the community but of which the prison service is unaware;
- a person was unaware of having a mental illness, or was aware of it but concealed it from others; or
- someone becomes mentally ill in prison.

Probation staff, community mental healthcare services, prison service staff and prison healthcare staff are all involved in identifying, managing, and treating prisoners' mental illness through these stages.

1 Understanding the need for mental healthcare in prisons

Shortage of data

6. There is no clear picture of the extent or nature of mental ill health in prisons, nor on how much is spent on treatment and whether the money is well spent. The head of the National Audit Office, when it reported on mental health in prisons in 2017, said:

> The data on how many people in prison have mental health problems and how much government is spending to address this is poor. Consequently government do not know the base they are starting from, what they need to improve, or how realistic it is for them to meet their objectives. Without this understanding it is hard to see how government can be achieving value for money.[6]

7. The Ministry of Justice admitted that it had little information on the extent of mental illness in prisons:

> 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. In addition, prisoners can experience mental health issues at any time during their sentence but we only systematically assess need at reception into prison.[7]

8. It went on to say that understanding the extent of the need for mental healthcare was clouded by a lack of a clear definition, prisoners' complex needs and incompatible IT systems.[8]

Work being done to quantify the nature and extent of mental illness and other vulnerabilities amongst prisoners

9. The Department for Health and Social Care and NHS England and NHS Improvement (NHSE/I) jointly said a 'needs analysis' is being carried out for them (by the Centre for Mental Health) to help them to understand mental health and neurodiverse prevalence in prison:

> with the aim of providing comprehensive diagnostic and socio-demographic profiles of the mental health, psychological, trauma and emotional wellbeing caseloads in each prison. This covers all services commissioned by NHSE/I and includes services with personality disorder and neurodiverse caseloads (e.g. services for people with learning disabilities, autism, speech and language difficulties, ADHD, acquired brain injury).[9]

10. The Centre for Mental Health published a report on 25 June 2021 covering the first part of this work which covered the themes and findings from consultation and a literature

6 National Audit Office, Mental health in prisons, webpage accessed 13 July 2021
7 Ministry of Justice (MHP0044)
8 Ministry of Justice (MHP0044)
9 Department of Health and Social Care (MHP0062)

review carried out over the summer of 2020.[10] In that publication it said:

> This review was the first part of a two-stage process. NHS England and NHS Improvement has also commissioned Centre for Mental Health to conduct a mental health needs analysis across the English prison estate which will quantify the levels of service provided, need and (where possible) unmet need.[11]

11. In this first report the Centre for Mental Health said that much progress had been made in the 15 years that it has been reviewing this mental healthcare in prisons but that problems remain that "have been known and consistently reported for the last two decades."[12]

12. Kate Davies, Director for Health and Justice at NHS England, told us that the NHS conducts yearly audits of mental health needs in prison, but this did not take place in 2020 because of the covid-19 pandemic.[13] The only NHS audit relating to prisoners' mental health that has been published was in 2017 and only covered prisoners waiting for assessment and transfer under the Mental Health Act 1983.[14]

13. Even without up-to-date NHS data it is clear from the evidence submitted to this inquiry that a significant proportion of prisoners have a mental illness and this is often combined with other difficulties.[15] HM Inspectorate of Prisons reported that 71% of women and 47% of men surveyed by inspectors in prison self-reported having mental health problems.[16]

Existing research and estimates

14. The Centre for Mental Health has summarised the existing research, (all of which is more than five years old and some much older), on the prevalence of mental health diagnoses and other vulnerabilities:

> Most prisoners experience more than one vulnerability… 70% of prisoners meet the criteria for two or more diagnoses. With the single possible exception of autism, all of the vulnerabilities […] have a prevalence rate in prison very much higher than in the general population. Additionally, the experience of trauma and adverse childhood experiences is very common amongst prisoners […] It is therefore reasonable to state that by default, prisoners are vulnerable and have multiple and complex needs.[17]

15. Kate Davies told us 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.[18]

10 Centre for Mental Health, *The future of prison mental health care in England*, June 2021
11 Ibid p 4
12 Ibid p 7
13 Q130
14 The 2017 NHS Benchmarking Audit of Prisoner s waiting for MHA assessment, transfer and remissions, report summary, 2018, webpage accessed 26 July 2021
15 For example, learning disabilities, autism, speech and language difficulties, ADHD, acquired brain injury and substance abuse
16 *HM Chief Inspector of Prisons annual report: 2019 to 2020*, October 2020
17 Centre for Mental Health, *The future of prison mental health care in England*, June 2021
18 Q136

Adequacy of prison mental healthcare services

16. Evidence from HM Inspectorate of Prisons was that prison mental health treatment was not always adequate to meet the need for it. It set out some of the reasons for this:

> Prior to the COVID-19 pandemic, although inspectors found effective mental health support and services in some prisons, overall inspectors found that prisoners had inadequate access to mental health treatment at approximately half the adult male prisons inspected in both the 2018–19 and 2019–20 reporting years. Provision was not adequate to meet the high levels of need in some women's prisons. Inspections identified various reasons […] including inadequate service specification, chronic recruitment and retention issues, inadequate staff supervision, difficulties accessing patients due to the restrictions of the prison regime and a lack of suitable therapeutic spaces in which to offer services.[19]

17. A serving prisoner who is the Listener coordinator (peer support, trained by the Samaritans), Healthcare Rep, and Healthcare Council Member (for charity Uservoice) on the Albany site of HMP Isle of Wight, wrote to tell us of his experience:

> The scale of mental health issues in prisons is colossal, far bigger and worse than anyone can comprehend or wants to admit. There is nowhere near enough in place to determine the scale of the problem. The current self-referral process is not fit for purpose. People with genuine problems either don't want to burden mental health staff after hearing how overworked they are or have no faith in the staff or the system.[20]

18. Another prisoner told us: "In the community I had a CPN [Community Psychiatric Nurse] with regular contact and a prescriber when I needed my medications changing. Inside, it seems to be the person who shout the loudest gets the psychiatrist and/or medications!"[21]

19. In its 2017 report, the National Audit Office said that NHS England collected information on the number of prisoners in treatment for mental illness, which at that time was 10% of the prison population in England. It added "there may be more people in treatment who are not captured in these data".

20. **While there have been improvements in prison mental healthcare, provision is still not adequate. The high unmet need for treatment for mental illness in prisons is surprising and disappointing. Around 10% of prisoners were recorded as receiving treatment for mental illness with one suggestion that as many as 70% may have some form of mental health need at any one time. NHS work is long overdue to quantify the gap between mental health treatment needs and the services provided.**

21. ***The NHS should use its prison mental health treatment 'needs analysis' to quantify shortfalls in mental health services, make plans and allocate resources so mental healthcare in prisons is at least equivalent to services outside prisons, having taken account of the specific needs of the prison population.***

19 HMI Prisons (MHP0064)
20 MHP0084
21 MHP0073

2 Commissioning prison mental healthcare services and models of care

Commissioning mental healthcare services

22. Healthcare services can be fragmented between a range of public and private providers offering primary or secondary care, physical or mental healthcare or combinations of all or any of these alongside substance abuse services. Practice Plus Group[22] said that the split can result in people receiving no care:

> In a primary / secondary split a patient may not be sufficiently 'serious' for secondary care even though their complexity means a primary care team may not have the right skills and resources. Sadly this can result in people receiving no care and this is a theme seen in deaths in custody.[23]

23. A serving prisoner told us how this happens in practice:

> I see people every day with deep-rooted issues like complex PTSD, who only have a CBT [cognitive behavioural therapy] practitioner for support, even then they keep getting pushed off of mental health's books. "I can't give you the help you need, the only person who can help you does not have time to see you".[24]

24. Juliet Lyon, Chair of the Independent Advisory panel on Deaths in Custody told us another drawback of complex commissioning arrangements was communication failures:

> 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.[25]

25. We also heard concerns about how the commissioning process can affect the quality of healthcare services. The Royal College of Psychiatrists, for example, said:

> The competitive tendering process for awarding healthcare contracts in prison has not had the desired effect of improving the quality of services. It is our experience that too often the main criterion for awarding contracts is cost, to the detriment of clinical quality and sustainability.[26]

26. **Healthcare services can be fragmented, meaning people receive no or inadequate care.** ***NHS England and NHS Improvement should set out how they intend to bridge existing gaps in care and resolve the problems that result from fragmented service provision to ensure that all patients receive access to appropriate and adequate care.***

27. **Cost and quality are essential criteria on which to assess bid submissions in**

22 Practice Plus Group is commissioned to provide healthcare including mental health in over 50 prisons in England
23 Practice Plus Group (MHP0016)
24 MHP0084
25 Q94
26 Royal College of Psychiatrists (MHP0052)

procurement processes. All commissioned services need to be cost effective and provide value for money, but cost should not be prioritised at the expense of quality. *NHS England should set out how they balance cost and quality criteria when procuring services.*

Models of care

Integrated care

28. NHS England's national specification for prison mental healthcare outlines that all prisons should provide an integrated model, with self-help at the bottom step and specialist mental health services for those with marked mental illness at the top but the evidence is that this is not a reality in many prisons. The Centre for Mental Health (CMH) in its work for the NHS has found that:

> Integrated mental health services were very limited in their offer to people who did not meet the criteria for secondary mental health care, […] (typically little or no psychological intervention).[27]

29. CMH also found large disparities in what is provided across the English prison estate. "We found variation of mental health provision even within a single provider across different establishments."[28]

Whole prison approaches

30. Integrated care is an NHS concept where barriers within the healthcare system are broken down so that primary and secondary, mental and physical care can be delivered seamlessly in a patient-centred way. Within the prison sector there is another related but separate concept known as the 'whole prison approach'. The Ministry of Justice, the Department for Health and Social Care, HMPPS, NHS England and Public Health England have committed to the 'whole prison approach in their national partnership agreement, where it is described as an "approach to health and wellbeing that ensures that regime, activities and staffing facilitate an environment that promotes good health and wellbeing and reduces violence for all prisoners, including those with protected characteristics".[29]

31. Practice Plus Group, while recognising that the purpose of imprisonment is to punish as well as rehabilitate, described for us the range of issues that need to be addressed if a 'whole prison approach' is to be effective in promoting mental health and well-being:

> Prisons are intended to punish. The emphasis in the wider prison system on rehabilitation only partially mitigates the impact of this inherently detrimental environment and doesn't yet deal effectively with less intended and controlled factors such as a lack of personal safety, exposure to widespread drug misuse, ageing and inappropriate buildings, the lack of meaningful work and, often, uncertainty over sentencing and opportunities for release.

27 Centre for Mental Health, *The future of prison mental health care in England*, June 2021, p 16
28 Ibid p 16
29 National Partnership Agreement for Prison Healthcare in England 2018–2021, p 9

> Our experience is that those presenting with mental health deterioration often report 'prison issues' as at least part of the cause [...][30]

32. The Prisoner Governors' Association also described 'prison issues':

> Prisons are loud, unsafe places for vulnerable people who are often targeted by more confident and bullish prisoners. They are awash with drugs and the associated bullying and taxing of this illicit trade. Staffing levels are inadequate to supervise large numbers of unlocked prisoners resulting in those at risk or in crisis being missed in the melee of day to day prison life.[31]

33. Some prisons are safe, secure, and respectful environments that support inmates to progress towards release. For example, HM Inspectorate of Prisons' reports show that 'prison issues' such as illicit drugs, debt, threat, violence and disrespect are managed effectively at Warren Hill[32] and Grendon.[33] Both these prisons house prisoners on long sentences for serious crimes. Prisons with continual 'churn', such as the major local prisons, face other challenges.

34. There are initiatives within HMPPS and the Youth Custody Service that seek to adopt a 'whole prisons approach', for example the 'trauma-informed approach' for women prisoners, 'SECURESTAIRS' for children and young people, and in specialist units for some prisoners with personality disorders and other serious psychiatric problems.

35. The Ministry of Justice's 2018 Female Offender Strategy set out that women in prison were twice as likely as male prisoners to report mental health problems.[34] The strategy contains commitments to adopting a trauma-informed approach in women's prisons taking account of the very many women prisoners who are victims of abuse. The trauma-informed approach is only beginning to be introduced in women's prisons. We are currently conducting a separate inquiry into women in prison that will look in depth at the issues relating to women prisoners and what progress has been made with the Female Offender Strategy.[35]

36. We have previously reported on children and young people in custody.[36] In those reports we welcomed the fact that the Youth Custody Service, NHS England and NHS Improvement were working to improve mental health and emotional wellbeing services across the youth estate with the 'SECURESTAIRS' framework. The Ministry of Justice submitted evidence that "SECURE STAIRS is a psychologically informed, trauma-based framework for integrated care that creates a single plan around the child. It is based on the idea that "every interaction matters" and input from every member of staff is fundamental. It is focused on the child's story, not on their diagnosis, offence, or other label."[37] In evidence to that inquiry Barnado's said that their workers see increasing cases involving children with mental health needs and that: "At the current time custody often

30 Practice Plus Group (MHP0016)
31 Prison Governors Association (MHP0057)
32 *Report on an unannounced inspection of HMP Warren Hill (18 November – 6 December 2019)*, March 2020
33 *Report on an unannounced inspection of HMP Grendon by HM Chief Inspector of Prisons 8–18 May 2017*, September 2017
34 Ministry of Justice, *Female Offender Strategy*, 2018, p 27
35 Justice Committee, Women in prison inquiry, accessed 15 July 2021
36 *Children and Young People in Custody (part 2): The Youth Secure Estate and Resettlement*, Sixteenth Report of Session 2019–21, HC 922, February 2021, pp 12–16. See also *Children and Young People in Custody (part 1): Entry into the youth justice system*, Twelfth Report of Session 2019–21, HC 306, November 2020
37 Ibid, p 14

acts as a barrier to obtaining appropriate mental health support for young people."[38] With the exception of Oakhill, all 19 secure children's home, secure training centres and youth offender institutions are eligible for SECURESTAIRS programmes. More than 600 staff have been trained, and staff have been fully recruited to more than half those institutions.

37. In 2011, the NHS and HMPPS jointly introduced a new Offender Personality Disorder (OPD) pathway. According to the Centre for Mental Health (CMH) around 1,700 prisoners are 'receiving interventions' under OPD with most of them participating in intensive treatment programmes often in specialist units. These include 'Therapeutic Communities' and 'Psychologically Informed Planned Environments' that are based around a whole prison approach. However, the CMH reported concerns that lower risk prisoners with less severe personality disorders were not receiving appropriate treatment:

> Many prisoners who pose low or moderate risk will also have personality disorder and most will receive little or no intervention and will be managed by staff who are often not adequately trained for this task.[39]

38. **Initiatives such as integrated healthcare, the trauma-informed approach in the women's estate, SECURESTAIRS in the youth estate, and the intensive programmes used on the Offender Personality Disorder pathway, are all welcome as far as they go. The comparatively few such services as yet provided within the youth estate have been relatively recently introduced.**

39. ***The NHS should expand on its work to commission integrated healthcare across all three estates so that prisoners can access proper physical and mental healthcare services at primary and secondary level as appropriate and without undue delay.***

40. ***As the covid-19 restrictions in prisons are released, HMPPS (including the Youth Custody Service), should have plans ready for how it will reinvigorate its measures to control unwelcome and unintended issues such as substance abuse and violence in prisons.***

38 *16th Report - Children and young people in custody*, p 12

39 Centre for Mental Health, *The future of prison mental health care in England: A national consultation and review*, June 2021, p 34

3 Mental illness in prison

Community sentences for those with mental health problems

41. Sentencers can be faced with offenders who have a multitude of problems including mental illness but who are not so acutely mentally ill that treatment in hospital is required. The circumstances of their offences may be such that a community order would be an option if combined with treatment for their mental illness. To this end, Mental Health Treatment Requirement orders were introduced in 2005, but make up only 1% of community sentences.[40] The Ministry of Justice accepts that these orders have been under-used and is committed to increasing the availability of community sentences with treatment requirements. In its '*A Smarter Approach to Sentencing*' white paper it says:

> In the past the use of the existing treatment options available under a community sentence has been low. We, in partnership with the NHS, are increasing the availability and usage of Community Sentence Treatment Requirements (CSTRs), to deliver tailored interventions and support rehabilitation of those with a range of treatment needs.[41]

42. Alex Chalk, then the Prisons Minister, told us: "We have a target to increase the number of CSTRs [Community Sentence Treatment Requirements] with a mental health treatment requirement to cover 50% of England and Wales by 2023, and we want to go further still."[42]

43. **Too many offenders are imprisoned because community orders with mental health treatment requirements are unavailable in many areas. The Government's target that community orders with mental health treatment requirements should be available across 50% of England and Wales by 2023 is insufficiently ambitious. It is unacceptable that in many parts of the country and for years to come, sentencers will continue to be obliged to send offenders to prisons simply because appropriate community sentences are unavailable.**

44. ***The MoJ and the NHS should accelerate plans to increase the availability of Community Sentence Treatment Requirement orders, so these orders are available options for sentencers in all parts of England and Wales by 31 March 2023.***

Mental health screening on arrival in prison

45. Arrival in prison, whether for the first time or not, is a dangerous point for prisoners' mental health with concomitant risks of self-harm and suicide. This area has seen improvements: for example, since 2018 the NHS contract has required healthcare providers to carry out first-day screening for all prisoners arriving in prison.[43] The current NHS service specification also includes a follow-up assessment within seven days of arrival.[44]

46. Kate Davies, Director for Health and Justice at NHS England, told us how important the first night and seven-day follow-up screening is:

40 Q99
41 Ministry of Justice, *A Smarter Approach to Sentencing*, CP 292, September 2020, p 39
42 Q129
43 Q119
44 *Service specification Primary care service – medical and nursing for prisons 2020*, pp 17 and 46

> 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."[45]

47. A serving prisoner wrote to us about difficulties identifying mental health problems at the initial screening:

> The self-referral process involved in identifying mental health problems on initial reception to prison is not fit for purpose. First time prisoners are generally in a complete daze, or on auto-pilot upon initial reception to prison. It takes time for people to build up the confidence to talk about their ailing mental health, let alone self-refer to the mental health team.[46]

48. Kate Davies told us that not all prisoners are screened on arrival and that that a smaller proportion of Black, Asian and other Minority Ethnic prisoners get their follow-up health assessment than do white counterparts: "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,[47]

> … for second screening [it] is 65% for black and minority men and women and 73% for our white patients.[48]

49. Lower levels of screening for Black, Asian, and other Minority Ethnic prisoners are especially concerning given that the Lammy Review[49] demonstrated that Black, Asian and Minority Ethic individuals are less likely to be identified with problems such as learning difficulties or mental health concerns on reception at prison than other prisoners. Kate Davies told us: "It is very important that we identify where those outliers [prisons with lower screening rates for Black, Asian and other Minority Ethnic prisoners] are."[50] It was clear that this work was still to be done.

50. The Royal College of GPs submitted evidence about the levels of training of staff carrying out assessments:

> At present, there is a competitive tendering process for contracts and considerable operational variation across UK prisons as a result. First night and secondary screening assessments are undertaken mainly by primary care nurses or health care support workers under the supervision of a primary care nurse. These healthcare practitioners have variable experience in mental health and there is no consistent requirement for mental health training for the workforce in prisons. Additionally, officers at a third of prisons inspected in 2019 had not undertaken adequate mental health awareness training. It is therefore possible that men and women coming into prison with mental health issues are not being picked up either through

45 Q119
46 MHP0084
47 Q119
48 Q121
49 *The Lammy Review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System*, p48
50 Qq122–123

> the health entry screening processes or by prison staff…[51]

51. **It is unacceptable that one in 12 prisoners do not have a health screening appointment within 24 hours of arrival and that Black, Asian, and other Minority Ethnic prisoners who have a mental health condition are less likely to have that identified than their white counterparts.**

52. ***The NHS should identify why some establishments have difficulties screening prisoners within 24 hours of arrival and should put in place action plans with the healthcare providers at those establishments to remedy this.***

53. ***The NHS should review its mental health services specification so that mental health screening is always carried out by a competent mental health professional with experience of the criminal justice system.***

54. ***The NHS should accelerate its work to understand why there is a racial disparity in identifying mental health issues in prison and implement a solution.***

Identification of mental health problems that arise in prison

55. Prisoners may not disclose a mental health issue on arrival or prisoners' mental health may deteriorate while they are in prison. The Royal College of GPs submitted evidence about the importance of prison staff in identifying prisoners with mental health issues and directing them to mental health services:

> While in prison, mental health issues may be identified through behavioural observations by staff and healthcare teams on the wings and by self-reporting of problems by patients. Training of staff is essential to enable timely identification of mental health issues. Additionally, there needs to be reduced stigmatisation of vulnerability and accessible information about mental health services and the range of available support from mental health teams, prison chaplaincy, prison key workers and peer support workers. At present, information is frequently inaccessible to people with lower literacy skills, language barriers and neurodiversity issues which can leave them without a clear understanding of how they can be supported while in prison.[52]

56. Prison officers on residential wings receive introductory training about mental health as part of key-worker training.[53] The prison officer key worker initiative is promising but given the scale of mental ill health in prisons greater expertise would be valuable. Alex Chalk, then the Prisons Minister, told us that training is important but so too is experience:

> One of the most effective tools at your disposal is someone providing a bit of common sense and experience […] 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. […] I see holding on to prison officers, allowing them to develop that experience […] is so important in providing some of that immediate interface with

51 Royal College of General Practitioners (MHP0059)
52 Royal College of General Practitioners (MHP0059)
53 Q154

> people who are very often extremely complex, sometimes very damaged and potentially in need of mental health support.[54]

57. The Prison Officers Association told us that mental illness was increasing in prisons and called for better training for prison officers:

> The crisis of mental health in our prisons has intensified in recent years, with rising numbers of prisoners suffering from a variety of conditions, ranging from depression to serious personality disorders. An aging prison population is also causing an increase in dementia. With mental health problems getting worse, it is more important than ever that prison officers receive adequate training to support the mental health of all those in their care.[55]

58. MIND in Camden described the impact that the training it provides can have:

> In a follow-up meeting after training, the officer told us […] he was able to support a young man who had made attempts to take his own life. The officer was honest in saying that previously he would have said the man was 'just showing attention seeking behaviour' […] The detainee stabilised and upon release, told the prison officer 'you saved my life that time, truly'.
>
> […] immediate listening humanises the individual's distress, referrals can take a long time and many are refused. It also increases prison officers' confidence and job satisfaction, plus frees up overly stretched mental health services […] The officer said he's used what we taught him many times, and since has been given an award from the prison recognising his achievements.[56]

59. With respect to becoming mentally ill in prison, there are particular concerns about the effect of the (now defunct) Indeterminate Sentences for Public Protection on the mental health of those subject to them.[57] Several serving prisoners wrote to us about the impact that not having a parole date had on their mental health and their difficulties accessing the treatment programmes they needed to complete in order to reduce their risk to the public, leaving them feeling without hope. The Committee will follow this Report with an inquiry into IPP prisoners during the remainder of 2021.

60. The Parole Board set out how unidentified mental illness can hamper and delay its decisions: "All too often, mental health concerns are identified far too late in the parole process, which makes it very difficult to put in place measures to support the prisoner to engage meaningfully in their parole review, and can cause delays."[58]

61. **Prison officers and other operational staff play a vital role in identifying and supporting prisoners who need mental healthcare and signposting prisoners to this treatment. Having the time to talk to and listen to prisoners is a key part of this, particularly those with difficulties absorbing written information due to poor literacy, language barriers, or neuro-difficulties. We agree with the Prisons Minister that**

54 Q159
55 POA – the Professional Trades Union for Prison, Correctional & Secure Psychiatric Workers (MHP0039)
56 Mind in Camden (MHP0018).
57 UNGRIPP (MHP0061)
58 Parole Board for England and Wales (MHP0048)

experience should complement, not substitute training.

62. ***HMPPS should (with the Royal Colleges and other experts in the field of prison mental healthcare) develop training for prison officers and other operational staff on how to identify mental illness and how to support and signpost prisoners to treatment. It should establish regular refresher training.***

Effect of the covid-19 pandemic

63. HMPPS responded to the covid-19 pandemic by severely restricting social contact for prisoners among themselves, among those working in prison, and with friends and family. Prisoners were largely confined to their cells 23 hours a day, seven days a week and face-to-face visits from family and friends ended. Access to work, education, rehabilitative courses, the chapel, the gym, and library almost all stopped. This undoubtedly saved lives but has taken a toll on prisoners' mental health. HM Inspectorate of Prisons reported in February 2021

> The most disturbing effect of the restrictions was the decline in prisoners' emotional, psychological and physical well-being … In our fieldwork we saw a sense of hopelessness and helplessness becoming engrained… The cumulative effect of such prolonged and severe restrictions on prisoners' mental health and well-being is profound.[59]

64. Women prisoners have been particularly affected by a lack of contact with supportive fellow-prisoners[60] and not seeing their families. Male prisoners reported some decrease in anxiety at the beginning of the 'lockdown' due to a reduction in issues such as bullying, and a sense of the restrictions being necessary and for their own protection. One prisoner who wrote to us said "The only saving grace has been that we understand that for once, whether in person or the community we are all in the same boat."[61] However, prisoners across the male, female and children and young people's estates report feeling worse as time has gone on.[62] HM Inspectorate of Prisons described this as follows:

> Some prisoners described their low mood. Others had been diagnosed with clinical depression and prescribed antidepressant medication during the pandemic. Some felt that their unprecedented isolation was already causing them psychological damage. Others were concerned for friends who would go for days without coming out of their cell.
>
> […]
>
> Some adult prisoners described general anxiety about the implications for their health of catching COVID-19. With such prolonged periods behind their cell door without distraction, their anxieties had escalated and were reinforced by the news and conversations with their families. They worried about their health while they waited for COVID-19 test results. They wanted to talk to health care staff about their fears but were not able to see them.

59 HM Inspectorate of Prisons thematic review, *What happens to prisoners in a pandemic?*, February 2021, p4
60 POA – the Professional Trades Union for Prison, Correctional & Secure Psychiatric Workers (MHP0039)
61 MHP0084
62 HM Inspectorate of Prisons thematic review, *What happens to prisoners in a pandemic?*, February 2021, Section 2

> […]
>
> Adult prisoners told us that they had struggled to access mental health services because of the COVID-19 restrictions. Prisoners who had been undergoing individual and group-based therapy before the pandemic said that their mental health had deteriorated when these services had been abruptly suspended. Inevitably, some prisoners were due to be released into the community without completing their prescribed therapy.[63]

65. Many of the prisoners who wrote to us told us how hard they had found it. For example one said "covid-19 means all of us are to one extent or another emotionally scarred." And from another "at weekends we could be in this solitary confinement for 60 hours at a time".[64]

66. The POA told us that the conditions in prisons were affecting the mental health of staff even before the pandemic: "The soaring levels of prisoner violence, self-harm and suicides have an appalling effect on staff mental health."[65] Phil Copple, Director General in HMPPS, drew our attention to the contribution of frontline staff during the pandemic:

> 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.[66]

67. One of the serving prisoners who wrote to us for this inquiry praised the staff:

> Reward the prison officers and nurses who've worked during the pandemic. Most of whom couldn't go home, slept at friends/other officers homes to ensure their families wasn't put at transmission risk, that the officers could keep coming to work, the prison officers and nurses are overlooked heroes. As are prison chaplains too.[67]

68. **We recognise that prison staff have been under extra pressure during the pandemic and may face uncertainty as the prison restrictions are eased. We would like to express our appreciation again of all those who work in prisons.**

69. We asked Dame Anne Owers, who is National Chair of the Independent Monitoring Boards, and was Her Majesty's Chief Inspector of Prisons between 2001 and 2010, what response would be needed following the pandemic. She said:

> 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."[68]

63 HM Inspectorate of Prisons thematic review, What happens to prisoners in a pandemic?, February 2021, pp 24–25
64 MHP0071
65 POA – the Professional Trades Union for Prison, Correctional & Secure Psychiatric Workers (MHP0039)
66 Q172
67 MHP0071
68 Q93

70. We asked Alex Chalk and Kate Davies about the deterioration in prisoners mental health and what they planned to do in response. They said they hoped to continue some innovations introduced during the pandemic including video medical appointments and the scheme to prevent prisoners becoming homeless on release.[69] There did not appear to be a plan in place to address the scale of demand for mental health treatment that has built up during the pandemic.

71. **Prisoners have shared the anxieties of the general population about possibly becoming ill themselves with covid-19 or their loved ones becoming ill. This has been combined with the most severe restrictions on their daily lives, going beyond those experienced by the general population. For example, family contact was restricted, and in circumstances where enhanced digital access was not available, the restriction on family access would potentially have exacerbated the effect on prisoners' mental health. We recognise and understand that the restrictions on prisoners during the period of the pandemic will have saved numerous lives, but, we are concerned about the impact of the pandemic on prisoners' mental health and how well prepared HMPPS and NHS will be for the increase in the need for mental healthcare services as a result.**

72. ***The Ministry of Justice, HMPPS and NHS England should take urgent steps to increase provision of mental healthcare services over the coming 12 months so that prisoners whose mental health has deteriorated because of the pandemic can be treated.***

73. ***HMPPS should build on its existing management guidance and occupational health services to increase its support for the mental well-being of those who work in prisons.***

Transfers to secure hospital settings for prisoners with acute mental illness

74. The NHS's 14-day target for transferring acutely ill prisoners to mental health beds is not working because of a shortage of secure mental health beds. As a result, acutely ill people are being held (some for many months) without access to the medical treatment they need. Recent research has found that average transfer times were as follows: to high security beds = 159.6 days; medium security = 58.6 days; low security = 54.8 days; and psychiatric intensive care = 16.1 days.[70] Ill prisoners may be kept in segregation owing to the risk they pose to others. The government proposes introducing a statutory time limit for transfers, but not until new NHS good practice guidance on transfers (issued on 10 June 2021) has been 'embedded'.

75. Phil Copple, Director-general HM Prison Service set out some of the impacts of delays in transferring prisons with acute and serve mental illnesses promptly to hospital:

> 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.

69 Q171–172

70 The Royal College of Psychiatrists (MHP0052) referred to Craster, L. and Forrester, A. (2020), "Mental Health Act transfers from prison to psychiatric hospital over a six-year period in a region of England", Journal of Criminal Psychology, Vol. 10 No. 3, pp. 219–231.

> […] 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.[71]

76. In the white paper on reforming the Mental Health Act 1983, the Department for Health and Social Care and the Ministry of Justice have proposed introducing a statutory time limit for transfers but not until after new guidance (which was issued by the NHS on 10 June 2021) has been 'embedded':

> … we will introduce a 28 day time limit, split into two sequential, statutory time limits of 14 days each: first from the point of initial referral to the first psychiatric assessment, and then from the first psychiatric assessment until the transfer takes place.
>
> …Stakeholders […] have argued that enshrining the time limit in statute could result in unintended consequences if not carefully managed. For example, clinicians may avoid recommending hospitalisation if they, or their employing authority, are likely to be penalised for not meeting the deadline [...] we will not commence this provision until the new NHSEI[72] guidance is properly embedded.[73]

77. Historically, there was a view that some personality disorders were untreatable, but according to the Royal College of Psychiatrists this is no longer the case: "Recent research makes it clear that mental health services can, and should help people with personality disorders."[74] We are concerned that the Independent Monitoring Boards said one reason some acutely unwell prisoners are held in segregation is because "some very unwell prisoners fall outside the scope of such [Mental Health Act] assessments, because their behaviours, however extreme, are deemed not to derive from treatable mental health conditions."[75]

78. **It is inappropriate that severely mentally ill prisoners are kept in prison, sometimes in segregation. Despite the best efforts of prison staff this can result in periods of inhumane treatment. We welcome the proposal to introduce statutory time limits for transferring prisoners with acute and severe mental illness to appropriate mental health inpatient beds, but this will not solve the underlying problem which is the shortage of appropriate secure mental health inpatient facilities.**

71 Q124
72 NHSEI stands for NHS England and NHS Improvement
73 Reforming the Mental Health Act, webpage accessed 5 July 2021
74 Royal College of Psychiatrists, Personality disorder, webpage accessed 15 July 2021
75 Independent monitoring boards (MHP0036)

79. ***The Ministry of Justice should work with the Department for Health and Social Care and the NHS to increase immediately the availability of mental health inpatient beds for prisoners from those prisons that have the most difficulty transferring prisoners within the time limit, including for those who are considered by some of those involved to have 'untreatable' conditions.***

80. ***HMPPS and the NHS should gather and publish monthly information for every establishment (without naming establishments to protect patient confidentiality) on the number of prisoners awaiting transfers to inpatient care for mental illness and for how long they have been waiting.***

Joining up services on arrival at and departure from prison

81. There are longstanding difficulties ensuring continuity of medical care for prisoners as they arrive, move around the prison system, and are released. Practice Plus Group told us that it often takes too long for prisoners' medical information to be made available to those responsible for looking after them when they arrive in prison:

> The challenge of supporting people on arrival is exacerbated by the lack of access to information. Mental health services electronic patient notes are not accessible at the point of arrival and information available via the general practice electronic medical records systems is limited.[76]

The importance of getting information to the right people was set out starkly by the Independent Advisory Panel on Deaths in Custody: "Investigations frequently raise problems with information transfer as a cause of death."[77]

82. Kate Davies, Director of Health and Justice at NHS England, told us that some of the apparent barriers to sharing data had been overcome as part of the response to the pandemic. She said:

> 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.[78]

83. Further problems arise at release. Martin Jones, Chief Executive Officer of the Parole Board,[79] told us of the difficulties the Parole Board can face making sure that appropriate care is available in the community so that higher-risk prisoners (who are those that the Parole Board decides about) can be released safely.

> 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,

76 Practice Plus Group (MHP0016)
77 Independent Advisory Panel on Deaths in Custody (MHP0053)
78 Q172
79 The sentences dealt with by the Parole Board include life sentences, indeterminate sentences for public protection, some fixed sentences and recall cases (meaning that the offender was previously released but has been subsequently returned to prison custody). The Parole Board can also advise on moves of some prisoners from a closed to an open prison.

> that risk can be managed in the community, […][80]

> It is not at all unusual for us to find that a case will take 18 months to two years to reach a conclusion […][81]

84. The Parole Board described a vicious circle where it cannot authorise release without community services being in place, but community mental health teams will only accept responsibility after release has been approved:

> Parole Board members have experienced serious problems in community mental health teams only accepting responsibility for community management and supervision post-release, when release has been approved by the Parole Board. This is an issue as mental health may be an active risk management factor in the community and the Parole Board is unable to support release until community mental health support is confirmed.[82]

Martin Jones also told us that not providing appropriate support can result in prisoners being returned to prison: "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 […]"[83]

85. Most prisoners are lower risk and are released without the Parole Board being involved. Many of those who submitted written evidence to this inquiry told us of communication problems and other difficulties that meant that mental healthcare often stopped on release. For example, the Royal College of GPs said:

> Prisoners who do not have a fixed address prior to release face real challenges as to who is responsible for taking over care. Even where referrals to community mental health services are made, patients are frequently not contacted by community teams in a timely manner after release.[84]

86. Kate Davies told us of the importance the NHS places on its new 'care after custody' programme (known as RECONNECT).[85] She told us of the need to ensure prisoners could continue to get the medications prescribed to them while in prison and be able to continue cognitive therapy or similar programmes when they are released. She told us "unfortunately because of Covid [RECONNECT] has not yet got up to speed as we would have liked."[86]

> there are 11 [pathfinders]. We are now rolling out to have the coverage of RECONNECT services across the board by 2024.[87]

The Ministry of Justice told us that it is piloting Health and Justice Partnership Co-ordinators at five prisons to help improve continuity of medical care on release.[88]

80 Q111
81 Q114
82 Parole Board for England and Wales (MHP0048)
83 Q115
84 Royal College of General Practitioners (MHP0059)
85 The NHS Long Term Plan, Appendix on Health and the justice system, para 10, webpage accessed on 12 July 2021.
86 Q126
87 Q170
88 Ministry of Justice (MHP0044)

87. **Making medical information systems interoperable between prisons and the community is challenging but vital if appropriate care (including the correct medication) is to be provided from arrival in prison through to release. Progress has been made during covid-19 and this should be built on.**

88. ***As a matter of urgency, the Ministry of Justice, the Department for Health and Social care, HMPPS and NHS England should introduce arrangements so that all prisoners' medical records are swiftly available between prisons and between the community and prison and vice versa. They should set a joint target date for this work to be completed and a timeline towards it.***

89. **Some parole decisions are delayed because prisoners applying for parole have undiagnosed mental illness that limit their participation in the parole application process. There are further delays due to insufficient co-operation from community mental health teams in arranging packages of services for prisoners for their release.**

90. ***Prison healthcare providers should systematically assess the mental health of prisoners coming up for parole and make sure that any needing support and treatment have it in good time before they make an application.***

91. ***NHS England should liaise with the Parole Board to identify local areas where there are problems arranging mental health treatment packages for prisoners under consideration for parole. NHS England should then work with the new NHS Integrated Care Systems and providers to help them understand and fulfil their responsibilities so that these prisoners may be released safely and promptly.***

92. **Despite longstanding difficulties arranging continuity of healthcare for prisoners on their release, the NHS RECONNECT programme, which is meant to resolve these problems, is in its infancy. In the meantime, prisoners who have been receiving treatment in prison for mental illnesses are often released to find that there are no services for them in the community, including no medication. The transition from prison to life outside is challenging enough for these prisoners without this sudden withdrawal of their mental health support and treatment. It does not benefit the public if these prisoners fall into chaotic lifestyles, with the increased risk of re-offending that brings, because the support and treatment they had in prison has been removed.**

93. ***The NHS should learn early lessons swiftly from its RECONNECT pathfinder projects and accelerate roll-out of the most important features across all prisons in the interim between now and 2024 when it intends to have completed the full roll-out. Similarly, HMPPS's five Health and Justice Partnership Co-ordinator pilots should be evaluated as soon as possible and if this evaluation is positive, they should be implemented across all prisons. The findings from the pathfinders and the pilots should be published.***

4 Use of prison to accommodate mentally ill people because community care is not available

'Place of safety' under the Mental Health Act 1983

94. Some people who are acutely mentally ill are being sent to prison as there is nowhere else that is safe for them to be. Prisons are used as an emergency 'place of safety' under the Mental Health Act 1983 simply because there is no mental health bed available for them in the community.[89] People can be kept in a place of safety under the Mental Health Act for up to 36 hours if there is medical advice to support it.[90]

95. Dr Russell Green, Medical Director, Mental Health and Substance Misuse, at Practice Plus Group,[91] set out for us the difficulties faced by the courts that result in some acutely mentally ill people being sent to prison:

> When someone is detained by the police and it is identified that they are mentally unwell, they get a full assessment by a psychiatrist or other appropriately qualified person. If, at that point, it is recognised that they need to be in hospital, the process, if necessary, of detaining them under the Mental Health Act should happen and they should go to hospital. What seems to happen is that it does not happen quickly enough. The clock, in a sense, is running and they find themselves before a judge or magistrate before the process of completing the Mental Health Act assessment is done or often before a bed can be found. At that point—and I have every sympathy with the court—they are left in the position of saying, "What else can we do?" Therefore, the person ends up in prison.
>
> My experience is that everyone within that process is trying to do their best, but I suspect one of the big challenges is the availability of a bed on the local mental health ward, which means there just is not time to source a bed somewhere else.[92]

96. In January 2021, the Department of Health and Social Care and the Ministry of Justice made a commitment to end the use of prison as a place of safety in their white paper on reforms to the Mental Health Act.[93] This commitment is, however, dependent on the establishment of viable alternatives:

> It is important to prepare for any legislative change with the relevant adaptations on the ground, supported by the necessary new investment. We will consider introducing guidance for the courts and will ensure that

89 A 'place of safety' is defined in section 135(6) of the Mental Health Act 1983 as: "residential accommodation provided by a local social services authority; a hospital; a police station; an independent hospital or care home for mentally disordered persons; or any other suitable place the occupier of which is willing temporarily to receive the patient." Prisons are not mentioned.

90 Mental Health Act 1983 sections 135 and 136

91 Practice Plus Group is commissioned to provide healthcare including mental health in over 50 prisons in England.

92 Q25

93 Reforming the Mental Health Act, webpage accessed 5 July 2021

> the necessary adaptations and investment are in place before legislative changes are commenced as a final step to delivering this objective.[94]

97. **We welcome the proposal in the Mental Health Act Reform white paper to end the use of prison as a 'place of safety' and the recognition that this must be supported by investment in alternatives. Problems with access to emergency mental health services (including a shortage of beds on general psychiatric wards) are at the heart of the problem.**

98. ***The Government must, as a matter of urgency, see through its proposal to establish viable alternatives so that prisons are no longer used as a place of safety under the Mental Health Act 1983. We recommend that the Department of Health and Social Care and the Ministry of Justice set a target to eliminate use of prison in this way by 31 March 2022 and monitor progress monthly towards this target in each NHS region in the meantime.***

Remands under the Bail Act 1976

99. In addition to the Mental Health Act 1983, there are provisions in the Bail Act 1976 that enable the courts to remand an adult to prison[95] for their 'own protection' from self-harm or harm from others, or in a child's case for their own 'welfare', without that person being convicted or sentenced – even in cases where the charge they face could not result in a prison sentence. There is no time limit and no requirement for a medical opinion.

100. Prisoners remanded to custody under the Bail Act 1976 may be kept in prison for a considerable time. These remands are used most often for women.[96] A Centre for Mental Health's recent review received evidence from Low Newton women's prison that in the three years 2017–2019:

> 18 women had been remanded for their own protection, three of these on more than one occasion with an average stay of 88 days, ranging from one day to one year. The primary reason appears to be for self-harm."[97]

101. The All Party Parliamentary Group on Women in the Penal System reported that "Using this power the courts can remove someone's liberty without expert evidence or any formal investigation into their circumstances, and without them having legal representation"[98] and "it is wrong in principle and damaging in practice for the most punitive sanction available to the state to be used to make up for failings in the community."[99] The government has not committed to amending the Bail Act 1976 although the Ministry of Justice is conducting a review into this issue that is due to report by the end of the year.[100]

102. NHS England provides liaison and diversion services to: identify people who have

94 ibid
95 Remands take place while a court case is proceeding.
96 All Party Parliamentary Group on Women in the Penal System, *For their own protection*, The Howard League for Penal Reform, 2020, p 2–3
97 Centre for Mental Health, *The future of prison mental health care in England: A national consultation and review*, , 25 June 2021
98 All Party Parliamentary Group on Women in the Penal System, *For their own protection*, The Howard League for Penal Reform, 2020, p 1
99 Ibid, p 1
100 HC Deb, 5 July 2021, c666

mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice [and] refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.[101] It is clear from the problems we have set out above that these services do not always work effectively for people who are mentally ill.

103. **The Courts use the provisions in the Bail Act 1976 to remand people to prison for their own protection or welfare only because proper alternatives in the community are not available. We are concerned about the lack of safeguards under this provision, the length of time men, women and children may be remanded, and the unsuitability of prison for them. The use of prisons in this way is wrong in principle.**

104. ***The Government should bring forward legislation by 31 March 2022 to amend the Bail Act 1976 so that it is unlawful to remand anyone to custody simply for their own protection or welfare.***

101 NHS England, About Liaison and diversion, webpage accessed 26 July 2021

Conclusions and recommendations

Understanding the need for mental healthcare in prisons

1. While there have been improvements in prison mental healthcare, provision is still not adequate. The high unmet need for treatment for mental illness in prisons is surprising and disappointing. Around 10% of prisoners were recorded as receiving treatment for mental illness with one suggestion that as many as 70% may have some form of mental health need at any one time. NHS work is long overdue to quantify the gap between mental health treatment needs and the services provided. (Paragraph 20)

2. *The NHS should use its prison mental health treatment 'needs analysis' to quantify shortfalls in mental health services, make plans and allocate resources so mental healthcare in prisons is at least equivalent to services outside prisons, having taken account of the specific needs of the prison population.* (Paragraph 21)

Commissioning prison mental healthcare services and models of care

3. *Healthcare services can be fragmented, meaning people receive no or inadequate care. NHS England and NHS Improvement should set out how they intend to bridge existing gaps in care and resolve the problems that result from fragmented service provision to ensure that all patients receive access to appropriate and adequate care.* (Paragraph 26)

4. Cost and quality are essential criteria on which to assess bid submissions in procurement processes. All commissioned services need to be cost effective and provide value for money, but cost should not be prioritised at the expense of quality. *NHS England should set out how they balance cost and quality criteria when procuring services.* (Paragraph 27)

5. Initiatives such as integrated healthcare, the trauma-informed approach in the women's estate, SECURESTAIRS in the youth estate, and the intensive programmes used on the Offender Personality Disorder pathway, are all welcome as far as they go. The comparatively few such services as yet provided within the youth estate have been relatively recently introduced. (Paragraph 38)

6. *The NHS should expand on its work to commission integrated healthcare across all three estates so that prisoners can access proper physical and mental healthcare services at primary and secondary level as appropriate and without undue delay.* (Paragraph 39)

7. *As the covid-19 restrictions in prisons are released, HMPPS (including the Youth Custody Service), should have plans ready for how it will reinvigorate its measures to control unwelcome and unintended issues such as substance abuse and violence in prisons.* (Paragraph 40)

Mental illness in prison

8. Too many offenders are imprisoned because community orders with mental health treatment requirements are unavailable in many areas. The Government's target that community orders with mental health treatment requirements should be available across 50% of England and Wales by 2023 is insufficiently ambitious. It is unacceptable that in many parts of the country and for years to come, sentencers will continue to be obliged to send offenders to prisons simply because appropriate community sentences are unavailable. (Paragraph 43)

9. *The MoJ and the NHS should accelerate plans to increase the availability of Community Sentence Treatment Requirement orders, so these orders are available options for sentencers in all parts of England and Wales by 31 March 2023.* (Paragraph 44)

10. It is unacceptable that one in 12 prisoners do not have a health screening appointment within 24 hours of arrival and that Black, Asian, and other Minority Ethnic prisoners who have a mental health condition are less likely to have that identified than their white counterparts. (Paragraph 51)

11. *The NHS should identify why some establishments have difficulties screening prisoners within 24 hours of arrival and should put in place action plans with the healthcare providers at those establishments to remedy this.* (Paragraph 52)

12. The NHS should review its mental health services specification so that mental health screening is always carried out by a competent mental health professional with experience of the criminal justice system. (Paragraph 53)

13. *The NHS should accelerate its work to understand why there is a racial disparity in identifying mental health issues in prison and implement a solution.* (Paragraph 54)

14. Prison officers and other operational staff play a vital role in identifying and supporting prisoners who need mental healthcare and signposting prisoners to this treatment. Having the time to talk to and listen to prisoners is a key part of this, particularly those with difficulties absorbing written information due to poor literacy, language barriers, or neuro-difficulties. We agree with the Prisons Minister that experience should complement, not substitute training. (Paragraph 61)

15. *HMPPS should (with the Royal Colleges and other experts in the field of prison mental healthcare) develop training for prison officers and other operational staff on how to identify mental illness and how to support and signpost prisoners to treatment. It should establish regular refresher training.* (Paragraph 62)

16. We recognise that prison staff have been under extra pressure during the pandemic and may face uncertainty as the prison restrictions are eased. We would like to express our appreciation again of all those who work in prisons. (Paragraph 68)

17. Prisoners have shared the anxieties of the general population about possibly becoming ill themselves with covid-19 or their loved ones becoming ill. This has been combined with the most severe restrictions on their daily lives, going beyond those experienced by the general population. For example, family contact was restricted, and in circumstances where enhanced digital access was not available, the restriction on family access would potentially have exacerbated the effect on

prisoners' mental health. We recognise and understand that the restrictions on prisoners during the period of the pandemic will have saved numerous lives, but, we are concerned about the impact of the pandemic on prisoners' mental health and how well prepared HMPPS and NHS will be for the increase in the need for mental healthcare services as a result. (Paragraph 61)

18. *The Ministry of Justice, HMPPS and NHS England should take urgent steps to increase provision of mental healthcare services over the coming 12 months so that prisoners whose mental health has deteriorated because of the pandemic can be treated.* (Paragraph 62)

19. *HMPPS should build on its existing management guidance and occupational health services to increase its support for the mental well-being of those who work in prisons.* (Paragraph 63)

20. It is inappropriate that severely mentally ill prisoners are kept in prison, sometimes in segregation. Despite the best efforts of prison staff this can result in periods of inhumane treatment. We welcome the proposal to introduce statutory time limits for transferring prisoners with acute and severe mental illness to appropriate mental health inpatient beds, but this will not solve the underlying problem which is the shortage of appropriate secure mental health inpatient facilities. (Paragraph 78)

21. *The Ministry of Justice should work with the Department for Health and Social Care and the NHS to increase immediately the availability of mental health inpatient beds for prisoners from those prisons that have the most difficulty transferring prisoners within the time limit, including for those who are considered by some of those involved to have 'untreatable' conditions.* (Paragraph 79)

22. *HMPPS and the NHS should gather and publish monthly information for every establishment (without naming establishments to protect patient confidentiality) on the number of prisoners awaiting transfers to inpatient care for mental illness and for how long they have been waiting.* (Paragraph 80)

23. Making medical information systems interoperable between prisons and the community is challenging but vital if appropriate care (including the correct medication) is to be provided from arrival in prison through to release. Progress has been made during covid-19 and this should be built on. (Paragraph 87)

24. *As a matter of urgency, the Ministry of Justice, the Department for Health and Social care, HMPPS and NHS England should introduce arrangements so that all prisoners' medical records are swiftly available between prisons and between the community and prison and vice versa. They should set a joint target date for this work to be completed and a timeline towards it.* (Paragraph 88)

25. Some parole decisions are delayed because prisoners applying for parole have undiagnosed mental illness that limit their participation in the parole application process. There are further delays due to insufficient co-operation from community mental health teams in arranging packages of services for prisoners for their release. (Paragraph 89)

26. *Prison healthcare providers should systematically assess the mental health of prisoners*

coming up for parole and make sure that any needing support and treatment have it in good time before they make an application. (Paragraph 90)

27. *NHS England should liaise with the Parole Board to identify local areas where there are problems arranging mental health treatment packages for prisoners under consideration for parole. NHS England should then work with the new NHS Integrated Care Systems and providers to help them understand and fulfil their responsibilities so that these prisoners may be released safely and promptly.* (Paragraph 91)

28. Despite longstanding difficulties arranging continuity of healthcare for prisoners on their release, the NHS RECONNECT programme, which is meant to resolve these problems, is in its infancy. In the meantime, prisoners who have been receiving treatment in prison for mental illnesses are often released to find that there are no services for them in the community, including no medication. The transition from prison to life outside is challenging enough for these prisoners without this sudden withdrawal of their mental health support and treatment. It does not benefit the public if these prisoners fall into chaotic lifestyles, with the increased risk of re-offending that brings, because the support and treatment they had in prison has been removed. (Paragraph 92)

29. *The NHS should learn early lessons swiftly from its RECONNECT pathfinder projects and accelerate roll-out of the most important features across all prisons in the interim between now and 2024 when it intends to have completed the full roll-out. Similarly, HMPPS's five Health and Justice Partnership Co-ordinator pilots should be evaluated as soon as possible and if this evaluation is positive, they should be implemented across all prisons. The findings from the pathfinders and the pilots should be published.* (Paragraph 93)

Use of prison to accommodate mentally ill people because community care is not available

30. We welcome the proposal in the Mental Health Act Reform white paper to end the use of prison as a 'place of safety' and the recognition that this must be supported by investment in alternatives. Problems with access to emergency mental health services (including a shortage of beds on general psychiatric wards) are at the heart of the problem. (Paragraph 97)

31. *The Government must, as a matter of urgency, see through its proposal to establish viable alternatives so that prisons are no longer used as a place of safety under the Mental Health Act 1983. We recommend that the Department of Health and Social Care and the Ministry of Justice set a target to eliminate use of prison in this way by 31 March 2022 and monitor progress monthly towards this target in each NHS region in the meantime.* (Paragraph 98)

32. The Courts use the provisions in the Bail Act 1976 to remand people to prison for their own protection or welfare only because proper alternatives in the community are not available. We are concerned about the lack of safeguards under this provision, the length of time men, women and children may be remanded, and the unsuitability of prison for them. The use of prisons in this way is wrong in principle. (Paragraph 103)

33. *The Government should bring forward legislation by 31 March 2022 to amend the Bail Act 1976 so that it is unlawful to remand anyone to custody simply for their own protection or welfare.* (Paragraph 104)

Formal minutes

Tuesday 21 September 2021

Members present:

Sir Robert Neill, in the Chair

Rob Butler	Kate Hollern
Angela Crawley	Laura Farris
Janet Daby	Dr Kieran Mullin
Maria Eagle	Andy Slaughter

The following declarations of interest to the inquiry were made.[102]

Draft Report (*Mental health in prison*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 104 read and agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

[Adjourned till Tuesday 19 October at 1.45 pm

102 For a full record of interests in relation to this inquiry see the formal minutes for the inquiry pertaining to meetings on 8 June 2021 and 22 June 2021.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 08 June 2021

Dr Sarah Hewitt, Consultant Forensic Psychiatrist, Central and North West London NHS Foundation Trust; **Dr Russell Green**, Medical Director Mental Health and Substance Misuse, Practice Plus Group; **Dr Sarah Allen**, Consultant Clinical Psychologist and Lead Psychologist for Health and Justice and OPD Services, Central and North West London NHS Foundation Trust	Q1–39
Dr Jake Hard, Chair, Secure Environments Group, Royal College of General Practitioners; **Dr Josanne Holloway**, Chair of the Faculty of Forensic Psychiatry, Royal College of Psychiatrists; **Simon Newman RN**, Head of Healthcare, HMP Berwyn, Betsi Cadwaladr University Health Board	Q40–81

Tuesday 22 June 2021

Dame Anne Owers, Chair, Independent Monitoring Boards; **Juliet Lyon CBE**, Chair, Independent Advisory Panel on Deaths in Custody; **Martin Jones**, Chief Executive Officer, Parole Board	Q82–115
Alex Chalk MP, Parliamentary Under-Secretary of State, Ministry of Justice; **Kate Davies CBE**, Director for Health and Justice, NHS England and NHS Improvement; **Phil Copple**, Director General for Prisons, HM Prison and Probation Service	Q116–172

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

MHP numbers are generated by the evidence processing system and so may not be complete.

1 Asylum Welcome (MHP0043)

2 Befriending and Support Team for Foreign Nationals in HMP Wandsworth (BEST) (MHP0019)

3 British Psychological Society (MHP0045)

4 Buck, Dr Gillian (Senior Lecturer in Social Work, University of Chester) (MHP0013)

5 CNWL Foundation Trust, Health and Justice Services Directorate (MHP0029)

6 CNWL Foundation Trust, Health and Justice Services Directorate (MHP0027)

7 CNWL Foundation Trust, Health and Justice Services Directorate (MHP0028)

8 Centre for Mental Health (MHP0026)

9 Clinks (MHP0041)

10 Criminal Justice Alliance (MHP0046)

11 De Profundis LTd (MHP0011)

12 Department of Health and Social Care (MHP0062)

13 G4S Custody & Rehabilitation Services (MHP0058)

14 HMI Prisons (MHP0064)

15 Howard League for Penal Reform (MHP0055)

16 INQUEST (MHP0063)

17 Independent Advisory Forum on Deaths in Custody (MHP0053)

18 Independent monitoring boards (MHP0036)

19 Ismail, Nasrul (Lecturer in Criminology, School for Policy Studies, University of Bristol) (MHP0025)

20 Jamwal, Mr Rameshwar (President, Criminologists Society of J&K, India) (MHP0004)

21 Keep Prisons Single Sex (MHP0003)

22 Leese, Dr Maggie (Head of Department, Teesside University); Dr Victoria Bell (Principal Lecturer, Teesside University); and Jennifer Ferguson (Research Associate, Teesside University) (MHP0037)

23 Mackenzie, Dr Jay-Marie (Senior Lecturer, The University of Westminster); and Dr Coral Sirdifield (Research Fellow, University of Lincoln) (MHP0032)

24 McManus, Sally (Senior Lecturer, Violence and Society Centre, City, University of London and NatCen Social Research); Prof Traolach Brugha (Professor of Psychiatry, Department of Health Sciences, University of Leicester); and Professor Paul Bebbington (Emeritus Professor of Psychiatry, Division of Psychiatry, UCL) (MHP0033)

25 Maslaha (MHP0060)

26 Mind in Camden (MHP0018)

27 Ministry of Justice (MHP0044)

28 Moran, Professor Dominique (Professor in Carceral Geography, University of Birmingham) (MHP0005)

29 NACRO (MHP0049)

30 Nottinghamshire Healthcare NHS Foundation Trust (MHP0038)

31 POA – the Professional Trades Union for Prison, Correctional & Secure Psychiatric Workers (MHP0039)

32 POhWER (MHP0022)

33 Padfield, Professor Nicola (Professor, University of Cambridge) (MHP0014)

34 Parole Board for England and Wales (MHP0048)

35 Pattinson, Ms Tamara (MHP0002)

36 Practice Plus Group (MHP0016)

37 Prison Governors Association (MHP0057)

38 Prison Reform Trust (MHP0030)

39 Prisoner Learning Alliance (MHP0006)

40 Rethink Mental Illness (MHP0020)

41 Royal College of General Practitioners (MHP0059)

42 Royal College of Nursing (MHP0010)

43 Royal College of Psychiatrists (MHP0052)

44 Royal College of Psychiatrists, Quality Network for Prison Mental Health Services (QNPMHS) (MHP0047)

45 Royal College of Speech and Language Therapists (MHP0051)

46 Samaritans (MHP0056)

47 Slade, Dr Karen (Associate Professor of applied forensic psychology , Nottingham Trent University); and Rich Pickford (Knowledge Exchange and Impact Officer, Nottingham Civic Exchange) (MHP0009)

48 Swansea Bay University Health Board (MHP0040)

49 Takeda UK Ltd (MHP0050)

50 The Centre for Crime and Justice Studies (MHP0035)

51 The Disabilities Trust (MHP0031)

52 Think Through Nutrition (MHP0012)

53 Tomczak, Dr Philippa (Principal Research Fellow, University of Nottingham) (MHP0008)

54 UNGRIPP (MHP0061)

55 VoiceAbility (MHP0017)

56 Weston, Claire (MHP0021)

57 Women in Prison (MHP0054)

58 Youth Justice Board (MHP0034)

59 Zahid Mubarek Trust (MHP0023)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2021–22

Number	Title	Reference
1st	The Coroner Service	HC 68
2nd	Rainsbrook Secure Training Centre	HC 247
3rd	The future of legal aid	HC 70
4th	Covid-19 and the criminal law	HC 71
1st Special	The future of the Probation Service: Government Response to the Committee's 18th Report of 2019–21	HC 475
2nd Special	Rainsbrook Secure Training Centre: Government Response to the Committee's Second Report of 2021–22	HC 565
3rd Special	The Coroner Service: Government Response to the Committee's First Report	HC 675

Session 2019–21

Number	Title	Reference
1st	Appointment of Chair of the Office for Legal Complaints	HC 224
2nd	Sentencing Council consultation on changes to magistrates' court sentencing guidelines	HC 460
3rd	Coronavirus (COVID-19): The impact on probation services	HC 461
4th	Coronavirus (Covid-19): The impact on prisons	HC 299
5th	Ageing prison population	HC 304
6th	Coronavirus (COVID-19): The impact on courts	HC 519
7th	Coronavirus (COVID-19): the impact on the legal professions in England and Wales	HC 520
8th	Appointment of HM Chief Inspector of Prisons	HC 750
9th	Private prosecutions: safeguards	HC 497
10th	Sentencing Council consultation on sentencing guidelines for firearms offences	HC 827
11th	Sentencing Council consultation on the assault offences guideline	HC 921
12th	Children and Young People in Custody (Part 1): Entry into the youth justice system	HC 306
13th	Sentencing Council: Changes to the drugs offences definitive guideline	HC 751

Number	Title	Reference
14th	Appointment of the Chair of the Independent Monitoring Authority	HC 954
15th	Appointment of the Chief Inspector of the Crown Prosecution Service	HC 955
16th	Children and young people in custody	HC 922
17th	Rainsbrook Secure Training Centre	HC 1266
18th	The future of the Probation Service	HC 285