Equality and Human Rights Commission consultation on non-natural deaths of detained adults with mental health conditions in England and Wales

The Prison Reform Trust is an independent UK charity working to create a just, humane and effective penal system. We do this by inquiring into the workings of the system; informing prisoners, staff and the wider public; and by influencing Parliament, Government and officials towards reform.

The Prison Reform Trust is grateful for the opportunity to respond to the Equality and Human Rights Commission's Inquiry. The Inquiry will focus on human rights in the treatment of people who have mental health needs of learning disabilities. In particular, the Inquiry will explore:

- What happens to people with these conditions when they are held in custody?
- What can be done to improve treatment or conditions for them?

Background

Mental health problems are prevalent among prisoners, but it is difficult to quantify because there has not been a fully robust audit of mental health in the prison population since 1998[i].

More recent data confirm that mental health morbidity is much higher in prisons than outside. As cited in the Prison Reform Trust's *Prison Factfile*, a 2013 survey found that 25% of women and 15% of men in prison reported symptoms indicative of psychosis, as compared to a rate of 4% in the general population[ii]. While about 16% of the general public suffer from anxiety and depression, this was true of 49% of women and 23% of male prisoners. The same study found that 49% of women and 21% of male prisoners reported having attempted suicide, as compared to about 6% in the general population[iii].

The National Offender Management Service (NOMS) publishes a wealth of statistics about deaths in custody:

In the year ending March 2014, NOMS recorded 88 self-inflicted deaths; the highest number in the past ten years. In the five previous years (2009-2013) the average annual number of self-inflicted was 59, so 88 represents a dramatic increase. The shift is not explained by a rise in the total prison population, as the rate per 1000

prisoners increased from 0.6 deaths in the 12 months to the end of March 2013 to 1.0 deaths per 1000 at the end of March 2014[iv].

Figures published in the *Prison Factfile* shed further light on self-inflicted deaths in custody:

- Between 1990 and 2012, 462 young people aged 18-24 died in prison; 85% of these deaths were classified as self-inflicted
- In 2012, 30% of self-inflicted deaths were by prisoners held on remand, despite comprising 13% of the prison population on average during the year
- People on the basic regime represent 2% of the prison population, but accounted for 8% of self-inflicted deaths in custody between 2007 and 2012
- In an analysis of over 200 reports into self-inflicted deaths in custody, the Prisons and Probation Ombudsman found that nearly two-thirds of deaths took place in local prisons[v].

Human Rights

The EHRC Inquiry draws attention to the importance of the rights of prisoners under Article 2 ('the right to life') and Article 14 ('protection from discrimination'). These standards are extremely important in the context of non-natural deaths in custody of people with mental health needs or learning disabilities. Imprisonment places them in settings where their choices about how to meet their needs are restricted.

In addition to these standards, we believe that the European Prison Rules (2006) should inform the Inquiry's scope. In particular, EPR Basic Principle 1 holds that prisoners shall be treated with respect for human rights; and Principle 4 directs that: "Prison conditions that infringe prisoners' human rights are not justified by lack of resources.[vi]"

This submission will explore four approaches which – applied in combination – have the potential to prevent and reduce non-natural deaths in custody

- Diversion from the criminal justice system
- Maintaining decent and humane conditions in prison
- Identifying individuals vulnerable to suicide
- Empowering individuals to seek support during a crisis.

All four can help, but they must be applied in balance.

Diversion

Although the EHRC will focus on how vulnerable people are treated while in custody, the prior question is why people with mental health needs or learning disabilities have not been diverted from prison. Our recent joint report with the charity Inquest, *'Fatally Flawed'* explores the deaths of young adults in custody and indicates gaps in care and treatment leading up to their imprisonment. We should like to submit this report as part of our evidence to the EHRC inquiry: *Fatally Flawed: Has the state learned lessons from the deaths of children and young people in prison?* an in-depth analysis of the deaths of children and young people (aged 18-24) while in the care of the state.

The Parliamentary Joint Committee on Human Rights (2004) in its investigation of deaths in prison stated that the problem should not be seen in isolation from prior criminal justice processes:

> "The evidence we have gathered suggests that prison actually leads to an acute worsening of mental health problems. By sending people with a history of attempted suicide and mental health problems to prison for minor offences the state is placing them in an environment that is proven to be dangerous to their health and well-being.[vii]"

To prevent self-inflicted deaths in custody among people with mental health needs or learning disabilities requires greater use of alternatives to custody (such as community sentences) and diversion to mental health or social care (from courts or earlier in the criminal justice process). The Prison Reform Trust, together with over 30 organisations representing almost two million people across health, justice and civic society, promotes *Care Not Custody.*[viii] We welcome the Government's commitment to invest in (£75million Dept of Health funding), and promote, increased use of diversion and liaison services in police stations and courts across England with full roll-out by 2017.

Decent and Humane Conditions

HM Chief Inspector of Prisons, Nick Hardwick, recently stated:

> "Prisons are less safe. The reasons why any individual who is despairing tips over into a suicide are very diverse, but if you put together the lack of staffing levels, the overcrowding, the lack of activity, then I don't think it is credible to deny that those are contributory factors.[ix]"

Prison overcrowding increases the risk of self-inflicted deaths. Overcrowded local prisons:

- Hold people on remand
- Have a high turnover
- Have a high proportion of prisoners in their first month of custody
- Provide fewer hours of meaningful activity

- Hold higher proportions of people who have problems with mental health or drug misuse.

All of these are well-established risk factors for self-inflicted death. In addition, overcrowded prisons are more stressful environments, due to cramped cells, the strain on basic resources such as diet, showers, and toilets, and the risk of victimisation by other prisoners. Staff, under pressure, have less time for first night schemes and proper assessments and less time to get to know prisoners personally or to give them caring attention.

Almost two-thirds of prison suicides occur in local prisons, although they hold 38 per cent of the total prison population[x]. The Joint Committee on Human Rights drew a link between overcrowding and an increased risk of self-inflicted deaths:

> "The overcrowding of the prison system . . . places people with drug and alcohol dependencies as well as mental illness in a system that is at breaking-point and unable to meet its duty of care to them.[xi]"

A report by the Criminal Justice Alliance, *Crowded Out? The impact of prison overcrowding on rehabilitation*, (2012) described other effects of prison overcrowding which contribute to an increased risk of self-inflicted death and self-harm:

> "Overcrowding places pressure on healthcare facilities, so that prisoners do not have access to the level of support they need. The disruption of churn can do damage to a prisoner's mental wellbeing;
>
> 26% of self-harm incidents occurred within the first month of arriving in a prison. The Prison and Probation Ombudsman found in an analysis of deaths in prison that the location of the cell was inappropriate in 10% of all cases. Examples included: holding Rule 45 prisoners (those who were deemed to be too vulnerable to be housed on normal location) on normal location due to overspill or overcrowding.[xii]"

Professor Alison Liebling's evaluation of the safer prisons initiative – based in 12 local prisons - found a statistical correlation between average rates of suicide in specific prisons and levels of distress among prisoners. The evaluation found that levels of distress could be reduced through: improved staff-prisoner relationships, increased purposeful activity, and enhanced safety. The study concluded:

> "Key ingredients of a survivable prison were safety, relationships, fairness, activity and individual level care. These were *provided* by: good first night centres; substantial induction and detoxification procedures; a dedicated reception area and staff; well-functioning inreach (with a broad remit); well motivated, responsive staff, with time to talk; careful use of power by staff; an ethos of de-escalation; an effective anti-bullying strategy; a predictable/consistent, high provision regime; having multiple sources of support (including Listeners, insiders and family contact); good communication, confidence among staff, good staff-management

> relationships; and a responsive regime where prisoners felt they could 'make things happen' by asking.[xiii]"

Clearly there is no easy way to measure the relationship between cost per prisoner and the quality of care. However, decent and humane conditions are undermined by budget cuts, and the Inquiry should consider the current deterioration in prison conditions in the light of EPR Basic Principle 4: "Prison conditions that infringe prisoners' human rights are not justified by lack of resources." Liebling's study demonstrates that treating all prisoners respectfully and decently is fundamental to reducing the risk of suicide.

Identifying those vulnerable to suicide or self-harm

ACCT: Assessment, Care in Custody and Teamwork, is the plan which focuses multi-disciplinary support on those identified as at acute risk and matches support to their individual needs. Opening an ACCT document is the gateway to the process. The ACCT plan has had mixed outcomes in preventing self-inflicted death.

A study of 180 self-inflicted deaths among prisoners in 2008 – 2010 found that 35 of those were on an ACCT; that is, only one in five of those who took their lives had been identified as currently at risk at the time of their death[xiv]. Two factors help to explain why four in five prisoners who suffered a self-inflicted death were not identified as being at risk at the time.

First, the characteristics of someone at risk of suicide are pervasive in prisons. A study in 2003 by Jenny Shaw of 172 self-inflicted deaths in custody identified characteristics which predicted a higher risk:

> • 110 (72%) had at least one psychiatric diagnosis identified at reception. The commonest diagnosis was drug dependence
>
> • 46 (32%) had a second (co-morbid) diagnosis, indicating more complex treatment needs
>
> • 95 (62%) had a history of drug misuse
>
> • 46 (31%) had a history of alcohol misuse
>
> • 78 (53%) had a history of self-harm
>
> • 89 (57%) had symptoms of psychiatric disturbance on reception to prison
>
> • 46 (30%) had a history of contact with NHS mental health services[xv].

Jenny Shaw *et al.* have written that:

> "Many of the risk factors for self-harm and suicide identified in this study are found in the general prison population. It is therefore recognised that those at risk of suicide are difficult to identify.[xvi]"

The second factor is that an acute risk of suicide is periodic. Crises of intense personal distress may be short-lived; the person might get through a crisis early in custody only to have it re-surface later.

It is crucial that prison staff be alert to signs that an individual is acutely at risk. However, suicide prevention strategies must acknowledge that the ACCT process has a low predictive power. The Prison Service cannot reduce suicide solely by focusing special treatment on a few who are identified by staff. An emphasis on the ACCT plan in targeting support may undermine broader changes to the social climate that could have a more significant impact.

Other studies have found that the ACCT process is not consistently working as it should. NOMS' 'National Safer Custody Managers & Learning Team' reported in 2011 that a two year audit cycle had reported weaknesses in more than half of the prisons audited in respect of:

- following the required ACCT process where it was appropriate so to do;
- completion of regular reviews and targeted reviews when circumstances change; and
- sharing of concerns between different disciplines with the prison when these indicate risk change.

The Prisons and Probation Ombudsman's (PPO) review, 'Self Inflicted deaths of prisoners on ACCT' was published in April, 2014. The PPO found:

> "Too many cases where the ACCT procedure is not followed as thoroughly as it should have been or where case reviews are not carried out within the specified timescales or information is not recorded. The ACCT should be a live plan which is reviewed and updates when a prisoner's circumstances or risk change, again this does not always happen.[xvii]"

The PPO found that ACCT processes were not correctly implemented or monitored in half of the cases of self-inflicted death that he investigated, with roughly a quarter of these being 'very poorly' implemented.

The Prison Reform Trust's programme, No One Knows, gathered evidence on the particular needs of prisoner who have learning disabilities or learning difficulties. Identification of a learning disability was patchy. No One Knows estimated that 20-30% of prisoners have learning disabilities or difficulties that interfere with their ability to cope with the criminal justice system. Yet, when No One Knows interviewed 173 selected prisoners, fewer than half had been screened or assessed to determine whether they had a learning disability or difficulty[xviii]. Figures on disability from the prisons inspectorate's prisoner survey are generally higher than NOMS statistics. As a consequence, NOMS data on deaths in custody are unlikely to be reliable

indicators of the numbers of self-inflicted deaths in custody involving people with learning disabilities.

The failure to identify many who have learning disabilities also leads to their receiving an inferior regime. No One Knows found that having a learning disability barred them from full participation in the prison regime. Enforced idleness left them at greater psychological risk; many experienced high levels of depression and anxiety.

The EHRC Inquiry states that it will value evidence about abuse and bullying. The Prisons and Probation Ombudsman drew attention to the fact that aggression and vulnerability often co-exist. The PPO's report on self-inflicted deaths of young prisoners found: "a mixture of poor behaviour, aggression and vulnerability (including mental illness and repeated acts of self harm) evident in a number of young adult deaths.[xix]" Many of the people who become vulnerable to thoughts of suicide are also likely to be identified by staff as difficult, aggressive, or disruptive prisoners.

No One Knows found that found that prisoners with learning disabilities or difficulties were five times as likely to have been subject to control or restraint; and three times as likely to have spent time in segregation. Therefore, the Prison Reform Trust is not convinced that anti-bullying measures are the best way to alleviate the distress of people who are vulnerable to self-harm and suicide. It is likely that many of these will be identified by prison staff as 'bullies'.

Those who are at heightened risk of suicide are unlikely to gain reassurance by anti-bullying measures if the same vulnerable people have disabilities which have not been recognised, exhibit behaviour which is labelled manipulative or deliberately disruptive, and if they have been segregated or restrained, while others who previously exploited them carry on with impunity.

Without the necessary support, especially in new and/or distressing situations, the impact of prison can render an individual vulnerable. Some of the characteristics typical of people who have learning disabilities or difficulties include:

- limited language ability, comprehension and communications skills
- difficulties understanding certain words, understanding and responding to questions, reading body language and following social cues
- some may not be able to tell the time
- limited memory capacity, or difficulties recalling information
- delays in processing information
- problems with ordering and sequencing

- they can be acquiescent and suggestible, and under pressure, might try to appease others.

Prison Reform Trust recommends that every prison provides for learning disability specialists, improves assessment services, ensures that conditions, communications and treatment do not discriminate against those with learning disabilities, and delivers specialised follow-up support.

Empowering individuals to seek support when in crisis

The Listeners scheme is a peer support system for suicide prevention, based on the work of Samaritans. Selected prisoners, trained and supported by Samaritans, are available to fellow prisoners who are feeling suicidal and who wish to speak confidentially to someone who is sympathetic. Crucially, access to a Listener can be made by a prisoner in confidence, thus empowering people in crisis to find support which is independent of the Prison Service. Listeners schemes operate in over 100 prisons.

Research on how the Listener scheme operates found that confidentiality was important to prisoners, who valued the reassurance that the Listener would not disclose what they had talked about[xx]. They felt that Listeners were empathetic, caring and understanding. The study also assessed the impact that access to a Listener had on people who were distressed:

> "Many of the prisoners interviewed explained that an effect of talking to Listeners was a feeling of having been helped and a greater sense of mastery over their problems; for example, having the space to talk about problems, and being helped by a Listener to explore them, often helped prisoners to see them in a new light. Not only that, but prisoners described talking to Listeners as having a cathartic effect by being able to off-load and release pent up feelings.[xxi]"

More can be done to ensure that Listener schemes are sustainable, for example by consulting Samaritans about what they need to work with prisons more efficiently.

Conclusions

In this submission to the Equalities and Human Rights Commission's Inquiry into Non-Natural Deaths in Custody, the Prison Reform Trust has identified a range of measures which will contribute to the prevention of self-inflicted deaths in custody, particularly among people with mental health needs and or learning disabilities.

There needs to be greater investment in, and use of, alternatives to custody and diversion to mental health care.

Inside prisons, the prevention of self-inflicted deaths requires a commitment to raise the standards of decency. Prisons need to reduce levels of distress through improved staff-prisoner relationships, increased purposeful activity, and enhanced safety. Specific measures that should be maintained, especially in local prisons, include: compassionate first night centres; sensitive detoxification programmes; consistent regimes delivering a range of purposeful activities; multiple sources of support (including Listeners and family contact); good communication throughout the prison and a responsive management which enables prisoners to sense that they can access help with practical difficulties by asking staff.

Lack of resources can never be used as an excuse for conditions that infringe prisoners' human rights. However the Prison Reform Trust is concerned that some of the good preventative work undertaken by safer custody teams is being eroded by exceptional pressures on the prison service in general and reduced staffing levels in particular.

Every prison should provide learning disability specialists, improve assessment services and deliver specialised support. In addition, managers should ensure that conditions, communications and treatment do not discriminate against those with learning disabilities.

More can be done to ensure that Listener schemes are sustainable, for example by consulting Samaritans about what they need to work with prisons more efficiently.

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